East Lancashire Hospitals
NHS Trust
A University Teaching Trust

QUALITY ACCOUNT

2021 - 22

Safe | Personal | Effective

CONTENTS

EAST LANCASHIRE HOSPITALS NHS TRUST – QUALITY ACCOUNT REPORT 2021-22

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 10,000 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

www.elht.nhs.uk

1.3 Our Future

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

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

Across Pennine Lancashire we now integrate more closely with providers in the primary, community, voluntary and faith sectors. Trust clinicians increasingly work with their professional colleagues from other organisations to provide Lancashire-based sustainable networks which determine the standards of care, the governance and the delivery of care pathways.

As part of Place Based Partnership working, our key priorities for 2022/23 are to:

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

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

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

Our quality commitments focus on initiatives that will:

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

Strengthening Our Partnerships

Working in partnership across the Pennine Lancashire Place Based Partnership (PBP), the Lancashire and South Cumbria Provider Collaborative Board (PCB) and wider Lancashire and South Cumbria Integrated Care System/Board (ICS/ICB) has been a fundamental part

of our improvement journey so far and will continue to underpin all our work as we continue that journey.

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

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

Key new priority workstreams across Place and System are shown below:

Pennine Lancashire Place Based Partnership	• Population health • Children, Young People and Maternity • Primary care and community-based services delivered in neighbourhoods, including long-term condition management and social care • Urgent and emergency care (via an A&E Delivery Board*) • Intermediate Care • Elective Care, Cancer and Diagnostics (overseeing Restoration and Recovery work) • Care Sector (including regulated care and wider care) • Mental Health • Learning Disabilities and Autism
Lancashire and South Cumbria Provider Collaborative Board	• Musculoskeletal/Trauma and Orthopaedics' • Frailty • Respiratory • Cardiac/Circulatory • Mental Health and Physical Health Integration
Lancashire and South Cumbria Integrated Care System/Board	• Health and Wellbeing of our Communities • Living Well • Managing Illness • Urgent and Emergency Care • End of Life Care, including Frailty and Dementia

1.4 Our Approach to Quality Improvement

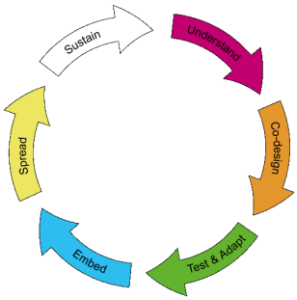
East Lancashire Hospitals NHS Trust has is committed to the continuous improvement of the quality of care provided and, in so doing, achieving our organisational aim 'to be widely recognised for providing Safe, Personal and Effective care.

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

To ensure that we are delivering Safe, Personal and Effective care we have a robust process for the identification and agreement of key improvement priorities. The Trust has an agreed set of improvement priorities covering 5 areas. Our improvement priorities are directly informed by our patient safety priorities identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation and wider Integrated Care Partnership, and in line with national requirements.

Improvement Practice:

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

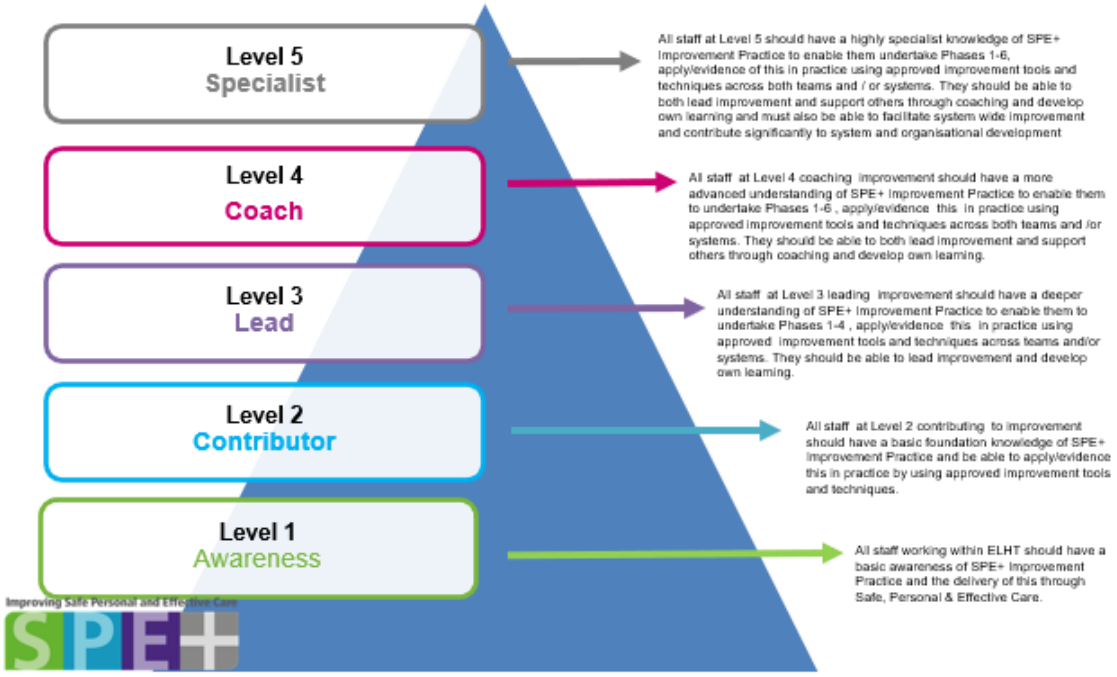


The development of our Improvement Practice has been supported through our involvement in the national NHS Improvement and NHS England Vital Signs Programme. Although this programme has now formally ceased, we continue to develop our Improvement Practice by continually reviewing national and internal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

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

SPE+ Improvement Practice Training Framework:

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

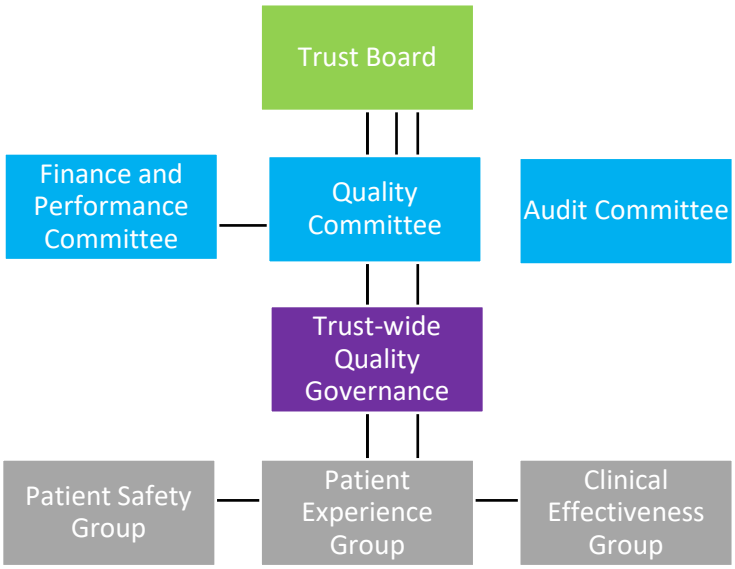


The Improvement Hub Team supports the organisation by coaching and facilitating on defined improvement programmes and projects linked to Trust and Divisional priorities. All Foundation doctors (FY 1&2's), Medical students (SSC 3&4's) and Trainee Advanced Clinical Practitioners contribute to and lead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

A staff development programme in improvement skills is in place both internally and through our membership of the Advancing Quality Alliance (AQuA). Professionals in training are supported to develop and participate in quality improvement projects. Support for projects is agreed within Divisions, approved through Divisional Clinical Effectiveness Committee and reported through to Clinical Effectiveness Committee.

Monitoring & Assurance:

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



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

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

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

Dr. Jawad Husain is the Executive Medical Director and the Lead for Clinical Quality.

Partnership Working:

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 2021-22. 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 2021-22.
- Performance during the last year against quality priorities set by the Trust.
- Performance during the last year against a range of nationally set quality indicators, initiatives and processes.
- Performance during the last year against a range of other quality indicators, initiatives and processes.

Our Quality Account has been developed over the course of 2021-22 as we have continually monitored and reported against our quality priorities and indicators both within the organisation and externally to the public, commissioners and regulators and at a national level. We invite you to provide us with feedback about this report, or about our services. If you wish to take up this opportunity, please contact:

Associate Director of Quality and Safety
East Lancashire Hospitals NHS Trust
Park View Offices
Royal Blackburn Teaching Hospital
Haslingden Road
BLACKBURN
BB2 3HH
Email: qualityandsafetyunit@elht.nhs.uk

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

The 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

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

The Care Quality Commission (CQC) conducted assurance interviews with three core services in 2021, in line with the Transitional Monitoring Approach (TMA) developed during the Covid 19 pandemic.

The core service lines completed online interviews with the CQC following submission of evidence, in line with a pre interview request. The CQC raised no concerns with regard to patient safety during or as a result of any of the three interviews, or the on-site visit in August 2021.

a) Urgent and Emergency Care, interviewed on 12 July 2021

b) Maternity (including Ockenden compliance), interviewed on 10 August 2021

c) Medicine (including older peoples services and stroke), interviewed on 21 September 2021

The TMA calls were informal and had no impact on the ratings above.

1.7 Our Chief Executive's Statement on Quality

East Lancashire Hospitals NHS Trust has continued to face the biggest challenge the NHS has ever faced with the COVID-19 pandemic. We have seen several periods where the number of patients being treated have risen and fallen sharply which has required a significant level of flexibility and resilience from our workforce. On 29 June 2021 we had the highest number of inpatients being treated for COVID-19 in the whole country whilst working tirelessly to restore elective and other services to their full capacity.

I have been in the post of Interim Chief Executive since September 2021. However, while this is a new role for me, I have been at the Trust for almost 10 years. I have always been exceptionally proud of our workforce and their commitment to providing the best quality of services for our patients and their passion to do that has not wavered in spite of the challenges faced since the virus arrived at our door on 15 March 2020.

Therefore, I am especially proud to introduce East Lancashire Hospital's NHS Trust's Quality Account 2021/22. This publication provides us with the opportunity to reflect on our quality achievements and successes over the last 12 months, as well as identifying areas where enhancements to quality can be made.

We are continuing to see significant demand for our services, especially our emergency care pathways which has a strain on our workforce and impacts patient experience. This is why I strongly believe the work outlined in this report is paramount to the Trust's ability to provide safe, personal and effective care whilst maintaining the wellbeing of our workforce.

I hope you find our latest annual Quality Account informative. I believe it to be an accurate account of the Trust's performance against our quality indicators. To the best of my knowledge, all the data and information presented in this 2021/22 Quality Account is true and accurate and the Quality Account has been approved by the Trust Board.

Martin Hodgson

Interim Chief Executive

2.0 PART TWO – QUALITY IMPROVEMENT

2.1 Our Strategic Approach to Quality

Introduction

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

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

Quality monitoring occurs through our Clinical Governance structure, reporting to the Board via the Quality Committee. The Quality Committee is informed by the Trust Wide Quality Governance Meeting (TWQG), Serious Incidents Requiring Investigation Panel (SIRI), Clinical Effectiveness Group (CEG), Patient Safety and Experience Group (PSG), Health and Safety Committee (H&SC), Internal Safeguarding Board and Infection Prevention and Control Sub-Committee. During the continued COVID 19 pandemic these sub-committees have reported directly through the TWQG to ensure relevant governance and escalation is still managed in the absence of that particular group. Divisional Directors or their agreed deputies attend and report at these committees. Reporting in Divisions replicates this corporate structure to ensure consistent reporting from 'floor to Board'.

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

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

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

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

The system continues to develop across Lancashire and South Cumbria, in line with the national move towards increased integration and we continue to support a system

wide approach to quality. As active system partners we continue to support the maintenance of quality at a system level as we continue to plan to develop healthcare services across the region.

Safe Care

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

In November 2019 the Trust was nominated as an Early Adopter of the Patient Safety Incident Response Framework (PSIRF), representing the NHS North-West region. The PSIRF model is described within the National Patient Safety Strategy (NPSS) and has underpinned changes to all aspects of Quality Governance and strengthens links to Improvement. The Pennine Lancashire region was significantly impacted by the Covid 19 global pandemic, which required refocused patient safety activity between 2020-2021.

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

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

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

Clinical Effectiveness

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

This portfolio includes:

a. National audits as mandated by the national contract
b. Other national audits included in the NHS England Quality Accounts list
c. Regional and local audits as determined by commissioners or regional bodies

d. Local quality audits (e.g. compliance with local care bundles)
e. Relevant national guidance (e.g. NICE)
f. Relevant National Confidential Enquiry (NCE) recommendations
g. Getting It Right First Time (GIRFT) data

Nationally there is a drive to collect continuous data to support real-time reporting on performance, supported by quality improvement activities delivered by audit providers. This has meant a continued focus on data completeness and data quality delivery within set deadlines to support ongoing learning and assurance from outcomes. Systems are also being developed in-house to support real-time data collection for local quality audits. To support this process there are Specialty Clinical Effectiveness leads supported by a Divisional Clinical Effectiveness Lead and a Quality and Safety Lead. They are responsible for developing the divisional portfolio of evidence and ensuring this includes all key priorities as well as ensuring alignment with other quality & safety intelligence i.e. patient safety and experience. This process is supported corporately by the Clinical Effectiveness Team.

Improvement (SPE+)

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

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

The Improvement Hub Team facilitate and support the delivery of the agreed Trust Improvement Priorities and Programmes of work, which comprises of 5 main priority areas:

- **Quality** improvement priorities
- **People** plan improvement priorities
- Operational delivery improvement priorities:
  - **Non-elective** pathways
  - **Elective** pathways
  - **Outpatient** pathways

The Quality Priorities for 2021/22 are defined from the current Quality Strategy (2017/19) and cover:

- Harms Reduction Programmes (HRP):
  - Falls
  - Medication Errors
  - Deteriorating Patient
  - Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) / CNST
  - SAFER Surgery
  - Infection Prevention
- End of Life Care
- Nutrition and Hydration

Our Quality improvement programme currently comprises a combination of:

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

In support of delivery of the key improvement priorities there is a combination of Trust-wide programmes e.g. Harms Reduction Programmes (HRP) and small projects registered by individual staff, teams, and departments. 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 Group.

During the Covid pandemic, we continued to prioritise the focus of Improvement work across the Trust to that which supported the organisational response to the pandemic and delivery of high-quality care for patients diagnosed with COVID-19, to support restoration of services and to ensure continued focus on key quality and safety issues.

Our future Quality improvement priorities will be directly informed by implementation of the Patient Safety Incident Reporting Framework (PSIRF), providing us with an opportunity to streamline and prioritise future improvement activity.

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

Monitoring and Improving the Safety Culture

The safety of both patients and staff in healthcare is influenced by the extent to which safety is perceived to be important. To help the Trust gain a better understanding and improve our safety culture in line with the National Patient Safety Strategy and the implementation of Patient Safety Incident Response Framework (PSIRF) the Trust is running a number of workshop with staff using the Manchester Patient Safety Framework (MaPSaF) which is designed to:

- Help teams recognise that patient safety is complex multidimensional concept
- Facilitate reflection on the patient safety culture with a team, division and Trust
- Stimulate discussion about the strengths and weaknesses of the patient safety culture
- Help understand how a Trust with a more mature safety culture might look
- Help the Trust evaluate any specific intervention to change the safety culture of the Trust

In addition, the Trust has also developed and introduced in 2022, Patient Safety Learning events which is a method of sharing learning from incidents to a wide range of staff and giving them the opportunity to look at the identified problems and why they happened, review the actions taken to improve safety and identify any further learning that may be required.

Mortality Reduction Programme

Over the last 12 months mortality indices have continued to be skewed by the effect of the coronavirus pandemic. The Trust, through the mortality steering group has focussed on assuring the quality of care and using the data to guide further enquiry.

The Trust continues to use the Structured Judgement Review (SJR) methodology via an electronic review process that is part of our patient safety risk management software system (Datix). The 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 mortality steering group has introduced quarterly thematic reviews from each division to identify key themes and triangulate these with other data sources.

The Trust continues to review all hospital deaths and has recently appointed additional medical examiners and medical examiner officers to roll out the medical examiner service to cover community deaths.

Personal Care

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

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

1. Friends and Family Test and local patient survey results remain a rich source of, relative, real-time patient and care feedback. From floor to Board can quickly obtain a snapshot of perceptions of care, with a Trust wide overview reported at the Patient Experience Group
2. Patient, Carer, and staff stories remain a crucial qualitative source of information, that influences our quality improvement work. These stories regularly feature at Trust Board and divisional meetings.
3. Complaints, concerns and soft intelligence are actively encouraged, and provide a smoke alarm to the organisation as to where we need to focus our attention. We support staff to provide the most appropriate and proportionate response to any matter.
4. National Surveys including the annual Adult In-Patient Survey, and national surveys of the Emergency Department, Maternity and the Children and Young People's Survey
5. The Trust continues to regularly meet with patient representative organisations such as Healthwatch - two local organisations (Healthwatch Lancashire and Healthwatch

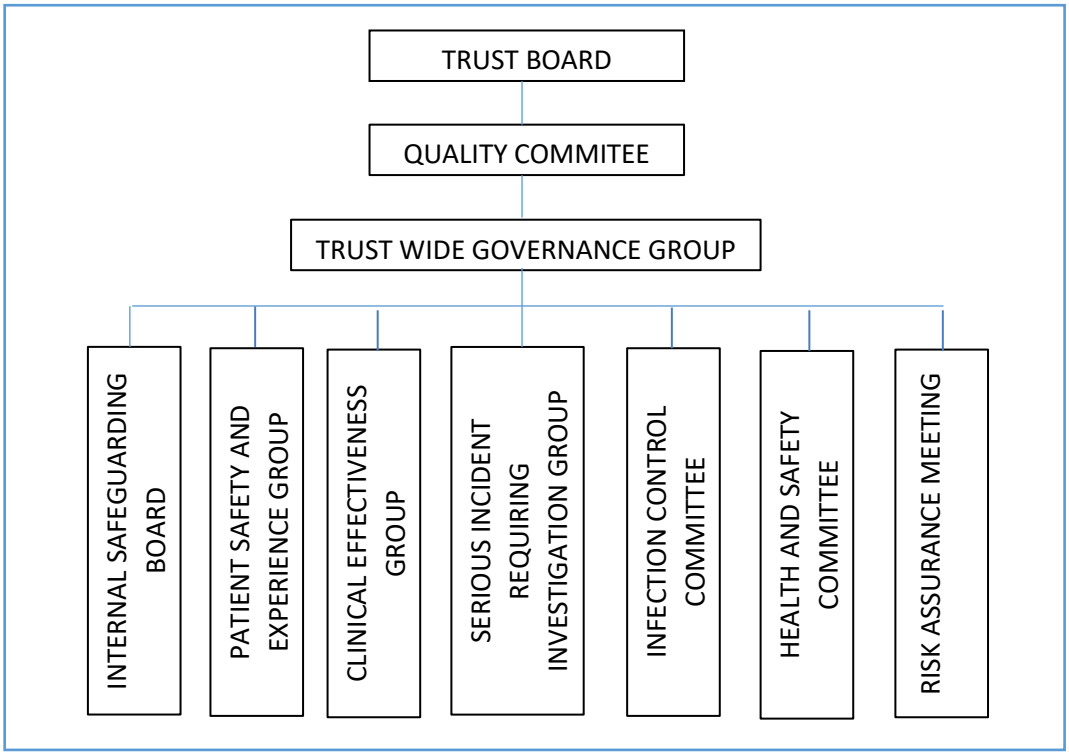
Blackburn with Darwen). Carers Service, N-Compass, VoiceAbility and Advocacy Focus. These organisations provide a critical friend role to the Trust, and we share best practice and regional and national initiatives in respect of patient experience.

6. Development of our Patient, Carer and Family Experience Strategy 2022-25.
7. The Trust's Public Participation Panel is well-established and actively involved in numerous projects and governance meetings. Whilst the Children and Young People's Forum is developing it approach to ensure we have a diversity of opinion as to how our services are delivered.

Governance Arrangements for Quality

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

Figure 1: Trust Governance Structures for Quality and Safety



2.2 Quality Monitoring and Assurance

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

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

The Trust Board is ultimately accountable for the delivery of quality outcomes and they are held to account by our regulators. Oversight of the Quality and Safety Framework is supported by a Quality 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.

During 2021-22 the East Lancashire Hospitals NHS Trust continued to provide and / or subcontracted 8 NHS Services. These services have been identified using the CQC's definition of regulated activities. The services provided during the year were:

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

The Trust has reviewed all the data available on the quality of care in all of these NHS services. The Trust continues to use its integrated quality, safety and performance scorecard to facilitate this and has begun using a Quality Dashboard to support triangulation. Reports to the Trust Board, the Quality Committee, Trust-wide Quality Governance Group and Senior Leaders Group all include data and information relating to quality of services. Progress

against last year's priorities for quality improvement, as set out in our Quality Account 2021-22; have been managed by way of these reporting functions.

The income generated by the NHS Services reviewed in 2021-22 represents 98% of the total income generated from the provision of NHS services by the East Lancashire Hospitals NHS Trust for 2021-22. (2020-21 98%).

2.3 Priorities for Quality Improvement 2022/23

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

Due to the response to the Covid pandemic there has been a delay in determining the future quality priorities for 2021-22 onwards and as an interim, work continued on the previous current Harms Reduction Programmes (Falls, SAFER Surgery, Medication Errors, Infection Prevention - Hand hygiene, MatNeoSIP, Deteriorating Patient), End of Life Care and Nutrition and Hydration.

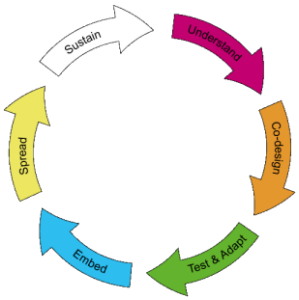
To refocus, a comprehensive engagement exercise was undertaken during June – December 2021. The workshops provided an opportunity to review the progress made against quality priorities from the last 3 years and to agree the future quality improvement priorities. The engagement exercise comprised of 5 virtual workshops:

1. **Friday 11th June 2021** – Quality Workshop 1: Senior Team (Senior Leadership Group/Quality Committee/Quality Governance Team/Improvement Hub Team/Divisional Triads)
2. **Friday 18th June 2021** – Quality Workshop 2: All staff
3. **Monday 28th June 2021** – Quality Workshop 3: Patients and Partners
4. **Friday 30th July 2021** - Reviewing early priorities from Developing Quality Priorities Workshops – Divisions
5. **Friday 3rd December 2021** - Report back the finalised Quality Priorities (both local & national) from previously held workshops

These priorities (see 1-5 below) will form part of the revised Quality Strategy 2022/25, the focus of the Patient Safety Incident Response Plan (PSIRP) and Quality Pillar.

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

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



The PSIRP priorities will supersede the current Harms Reduction Programmes. To provide assurance, a joint review will be undertaken by the Governance and Improvement Hub Quality Programme Leads for each of the current Trust-wide Harms Reduction Programmes and a closure report will be completed and presented at the relevant committees.

Our overall Improvement Programme will continue to comprise of a combination of:

Improvement Pillar	Improvement initiatives/programmes
Quality	• PSIRP Plan • Other key improvement priorities arising from National Reports/Audit, incidents, and complaints – Nutrition & Hydration, End of Life Care and Histopathology • Directorate and Divisional Quality Improvement Projects • Quality improvement (QI) projects for Staff in Training Groups
Non-Elective	• Improvement projects as agreed in the Emergency Care Improvement Plan
Elective	• Improvement projects as agreed in the Elective Improvement Plan
Outpatients	• Improvement projects as agreed in the Outpatient Improvement Plan
People	• People Strategy – Leadership and Organisational Development (OD) • Provider Collaborative Board improvement projects related to bank and agency spend improvement opportunities and Occupational Health Services. • Improvement Practice Training Offer – Relaunch of Level 2: Contributor & Level 3: Lead. Develop and launch Level 4: Coach
Other	
Partnership Working	• Lancashire and South Cumbria (LSC) System Model for Improvement launch and testing • Other Pennine Lancs priorities as required

Electronic Patient Record (e-PR) implementation	• Facilitation of Stop, Start, Continue process • Other selected change management/preparation activities
Waste Reduction Programme (WRP)	• WRP Training (Level 2 Improvement Practice: Contributor) • WRP Website development and management • WRP Ideas Registration • Other selected WRP projects

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 2021-22, The Trust was eligible for 55 national clinical audits and 8 national confidential enquiries. It participated in 95% (52) of these national clinical audits and 100% of the national confidential enquiries.

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 2021-22 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	Continuous	Yes	100%
Breast and Cosmetic Implant Registry (BCIR) -	BCIR	Continuous	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care (NACAP)	RCP	Continuous	Yes	100%
Elective Surgery (National PROMs Programme)	NHS Digital	Continuous	Yes	Ongoing
Fracture Liaison Service Database (FLSD) (FFFAP)	RCP	Continuous	Yes	100%
Fragility fracture post-operative mobilisation: a national audit on post-operative weight bearing instructions in adult patients undergoing surgery for lower extremity fragility fractures	BOA	Intermittent	Yes	Ongoing
Infection Prevention and Control (Care in Emergency Departments)	RCEM	Intermittent	Yes	Ongoing
Inflammatory Bowel Disease (IBD) Biological Therapies Audit	IBD Registry	Continuous	No	NA
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	Continuous	Yes	100%
Management of the Lower Ureter in Nephroureterectomy	BAUS	Intermittent	Yes	Ongoing
Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE)	BAUS	Intermittent	Yes	Ongoing
Myocardial Ischaemia National Audit Project (MINAP) - National Cardiac Audit Programme (NCAP)	NICOR	Continuous	Yes	100%
National Diabetes Inpatient Safety Audit (NDISA)	NHS Digital	Continuous	No	NA
National Acute Kidney Injury Programme	UKRR	Continuous	Yes	Ongoing
National Audit of Breast Cancer in Older Patients (NABCOP)	RCS	Continuous	Yes	100%

National Audit of Cardiac Rehabilitation	University of York	Continuous	Yes	100%
National Audit of Cardiac Rhythm Management (CRM)	NICOR	Continuous	Yes	100%
National Audit of Care at the End of Life (NACEL)	NHS benchmarking	Intermittent	Yes	100%
National Audit of Inpatient Falls (FFFAP)	RCP	Intermittent	Yes	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) - National Cardiac Audit Programme (NCAP)	RCP	Continuous	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	RCPCH	Intermittent	Yes	100%
National Bowel Cancer Audit (NBOCA)	NHS Digital	Continuous	Yes	100%
National Cardiac Arrest Audit (NCAA)	ICNARC	Continuous	Yes	100%
National Child Mortality Database	University of Bristol	Continuous	Yes	100%
National Comparative Audit of Blood Transfusion programme: 2021 Audit of NICE QS138 and PBM Survey	NHSBT	Intermittent	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 Transition (linkage with NPDA)	NHS Digital	Continuous	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	BSR	Continuous	Yes	100%
National Emergency Laparotomy Audit (NELA) Year 7	RCA	Continuous	Yes	100%
National Heart Failure Audit	NICOR	Continuous	Yes	100%
National Hip Fracture Database (FFFAP)	RCP	Continuous	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 Ophthalmology Database (NOD)	RCOphth	Continuous	No	NA
National Outpatient Management of Pulmonary Embolisms Audit	BTS	Intermittent	Yes	100%
National Paediatric Diabetes Audit (NPDA)	RCPCH	Continuous	Yes	100%
National Pregnancy in Diabetes Audit - Adults (NDA)	NHS Digital	Continuous	Yes	100%
National Prostate Cancer Audit (NPCA)	RCS	Continuous	Yes	100%
National Pleural Procedures Audit	BTS	Intermittent	Yes	100%
National Smoking Cessation Audit	BTS	Intermittent	Yes	100&
National Vascular Registry	RCS	Continuous	Yes	100%
Paediatric Asthma Secondary Care (NACAP)	RCP	Continuous	Yes	100%
Pain in Children (Care in Emergency Departments)	RCEM	Intermittent	Yes	Ongoing
Perioperative Quality Improvement Programme	RCA	Continuous	Yes	100%
Pulmonary Rehabilitation Organisational and Clinical Audit	RCP	Continuous	Yes	Ongoing
RESECT- Transurethral Resection and Single installation Mitomycine C evaluation in bladder cancer treatment	BURST	Intermittent	Yes	ongoing
Sentinel Stroke National Audit Programme (SSNAP)	RCP	Continuous	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	SHOT	Continuous	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	SAMBA	Intermittent	Yes	100%
Trauma Audit & Research Network (TARN)	TARN	Continuous	Yes	Ongoing
UK Foot and Ankle COVID-19 National Audit (UK- FA1CoN)	UHL	Intermittent	Yes	100%

Key to Audit Coordinator abbreviations	
BAETS	British Association of Endocrine and Thyroid Surgeons
BAUS	British Association of Urological Surgeons
BCIR	Breast and Cosmetic Implant Registry
BOTA	British Orthopaedic Trainees Association
BSR	British Society for Rheumatology
BURST	British Urology Researchers in Surgical Training
FFFAP	Falls and Fragility Fractures Audit Programme
HQIP	Health Quality Improvement Partnership
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care Audit & Research Centre

Key to Audit Coordinator abbreviations	
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
NICOR	National Institute for Cardiovascular Outcomes Research
NPDA	National Paediatric Diabetes Audit
RCA	Royal College of Anaesthetists
RCOG	Royal College of Obstetricians and Gynaecologists
RCOphth	Royal College of Ophthalmologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCPsych	Royal College of Psychiatrists
RCS	Royal College of Surgeons
RESECT	Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment
PROMs	Patient Recorded Outcome Measures
SAMBA	Society for Acute Medicine's Benchmarking Audit
TARN	Trauma Audit Research Network
SSISS	Surgical Site Infection Surveillance Service
UK- FA1CoN	UK Foot and Ankle COVID-19 National Audit
UKHSA	UK Health Security Agency
UKRR	UK Renal Registry

National Confidential Enquiries (NCE's)

Audit Title	Coordinator	Frequency	ELHT Participated	Data collection completed 2021 -22	Sample Submission
Medical and Surgical Clinical Outcome Review Programme: Epilepsy Study	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme Transition from child to adult health services	NCEPOD	Intermittent	Yes	Ongoing	100%
Medical and Surgical Clinical Outcome Review Programme: Crohn's Disease	NCEPOD	Intermittent	Yes	Ongoing	100%
Medical and Surgical Clinical Outcome Review Programme: Community Acquired Pneumonia	NCEPOD	Intermittent	Yes	Ongoing	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 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 69 national clinical audit reports and 5 National Confidential Enquiry reports were received and reviewed by the Trust in 2021-22. 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 Clinical Effectiveness Leads, this will be monitored via Trust Clinical Effectiveness Group to provide assurance that these reports are being reviewed and lessons learnt, and any subsequent recommendations and action captured
- The Medical Director / Designated Deputy may request clinical leads to present finding at Clinical Leaders Forum or Quality Committee for further assurance
- National audit activity which highlights the need for improvement will 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 Group and the Trust Quality Committee for on-going assurance and monitoring

180 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2021-22. The results of which were presented / scheduled to be presented at specialty/ multi-specialty audit or other appropriate forums and the Trust intends to take the following actions to improve the quality of healthcare provided:

- All local audit activity will continue to be presented and discussed at specialty/multi-specialty effectiveness meetings and/or appropriate forums where lessons learnt are captured, recommendations and actions agreed and shared to support improvement
- Monitoring of action matrices will occur at subsequent effectiveness or designated meetings to ensure that actions are implemented to agreed timescales led by the Specialty Clinical Effectiveness Lead
- All specialty effectiveness meeting minutes and action matrices will be shared for discussion at Divisional Clinical Effectiveness meetings or appropriate management forums. Outcomes will be included in divisional reporting to the Trust Clinical Effectiveness Group

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

2.4.2 Research and Development

The number of patients receiving relevant health services provided or subcontracted by ELHT in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee is 3952 recruited participants across 70 studies. We continued to recruit participants to Urgent Public Health Covid studies in the early part of 2021. In August 2021, National Institute of Health Research notified all sites that they should commence 'Operation: Restart', risk assessing paused and new studies and re-opening for recruitment and interventions wherever possible. Despite the challenges of COVID, the Trust continued to offer patients access to new, high quality research studies, with the local portfolio recovering strongly in the second half of the year.

2.4.3 National Tariff Payment System and CQUIN

As part of the response to the COVID-19 Pandemic the NHS adopted special payment arrangements for 2020/21 and 2021/22, removed the requirement to sign formal contracts and disapplied financial sanctions for failure to achieve national standards. A block payments approach for arrangements between NHS commissioners and NHS providers in England will remain in place for the 2021/22 financial year. Block payments to NHS providers are deemed to include CQUIN, and there will be no 2021/22 CQUIN financial incentive scheme (either CCG or specialised) for this entire period. To support the NHS to achieve its recovery priorities, CQUIN is being reintroduced from 2022/23

2.4.4 Care Quality Commission Compliance

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

The CQC conducted assurance interviews with three core services, in line with the Transitional Monitoring Approach (TMA) developed during the Covid 19 pandemic.

2.4.5 Data Quality Assurance

East Lancashire Hospitals NHS Trust submitted the following records during 2021-22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Records submitted from Apr 21 to Feb 22 (most recent figures):

- Admitted Patient Care 152,718
- Outpatient Care 593,592
- Accident & Emergency Care 182,939

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

Performance for Apr 21 to Feb 22 (most recent figures):

- Admitted Patient Care 99.9%
- Outpatient Care 100%
- Accident and Emergency Care 98.9%

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

Performance for Apr 21 to Feb 22 (most recent figures):

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

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

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

2.4.6 Information Quality and Records Management

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

The Data Security and Protection Toolkit sets out standards for maintaining high levels of security and confidentiality of information. Our Information Governance Assessment report for 21-22 is ongoing with the final submission due at the end of June 2022. The Data Security and Protection framework and workplan is overseen by the Information Governance Steering Group which is chaired by the trusts SIRO. The Information Governance Steering Group reports into the Trust's Audit Committee

2.4.7 Clinical Coding Audit

The following external clinical coding audits were carried out in 2021/22:

- **Data Security and Protection Toolkit Audit 2021-22 (200 episodes)** – Lancashire Coding Collaborative - lead auditor internal and second auditor provided by collaborative.

In addition to this, the department has one member of staff who has now qualified as a nationally Accredited Clinical Coding Auditor and they carried out the following internal coding audits (reduced due to COVID and staffing issues):

- Band 2 Performance Audits (50 episodes per coder x 4)
- Band 3 Chemotherapy Audits (50 episodes per coder x 4)
- Band 3 Promotion Audits (100 episodes per coder x 3)
- Targeted Band 4 Performance Audits (100 episodes per coder x 3)

- Chapter XVIII coding Audit (200 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 2021-22, 3402 enquiries were received from a variety of sources (1954 in 2020/21). The team reports key performance indicators to Executive and Divisional leads to closely monitor concerns raised and to ensure a timely response is provided. Within the enquiries, 389 were logged as formal complaints during this period (225 in previous year). Complainants are contacted as soon as possibly following raising their concerns.

The current policy ensures that complainants are kept informed and updated and that greater compassion is evident within responses. Further training is planned to raise awareness of complaints requirements and correct procedures to ensure that complaints are dealt with in a timely and appropriately manner, providing assurance that lessons are learned from complaints across the Trust and themes have been identified. This training includes local resolution, complaints policy, staff responsibilities and response writing. Regular reports now include more detail of these. Complainants have the right to take their complaint to the Parliamentary and Health Service Ombudsman if they remain dissatisfied with the Trust's response. During the financial year 2021-2022, 6 complaints were referred to the Ombudsman, 4 are currently under investigation by the Ombudsman and 2 are being reviewed for possible investigation.

2.6 Duty of Candour

The Duty of Candour (DOC) requirement (Health and Social Care Act 2008 Regulations 2014: Regulation 20), was established as a statutory duty for provider organisations in 2015 and is a requirement for registration with the Care Quality Commission (CQC). The Trust have developed a Being Open and Honest Policy to ensure an apology is given to all patients, families and carers where the Trust has caused moderate harm or above to a patient. The Trust has developed a Standard Operating Procedure for tracking and monitoring the delivery of Duty of Candour and a report is published twice weekly and made available to Divisional Quality and Safety Leads, to support clinical teams to deliver the regulation requirements in a timely manner. Oversight of the effectiveness of this procedure is vested in the Medical

Director and the Associate Director for Quality and Safety with assurance reports to the Trust's Quality committee. The Trust has an e-learning package for Duty of Candour which is available to all staff on the Trusts learning hub to access.

In September 2021 MIAA Internal Audit completed a Duty of Candour review to establish if the Trust had effective systems in place with regard to the statutory Duty of Candour regulations, and that there is compliance with the Trust Policy. Substantial assurance was provided, the review identified that controls were designed and operating effectively.

2.7 NHS Staff Survey Results

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

Indicator	Question	% Result
KF21 (Q15)	Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Workforce Race Equality Standard 1	86.3%
KF26 (Q14c)	In the past 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	14.1%

For Q15, ELHT has seen a decline on the previous year's percentage (87.2%), however this question has seen a decline nationally. ELHT is better than the national average of 82.5%.

For Q14c, ELHT has seen a significant improvement on the previous year's percentage (16.2%). ELHT is better than the national average of 19.5%.

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

3.1 Achievements against Trust Quality Priorities

Due to the COVID pandemic the Trust reviewed its Quality Priorities for the year and re-prioritised them to reflect:

- New quality priorities specifically linked to the organisational response to the pandemic
- Original priorities which needed to continue to support ongoing delivery of safe, personal and effective care.

The revised priorities are summarised below:

COVID/WINTER	NON-COVID
• COVID Cohort Wards • Ongoing COVID Management • Effective Flow / Site Management • Effective Ward Rounds/ Board Rounds • Effective and Safer Transfers • Improvement Weeks to support effective flow within the emergency pathway • Discharge to Assess • Frailty Improvement Plan	• Quality Harms Reduction Programme (key priorities) • SAFER Surgery – Briefs and Debriefs • End of Life Care • Nutrition and Hydration • Histopathology • Pharmacy • Improvement Practice Training • Staff in Training QI projects (144 x FY1/2, 81 x SSC 4 medical students, 9 TACPs – assigned to all the team)

The table below gives an overview of progress against the quality improvement priorities outlined above:

Improvement Priorities linked to COVID and Winter 2021-22	
COVID Cohort Wards	• Treatment escalation plan documentation implementation and embedding for all COVID-19 patients
Ongoing COVID management	• COVID rehabilitation pathway established for patients admitted to Critical Care with a diagnosis of COVID-19 • Long COVID service established in partnership with partners across Pennine Lancashire Integrated Care Partnership
Effective Flow / Site Management	• Development of ED Board-round app • Development of ED Criteria to Admit • Improvement of time to be seen in ED by the Acute Medical Team via in-reach • Improvement of specialty in-reach to ED • Continued improvement of Ambulance Handovers • Implementation of ED streamer tool and booked appointments at Burnley Urgent Care Centre, Accrington Minor Injuries Unit and Blackburn Urgent Care Centre • Identification of patient cohorts for admission to Albion Mill Intermediate Care Facility

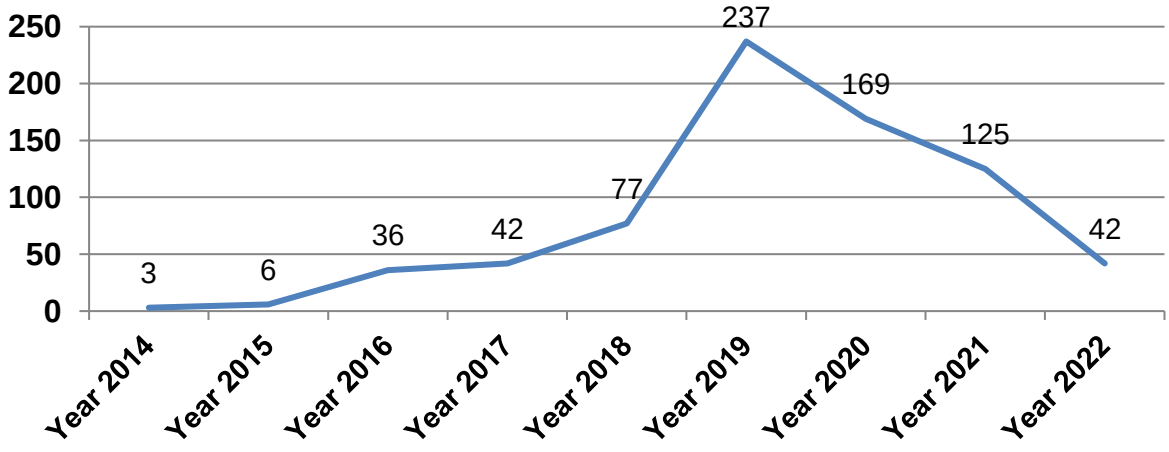
Effective Ward Rounds / Board Rounds	• Standard work for effective board rounds and ward rounds agreed • Implementation of improvement coaching on 10 medical wards • Rollout and launch of revised Daily MDT and Friday MDT Ward Round Proforma
Effective and Safer Transfers	• Identification of PDSAs to improve timeliness of transfer of patients from Royal Blackburn Hospital to community hospital sites. This resulted in an improvement of transfers by 2pm from 10% to over 60% and transfers between 2pm and 5pm increasing from 20% to over 50% • Rollout and launch of revised Trust Patient Transfer Decision Matrix
Improvement Weeks to support effective flow in the emergency pathway	• The Improvement Hub team facilitated several Improvement Weeks working with colleagues from across ELHT, Pennine Lancashire Place-Based Partnership and wider-Lancashire and South Cumbria Integrated Care System to facilitate a number of Improvement Weeks with a focus on supporting effective flow and discharge across the Emergency Pathway and focused on a number of improvement projects within each week: • #LSC Together Week June 2021 – focus on increasing utilization of the discharge lounge, improving timeliness of transfers to community, reduction in long length of stay • #LSCTogether Week October 2021 – focus on roll out of discharge care bundle and effectiveness of board and ward rounds. • Emergency Department Multi-Disciplinary Discharge Event December 2021 – focus on admission avoidance and increasing utilization of Intensive Home Support Service • #LSCTogether Weeks January 2022 – focus on reducing patients not meeting the criteria to reside (reduction of 35%) and increasing discharge by midday.
Discharge to Assess Value Stream Analysis Event	• Facilitation of 3day Value Stream Analysis event of the Discharge to Assess pathway with multi-agency stakeholders leading to agreement of Improvement Plan
Frailty Improvement Plan	• Facilitation of Pennine Lancashire Placed-Based Partnership event to review and agree future actions to develop Frailty Services across Primary, Community and Acute Care
Improvement Priorities (Non-COVID)	
Harms Reduction Programme	• Ongoing delivery of Harms Reduction Programme (refer to section 3.2 for details of achievements)
SAFER Surgery – Briefs & Debriefs	• Ongoing delivery of SAFER Surgery Improvement Programme (refer to section 3.2 for details of achievements)
End of Life Care (EOLC)	• Ongoing delivery of the EOLC Improvement Programme (refer to section 3.2 for details of achievements)
Nutrition and Hydration	• Ongoing delivery of Nutrition and Hydration Improvement Programme (refer to section 3.2 for details of achievements)

Histopathology	• Positive engagement from a variety of staff different staff roles in the improvement project • Early downward trend in Histology Reporting turnaround times • 3 working groups established and led by pathology staff – Communication, Processes and Environment • Introduction of daily huddles • Introduction of a structured monthly meeting • Removed non-value-added steps and waste from the frozen specimen reporting process and has increased capacity in other reporting processes • Created a cleaner and tidier working environment by developing and implementing standard work • Department selected for a visit from James Mountford (National Improvement Director NHS England) as part of the Improvement Practice at ELHT Day
Pharmacy	• Share to Learn process is being utilised by staff more frequently • Positive engagement from the wider team, has prompted staff champions to support sustainability • Two cross-site bitesize improvement PDSA events delivered – positive engagement and feedback from staff
Improvement Practice Training	• Re-launch of SPE+ Improvement Practice Training Levels 2 & 3 for all staff
Staff in Training	• Supporting staff in training to undertake quality improvement projects as part of their training requirements

Improvement Hub Activity

There are currently **451** Improvement Projects registered as 'live' – 'live' projects are classified as those in one of the SPE+ 6 phases.

Total number of Improvement Projects Registered (2014 – April 2022)



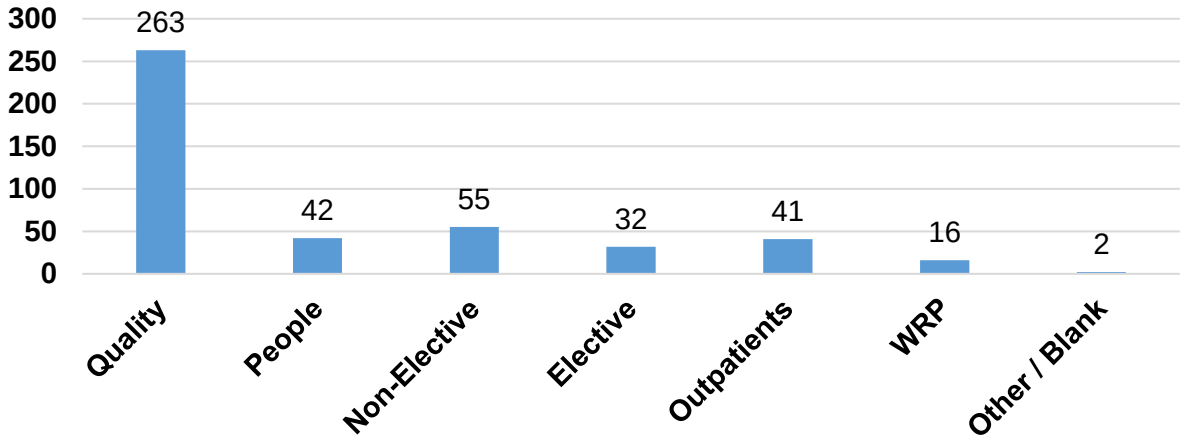
The significant increase of registered projects in 2019 shows the impact of the implementation of the improvement registration and triage processes. The decreases in years 2020 and 2021 reflect the impact of the Covid-19 pandemic and the response for some improvement activity to be stood-down and refocused. It may also reflect, the further work

and focus undertaken to 'prescribe' existing registered improvement projects to promote continuous improvement and establishing links to other key initiatives and programmes of work Trust-wide.

Total number and % of Improvement Projects Registered per Phase (2018 – April 2022)

Understand	Co-design	Test and Adapt	Embed	Spread	Sustain
181	48	98	36	15	73
40%	11%	22%	8%	3%	16%

Total number and % of Improvement Projects Registered per Improvement Pillar (2018 – April 2022)



3.2 Harms Reduction Programmes

ELHT's Harm Reduction Programmes encompass a number of different improvement initiatives designed to improve patient care and reduce harm. Each element of this programme has its own steering group, supported by the Quality Improvement Team, and updates are reported through to Patient Safety Group on a bi-monthly basis.

During the past 12 months, due to the response to the COVID-19 pandemic, some of these work streams have been stood down or have had to change their focus to support immediate priorities for patients presenting with COVID-19. As part of standing these programmes up again and prior to the *Developing the Quality Priorities Workshops*, a full review of the Harms reductions programmes over the last 3 years was undertaken in June 2021.

The tables below provides an overview of the aims and key achievements of each individual project over the last 3 years:

Key Achievements

Falls Reduction

Aim: To reduce the number of inpatient falls resulting in harm (low/minor and above) across all inpatient areas at ELHT by 10% by January 2022	
Key Achievements	
• Good representation and attendance across all divisions at the monthly Falls Strategy Group • Falls Change Package embedded across all inpatient ward areas • The SOP 004 has been reviewed and the revised SOP has been approved • Development of online training package to deliver enhanced care • The change package was revised to enable documentation that supported the changeover of staff undertaking 1:1 observations over a 24hr period • A 'Falls Awareness Week' was held in September 2021 across all four hospital sites to reinvigorate the change package • Implementation and roll-out of the monthly electronic Ward Falls Audit • The Falls Lead now attends Northwest Network of Falls Nurse and Falls Teams, which shares networking opportunities, good practice, common frustrations and ideas • Strategy Falls Group Meeting now monthly.	
Total number of Improvement Projects Registered linked to HRP (2018 – June 2021)	**4**

Infection Prevention & Control

Aim: To improve the rates of hand hygiene across the Trust (all areas)	
Key Achievements	
• The Prompt to Protect campaign was launched to promote a culture of openness around infection control issues and encourage staff to step in when they feel it is not right and needs challenging • 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 and promoting safety. Prompt to Protect has successfully been rolled out on 13 wards and departments across ELHT • It has been agreed that the NHSE / NHSI initiative 'Every Action Counts' will supersede this Harms Reduction Programme going forwards	
Total number of Improvement Projects Registered linked to HRP (2018 – June 2021)	**13**

Medication Errors

Aim: Reduction of Medicines Omissions especially for critical medicines and Reduction in dosing errors with Insulins
Key Achievements
• The second pilot of the new Diabetes Insulin Prescription, Administration and Monitoring booklet is now in the communication phase • A second Medicines Omission Trustwide audit has been undertaken • Coaching for Safety project for Self-Administration of Medicines across Maternity in-patient services with NHS Innovation Agency now initiated

• A Discovery Event was scheduled to obtain a deeper understanding of the reasons underlying medicines omissions in the Trust • The medicine management e-learning modules have now been re-launched as an inclusion to core learning for a broad range of ELHT staff groups • MSOC (Medicines Safety Optimisation Committee) is now implementing an innovations-planning a tracking tool to identify work areas linking these with identified risks, and supporting spread of good practices • 5 Minutes Facts educational documents have been prepared and circulated • We have had two Pharmacy specific questions added to the local monthly patient experience survey to check progress with their medicine's adherence • Transfer of medicines between wards, on admission and at discharge is also the subject of a related QI project • QI project to improve Patient Information, availability of Self Administration of Medicines and Medicines Handover at Discharge in is preparation • The QI project to reduce insulin medication errors through introduction of a comprehensive insulin prescribing booklet has been re-instated. • Datix incident report for medicines incidents has been expanded to record medicine name and Red Flag status • Pilot sessions for Pharmacy support to pre-operative assessment Clinics were completed • Guidance on managing red Flag drugs when the oral route is unavailable has been published and disseminated • QI plan for reduction of Parkinson's drugs omissions is in progress • To monitor and track medicines omissions through incident reporting has been developed • The Trust-Wide Medicines Safety Share 2 Care has been published, with content including specific coverage of Insulins safety	
Total number of Improvement Projects Registered linked to HRP (2018 – June 2021)	**34**

Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) / CNST

Aim: To reduce the national rate of preterm births from 8% to 6% and reduce the rate of stillbirths, neonatal deaths and brain injuries occurring during or soon after birth by 50% by 2025
Key Achievements
• Number of GROW (Gestation related Optimal Weight) trained staff continue to increase. GROW training continues on an annual mandatory basis • K2 Training Package- work has progressed with the Matrons and Maternity Service Practice Development Co-ordinator and the K2 training package has been rolled out across the service • Any pregnancy pathway that requires USS monitoring of fetal growth will now be monitored up to 39 weeks of pregnancy • A 'Rainbow Pregnancy' clinic has also been commenced now. This is a bespoke clinic for parents who have suffered from a subsequent pregnancy loss • Placenta Clinic -Two successful candidates have completed training. Funding has been approved for two further midwife sonographers, who have been appointed • The Saving Babies Lives care bundle 2 has been launched nationally • MBRACE- Perinatal Mortality Review Tool implementation has begun

• Introduction of the Feedback Friday across site in Theatres, Day Case and Elective Centre, focusing on shared learning from incidents and promoting positive change from these incidents • Funding has been secured (through the Local Maternity System) to provide training in fetal cardiotocograph (CTG) interpretation and management • A preterm birth clinic is now established on Monday mornings to support reduction of the preterm birth (PTB) rate • Comprehensive SharePoint site of all key workstreams linking to evidence for CNST • Improvement work on Maternity Communications and development of Maternity Communications Strategy (enhanced by Ockenden Report) • Still births halved over 3 years	
Total number of Improvement Projects Registered linked to HRP (2018 – June 2021)	**7**

Nutrition and Hydration

Aim: To reduce the number of serious incidents relating to nutrition assessment, oral nutrition and hydration on wards C2 and C4 to zero by December 2021.	
Key Achievements	
• Above bed visual management system created and trial in progress • Further training in catering regarding food for fingers • Nutrition prompt added to the ward round proforma • Timing of the meal trolley altered to allow a further 45 mins for ward rounds to be completed • Weight record chart currently in trial phase • Plan to create SOP for mealtimes to ensure one member of staff takes on the role of co-ordinator for every mealtime • Hot water flasks to be sourced to use as a test of change to measure efficiency of drinks delivery • Menus corrected and currently in print – all incorrect menus will be destroyed and replaced • Roles and responsibilities document created and shared • Commenced creation of a Nutrition and Hydration page on SharePoint to enable all staff to find all key information in one place	
Total number of Improvement Projects Registered linked to HRP (2018 – June 2021)	**17**

SAFER Surgery

Aim: To improve the safety culture in theatres for all operating lists, through compliance with the '5 steps to safer surgery' – WHO checklist by March 2021	
Key Achievements	
• Fortnightly virtual meetings are now to take place to help facilitate cross site meetings to discuss safer surgery and never event action plans • Introduction of debrief meetings and handover times • Brief/Debrief forms have now been standardised across sites. An electronic computer-based form has been developed to encourage real time completion • The 10,000ft initiative has been rolled out across all theatres and work to embed this initiative is still ongoing. The 10,000 feet initiative has been presented at four other	

Trusts. A collaborative research project is planned to measure the effect 10,000ft has had on safety • Electronic specimen process - developing and testing the use of ICE, for traceability of specimens taken in theatres and to support the move to an ePR in 2020 • Completed a theatre cap challenge – the aim to improve safety and break down hierarchy • Standardisation of swab count boards in all theatres • Communication- Never event issue of Share 2 Care has been shared across all theatres • Introduction of Policy of the month • Introduction of a closed Facebook page for theatres - The Facebook page now has over 200 theatre staff members • Introduction of Culture Programme • Introduction of scenario-based learning days • Launch of an on-line training module for the 5 Steps to Safer Surgery policy • VSA Event held for 'Prompt start times' has been a massive success with a marked improvement on theatre start times and increased theatre productivity • a training programme was devised to develop and strengthen the Band 7 Leadership. **RESPECT** (A Respectful Environment Providing Safe Personal and Effective Care Together) • New training opportunities for ODP's and Support Workers • Introduction and promotion of cross-site meetings due to substantive staffing recruitment	
Total number of Improvement Projects Registered linked to HRP (2018 – June 2021)	**3**

Deteriorating Patient

Aim: To reduce failures in recognising the deteriorating patient Due to the size and complexity of the Trust-wide project, 6 key workstreams with individual aims have been identified
Key Workstreams – Cardiac Arrests, Sepsis, Acute Kidney Injury (AKI), Early Warning Score (NEWS2), Fluid Balance and Safer Transfers
Key Achievements
• Cardiac Arrest Reporting Tool launched on DATIX • i-gels to be stocked on all Adult Crash Trollies, across all hospital sites • Revision of Resus Policy - roles and responsibilities re maintenance and equipment added to the Resus Policy • i-gels added to the BLS/ILS Band 5 & 6 training • Marshalls Laryngoscopes added as stock on Resus Trollies • Defib Replacement Programme commenced • QI Project commenced to address current issues with Datix recording • Letter received from the Medical Director for Clinical Effectiveness from NHS England • Sepsis Taskforce Group commenced • Click the clock implemented for both adult and paediatric inpatient areas and ED • Sepsis Share to Care Edition published and disseminated • All Adult, Paediatric, Maternal and Neutropenic Sepsis care bundles have been redesigned to describe suspicion of sepsis, with greater emphasis on recognising alternative or more likely diagnoses

• All Suspicion of Sepsis care bundles continue to be revised and updated as per National Guidance and the Trust Management of procedural documents Policy • AKI Share to Care Edition published and disseminated • New format of the AKI Data Report agreed and launched • Launch of revised AKI Care Bundle (aid memoir format) and new Pocket Card • AKI Patient Information Leaflet revised and approved • First Trust AKI Study Day took place • AKI section and GP Follow-up Actions added to Patient Hospital Discharge Letter to improve communication with primary care services • Management of Hyperkalaemia – new information published on Oli • Support from Acute Care Team (ACT) HCA's is now in place to action AKI 3's earlier • AKI SHMI data indicates that the Trust is now within expected levels for mortality • QI project is underway in collaboration with IHSS with regards to the management of AKI in the community to identify this who can be managed at home to prevent admission to secondary care • AKI data indicates that new referrals to the Acute Care Team have reduced significantly • AKI E-learning package is now complete and will be available to all staff • All Adult, Maternity, Community and IHSS NEWS2 Observation Charts have been standardised and continue to be revised and updated as per National Guidance and the Trust Management of procedural documents Policy • NEWS2 observation charts removed from Epidural and PCA Pain Charts • Clinical Observations Policy revised • Pendle Community Hospital Escalation QI Project Launched – bespoke SOP developed to support staff and this QI project • E-EWS observations launched in 2020 as part of the e-Lancs ePR project • Fluid Balance Electronic Audit Tool developed • Fluid Balance Chart added to ED Nursing Booklet • A Fluid Balance change package has been developed and is available on the Learning Hub • Pilot under review to investigate using the ward-based pharmacists to educate and continually improve IV fluid management • Fluid Stewardship Group commenced • Revised Trust Drug Prescription Chart launched to include with gate fold fluid section and good guidance for choice and dose of fluid, plus easy to capture indication with a checkbox • Safe Patient Transfer sub-group set up • Safer Transfer QI Project commenced • Adult Transfer Policy significantly revised and relaunched • Trust Patient Transfer Decision Matrix significantly revised and relaunched - now includes Adults, Maternity and Paediatrics	
Total number of Improvement Projects Registered linked to HRP (2018 – June 2021)	**21**

End of Life Care

Aim: To improve the quality of care of inpatients at ELHT in the last days of their life, to at least National Average (NACEL) by 2021 (2022 report). Due to the size and complexity of the Trust-wide project, 5 key priorities have been identified.	
Key Achievements	
• Bereavement Survey - As of March 2021, the family/carer of every inpatient who that has died during their admission (RBH only) now has the opportunity to provide qualitative feedback on the quality of care their loved one received in the last days of their life • 7/7 week bereavement support line, now 5/7 a week, supporting families of patients who died from Covid-19. So far, over 1000 families have been contacted • Development and roll out of 1) the symptom observation chart, 2) the discharge checklist, for patients in the last days of life and 3) The Care and support in the last days of life leaflet • Dying matters awareness week 2021 - As a Trust we worked together with the ICS to use existing resources for dying matters • Checklist for Matrons to prompt the NACEL questions/best practice in care in the last days of life developed • A task and finish group meeting was set up in CIC to devise a template for reflection in practice for end of life care • Visiting guidance to support staff was developed - for families visiting loved ones who are in the last days of life • Car parking vouchers enabling families to park free of charge • NAPF End of life/Bereavement template developed • Widening support for homeless people - initial meeting held with a Burnley charity • Palliative care/bereavement link group • CIC & MEC Divisional EOLC groups • Palliative care/bereavement link nurses – data base developed to ensure that there are link nurses who attend the meetings regularly in all areas • Education – Care of the dying training to delivered regularly to staff across the trust – face to face training and training via MS teams available. Symptom management training, bereavement workshop, verification of expected death, palliative care for health care assistants available to staff. Bespoke training also offered and delivered • Syringe pumps – Following an option appraisal the 3rd edition syringe pumps have been introduced for use in RBH. SOP and guidance for staff developed. Syringe pump training provided regularly.	
Total number of Improvement Projects Registered linked to HRP (2018 – June 2021)	**7**

3.3 Achievement against National Quality Indicators

3.3.1 Summary Hospital Level Mortality Indicator (SHMI)

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

The latest published SHMI trend data up to September 2021 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	Latest published rolling 12 months to Nov-21
East Lancashire NHS Trust SHMI Value	1.051
East Lancashire NHS Trust % of deaths with palliative care coding	32
East Lancashire NHS Trust SHMI banding	2 (as expected)
National SHMI	1.00
Best performing Trust SHMI	0.716
Worst performing Trust SHMI	1.195
Trust with highest % of deaths with palliative care coding	64
Trust with lowest % of deaths with palliative care coding	11

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

Following a deterioration in mortality indicators during the pandemic the trust has had steadily improving mortality indices and as of April 2021 Mortality is within the expected range for both Hospital Standardised Mortality Ratio (HSMR) and SHMI.

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

- Introducing an Electronic Patient record which will improve the quality of coded data to make the coded diagnosis and comorbidities as accurate as possible.
- Engaging with experts from Dr Foster and experts in public health to evaluate the effects of the pandemic on longer terms patient outcomes.
- Reviewing alerting groups and where appropriate undertaking quality improvement in these areas.
- Focusing on end-of-life care both within the trust but also across the wider system.
- Continuing our work on dissemination of 'lessons learned' to ensure organisational learning is maximised.

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	32%
National percentage of deaths with palliative care coding	39%
Trust with highest percentage of deaths with palliative care coding	64%
Trust with lowest percentage of deaths with palliative care coding	11%

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

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

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

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

3.3.3 Patient Recorded Outcome Measures (PROMs)

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

The two procedures are:

- Hip Replacement
- Knee Replacement

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

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

3.3.3.1 Hip Replacement Surgery

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

3.3.3.2 Knee Replacement Surgery

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

**PROMs outcome data covering April 2020 to March 2021 published by NHS Digital Hospital, currently shows no returns from ELHT during this period for both Pre & Post op questionnaires – ELHT records show that only 5 pre-op questionnaires were completed for this period due to the COVID Pandemic. PROMs data for 2021-22 has yet to be published.*

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

ELHT has a process in place to ensure patients receive a pre-operative questionnaire via the post; completion is prompted during their telephone pre-operative assessment.

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

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

A verbal request sheet has been scripted to ensure standardisation of information given to maintain and improve participation rates.

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

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

3.3.4 Readmissions within 28 Days of Discharge

The following table sets out the Trust's performance during 2021-22 for emergency admissions within twenty-eight days of discharge. We have used Dr Foster data which provides national benchmarking from the National Hospital Episodes Statistics data. The Health and Social Care Information Centre (HSCIC) do not provide data on readmissions at the level of detail required. Figures shown are as at April 22:

All ages	2014/15	2015/16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22 (Apr – Aug 21)
Readmission Rate	8.74%	8.79%	8.44%	8.30%	8.62%	9.07%	9.73%	9.83%
Age Band	2014/15	2015/16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22 (Apr – Aug 21)
0-15	11.22%	12.06%	12.21%	11.75%	12.51%	12.03%	11.43%	12.16%
16+	8.19%	8.05%	7.64%	7.54%	7.81%	8.52%	9.46%	9.42%

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 9.83% which is below the Dr. Foster risk adjusted expected rate of 10.28%. Compared to local acute hospitals, the Trust is just below the national rate of 10.18%.

- For the 0-15 age group, the rate is 12.16% which is higher than the expected rate of 10.22% and the national rate of 8.93%.

- For the 16+ age group the rate is 9.42% which is below the expected rate of 10.29% and better than the national rate of 10.27% reflecting good performance and **Safe**, **Personal** and **Effective** care in terms of discharge planning.

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

The readmission and admission rates for ELHT are skewed by the fact that our assessment units (including assessment and ambulatory care) is coded as an 'inpatient admission'. Many of our pathways readmit children into the assessment unit, which is clinically appropriate and efficient, but this skews data.

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

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 is also available as a mobile phone App. Videos circulated across third sector for sharing with difficult to engage families
2. Hot clinics and emergency clinic slots have been set up and are working very successfully, for urgent paediatric consultant input – as an alternative to admission or readmission. Slots are accessed directly from GPs.
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. The Community Children's Nursing (CCN) service has been extended so that GPs can refer directly to the CCN rather than hospital for care and the hours have been extended to 22:00 to support out of hours GP referrals.
5. 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.
6. Consultant presence in COAU extended until 10pm Monday- Friday – to support more senior decision making.
7. Extended Community Children's Nursing service to a longer day / 7-day service (was previously Mon-Fri 8am-6pm service).
8. Discharge process tightened so that all discharges are reviewed at consultant level.
9. 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.
10. Allergy specialist nurse recruited February 2020 and extended to a second nurse July 2021 so that children and families with severe allergies can be managed safely at home and avoid admission and readmission for acute episodes. Also, the development of Allergy MDT with Consultant Paediatricians to manage allergy patients in a more seamless way.
11. Introduced direct ED referrals to our Children's Community Nursing Service to support admission avoidance.
12. Increased our nurse led clinics for respiratory, community nurses, epilepsy and allergy.
13. Children's Hub development– which is a multi-disciplinary community hub is on-going – which has shown initial reduction in admissions and need for secondary care interventions. There are plans to extend hub working in 2023/23.
14. Implementation of primary care pathways to support General Practitioners in the management of common childhood illnesses using RCPCH guidance
15. Developing an asthma severity score and associated pathway using QI methodology which is an ICS led pathway.
16. Developing an allergy pathway using QI methodology.
17. Developing same day emergency care model and 111 booked appointments in Paediatrics in next 12 months.
18. Exploring the use of a virtual ward within Paediatrics to support children post discharge.
19. Development of CNP services to offer nursing support for CYP with ADHD and ASD to empower families and carers with the tools to manage children with neurodevelopmental conditions
20. Diversification of child development centres offering therapeutic interventions and empower parents with strategies to support children with neurodevelopmental and neurodisability conditions

21. Developmental of CYP website to signpost families to self-help and access to specialist nursing services for support and guidance including signposting to third sector and the Blackburn with Darwen/East Lancashire Local Officer

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 high intensity users of acute services alongside CCG to develop a targeted approach
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. Participation by ELHT paediatrics in the NHSE SDEC task and finish group.

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

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

3.3.5 Responsiveness to Personal Needs of Patients

The relaxation of Covid-19 related restrictions has enabled the national programme of patient satisfaction surveys to re-commence. During 2020 Quality Health was commissioned by East Lancashire Hospitals NHS Trust to undertake the Adult National Inpatient Survey 2020,

It is also important to note that some scores will have been affected by the extra demand placed on the NHS during 2020.

The Adult Inpatient Survey sampled 1250 consecutively discharged inpatients, working back from the last day of November 2020. There were 460 responses received giving a final response rate of 39%. This is an improvement on the response rate of 37% in the 2019 survey.

Table 1 below details the nine questions where the Trust scored in the top 20%. Many questions have changed in the 2020 survey so a comparison with 2019 is not available.

Question	2019	2021
How did you feel about the length of time you were on the waiting list before your admission to hospital?	84.6%	**84.4%**
There were restrictions on visitors during the coronavirus pandemic. Were you able to keep in touch with your family and friends during your admission?	n/a	**82.0%**
Were you ever prevented from sleeping at night by any of the following? Hospital lighting.	n/a	**86.9%**
Were you ever prevented from sleeping at night by any of the following? None of these.	n/a	**47.7%**
Were you given enough privacy when being examined or treated?	94.0%	**96.5%**
Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?	73.2%	**80.8%**
To what extent did staff involve you in decisions about you leaving hospital?	n/a	**74.6%**
Were you given enough notice about when you were going to leave hospital/	71.3%	**74.2%**
Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	79.6%	**85.3%**

Table 1 – Questions where ELHT scored in the top 20% of Trusts surveyed by Quality Health

Table 2 below details the questions where the Trust scored in the bottom 20% and a comparison with the 2018 score if available. Two of the poorer performing benchmarked scores relate to the Doctors section of the survey. Whilst scores in this section are high in their own right, ELHT does not perform as well when compared to other Trusts surveyed by Quality Health. The Trust also has one of the lowest scores for quality of food compared to other Trusts surveyed by Quality Health. However, it should be noted that the score has improved from the 2019 survey.

Question	2019	2021
How would you rate the hospital food?	52.1%	**65.6%**
When you asked doctors questions, did you get answers you could understand?	76.4%	**85.7%**
When doctors spoke about your care in front of you, were you included in the conversation?	n/a	**83.3%**

Table 2 – Questions where ELHT scored in the bottom 20% of Trusts surveyed by Quality Health

Overall, feedback is consistent with the findings of the 2019 survey. Quality Health have recommended areas the Trust may want to consider strengthening. The survey details have been shared with all division for integration into their existing service improvement plans, where identified as required. The Trust's Quality Strategy and Patient Experience Strategy 2022-25 will monitor the progress of this work.

3.3.6 Recommendation from Staff as a Provider of Care

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

69% of staff said – if a friend or relative needed treatment they would be happy with the standard of care provided by the organisation.

78% of staff said – care of patients/services users is the organisations top priority.

The Trust scored 7.0 for the overall staff engagement score on the 2021 national staff survey which is significantly above the national average of 6.8 for Combined Acute and Community Trusts in 2021.

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

The Friends and Family Test (FFT) is a well-established means to capture whether patients that have recently received care within acute hospital Trusts would be happy for their friends or relatives to receive similar care within the same environment.

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

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

The following table sets out the percentage positive rating for the period April 2021 to March 2022 and also how these results compare with other Trusts nationally.

	April 2021	May 2021	June 2019	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Inpatient positive % rating												
ELHT	96	95	95	96	96	95	98	96	96	97	96	97
Nat Ave	95	95	95	94	94	94	94	94	94	94	94	Not yet available
A&E positive % rating												
ELHT	87	79	74	70	71	66	70	66	73	70	67	58
Nat Ave	84	82	79	76	77	75	75	76	80	81	77	Not yet available
Maternity positive % rating												
ELHT	95	92	93	89	91	91	84	90	88	91	91	88
Nat Ave	93	94	93	92	91	90	90	90	92	92	92	Not yet available
Community positive % rating												
ELHT	95	92	92	92	90	91	91	91	94	94	94	93
Nat Ave	95	96	96	95	95	94	93	93	94	94	94	Not yet available
Outpatients positive % rating												
ELHT	94	91	92	92	91	93	91	90	93	94	92	92
Nat Ave	93	93	93	93	93	92	93	93	93	93	93	Not yet available

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

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

Over 50,000 patients have provided feedback during April 2021 – March 2022. The Trust has received consistently high scores from inpatients, with an average of 96% of inpatients rating their overall experience as either very good or good.

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

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

3.3.8 Venous Thromboembolism (VTE) Assessments

	VTE RISK Assessments 21-22	1st April 2021- 31stMarch 2022 Q1	Q2	Q3	Q4	Total
ELHT	Number of VTE-risk assessed Admissions	32,381	32,665	33,087	32,817	131,360
	Total Admissions	33803-**98.2%**	33671-**98.2%**	33148-**98.5%**	33,227-**98.6%**	133,434 -**98.445%**
National	Number of VTE-risk assessed Admissions Total Admissions Percentage of admitted patients risk-assessed for VTE	National figures are not available because the submission was suspended due to the Covid-19 pandemic and yet to resume https://www.england.nhs.uk/?s=VTE				
	Best Performing Trust Worst performing Trust	National figures are not available because the submission was suspended due to the Covid-19 pandemic and yet to resume https://www.england.nhs.uk/?s=VTE				

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

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

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

The VTE committee now meets in a quarterly manner with reduced frequency compared to the previous year due to administrative support challenges as the administrative support provided is currently through Executive PA and not the Governance hub as in previous years.

The Committee terms of reference were updated to reflect the reduced frequency of VTE committee meetings at quarterly frequency currently than bimonthly as in the past.

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

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

- VTE committee terms of reference updated to quarterly frequency and to reflect the governance reporting arrangements currently in place.
- Further change envisaged with the documentation of VTE risk assessment from current Alcadion hospidea system to Cerner EPR system from November 2022. Educational events and training plans in place for the launch and roll out focused on VTE through the Divisional governance leads and matrons. This is yet another transition for medical and nursing professionals to get familiar with and supported with again since extramed electronic risk assessment implementation 2 years ago. Educational and awareness raising campaigns and ward based support resources as appropriate as part of the QI interventions to sustainably improve safety and quality are planned to be in place effectively to support this transition.
- One of the key changes in Cerner system is that the time of admission for clock start is calculated from the time of decision to admit made in Emergency department (ED) rather than the current clock start time which is the actual time of admission into the inpatient wards/beds from ED as captured on Cerner. This issue was extensively discussed via the medical directors' forum and consensus agreed by medical director to approve Cerner recommendation for clock start as "decision to admit time rather than actual admission time to inpatient ward bed". Impact of this change will only be known after the transition and will be closely monitored through the VTE committee and Patient Safety Group.
- Automated report generation is an expectation from the Cerner system and this has been requested to cover NICE quality standards and guideline standards related to VTE risk assessment and final reporting methodology and outcomes awaited from Trust Cerner team. Currently the data for organizational reporting is captured from Hospidea and linked to the Patient Administration System (PAS) and Electronic Patient Tracking System (EPTS) and this linkage will continue even after transition to Cerner system for Organisational reporting purposes.
- A Trust wide re-audit on VTE risk assessment has been agreed in principle and proforma and data collection tool approved through VTE committee to commence as a Trust wide Quality improvement project as prospective re audit in June 2022 and resultant action

plans based on findings will be implemented Trust wide to benefit patients and lessons learnt shared cross organizationally.

- Monitoring of VTE risk assessment and management of Hospital acquired VTE through formal quarterly reporting by all divisions through the Trust VTE committee which functions as a sub-committee of the Trust Patient safety group formerly called Patient Safety and Experience Group (PSEG) continues.

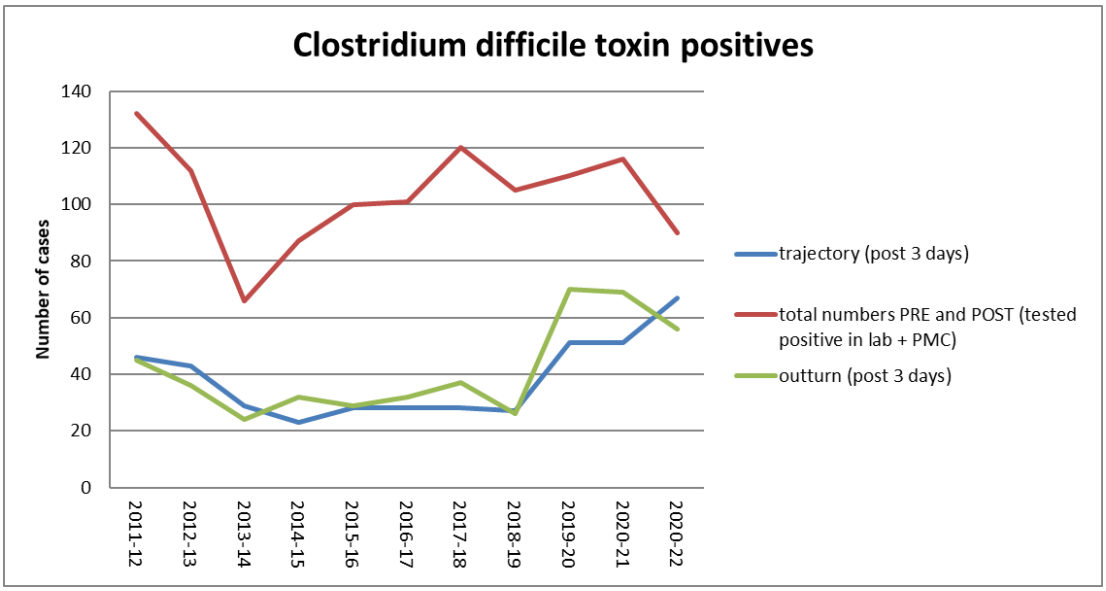
3.3.9 Clostridium Difficile Rates

The data made available to the Trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

The Trust reported 56 clostridium difficile positives 35 HOHA & 21 COHA the trajectory for 2021/22 was 67.

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 HOHA and the addition of a prior healthcare exposure element for community onset cases COHA.

Clostridium difficile toxin positive results from April 2021 – March 2022:



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

Assertive action on management of hospital acquired infections has been undertaken for a number of years to reduce the rate to the present level. Each case of HOHA & COHA are reviewed the themes, lapses and areas for learning are discussed at the C. difficile multidisciplinary CCG meeting and shared divisionally.

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

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

3.3.10 Patient Safety Incidents

NHS Trusts are required to submit the details of incidents which involve patients to the National Reporting and Learning System (NRLS) on a regular basis. The Trust uploads data via the NRLS on a weekly basis. The NRLS 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 the latest NRLS organisational data workbook and sets out the Trust's performance over the last eleven 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	**Oct 2015 to Mar 2016**	**April 2016 to Sept 2016**	**Oct 2016 to Mar 2017**	**April 2017 to Sept 2017**	**Oct 2017 to Mar 2018**	**April 2018 to Sept 2018**	**Oct 2018 to Mar 2019**	**April 2019 to Sept 2019**	**Oct 2019 to Mar 20**	**Apr 2020 to Mar 21**
ELHT number reported	6579	7010	7122	7032	7401	6426	6398	8128	8269	11,142
ELHT reporting rate	42.05	44.9	44.8	45.5	46.4	42.0	40.9	52.0	53.2	44.0
Cluster average number	4818	4995	5122	5226	5449	5583	5841	6276	6502	12,502
Cluster average reporting rate	39.6	40.7	41.1	43	43	44.5	46	50	51	58
Minimum value for cluster	1499	1485	1301	1133	1311	566	1278	1392	1271	3,169
Maximum value for cluster	11998	13485	14506	15228	19897	23692	22048	21685	22340	37,572
Patient safety incidents resulting in severe harm	**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**	**Oct 2019 to Mar 20**	**Apr 2020 to Mar 21**
ELHT number reported	16	13	8	14	9	6	9	5	6	19
ELHT % of incidents	0.2	0.2	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.2
Cluster average number	13.7	13.4	13.8	13	13.5	13.5	14	15	14.5	31
Cluster average reporting rate	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.3
Minimum value for cluster	0	0	0	0	0	0	0	0	0	4
Maximum value for cluster	85	75	67	92	78	74	62	76	91	137
Total incidents across cluster	1862	1826	1872	1821	1810	1771	1780	1896	1870	3,817

Cluster % of incidents	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.2
Patient safety incidents resulting in death	**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**	**Oct 2019 to Mar 20**	**Apr 2020 to Mar 21**
ELHT number reported	8	6	8	2	2	1	6	4	6	17
ELHT % of incidents	0.1	0.1	0.1	0	0	0	0.1	0	0.1	0.2
Cluster average number	5.7	5	5.5	5	5.3	5.1	5.2	4.8	5	24
Cluster average reporting rate	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Minimum value for cluster	0	0	0	0	0	0	0	0	0	0
Maximum value for cluster	37	36	31	29	24	22	23	24	22	146
Total incidents across cluster	780	690	751	661	712	706	678	628	666	3011
Cluster % of incidents	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2

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

The overall number of incidents reported by the Trust in the last reporting period has increased from the previous 3 years. Staff are encouraged and understand the importance of reporting all levels of incidents across the Trust so that learning can be shared. The Trust does however consistently report higher numbers of incidents compared with similar Trusts in the cluster, which demonstrates an open and honest culture within the Trust, this has reduced in the most recent reporting period, however these figures will be affected by the COVID pandemic starting within the reporting period.

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 however there has been an increase in the number of these severity of incidents in the reported period, again this will have been affected by the COVID pandemic.

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

- Recruitment of a new Patient Safety Incident Investigation (PSII) team, which investigate incidents that meet National or Local priorities defined in the PSIRF and the Trust Patient Safety Incident Response Plan.
- Development of incident investigation tools for incidents that do not meet the criteria to be investigated by the PSII team.

- New Terms of Reference for incident review groups at both Divisional and Trust level reflecting the new approach.
- Development of the Datix system to allow the effective management of incidents under the new framework.
- Introduction of assurance processes to ensure there is consistent culture of learning and improvement in line with PSIRF and the response to patient safety incidents.

3.3.11 Never Events

A Never Event is a serious incident that is recognised as being entirely preventable if all the correct guidance is followed and all our systems work to create a safe situation for patients and staff. Over 2021/22 the Trust has reported 4 incidents that meet the criteria of the NHS Never Event Framework:

Type of Never Event	Number
Incorrect Implant	1
Overdose of insulin due to incorrect device	1
Wrong site surgery	2

Three of the incidents above have been fully investigated and in all cases, the Trust found important learning that has been shared with staff across the organisation, with our commissioners and the patient and/or family. Detailed action plan for each incident have been developed, updated and assurance on the completion and embedding of learning is overseen by Patient Safety Group and Lessons Learned Group on a monthly basis.

The overdose of insulin incident at the time of producing this Quality Account was under investigation.

Learning from Never Event Incidents

On four occasions within 2021/22 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:

- Strengthening the team brief and debriefs process, ensuring all team members are actively involved, normal practice discussed with locum or agency staff, embedding in the 5 steps to safer surgery.
- Ensuring there are methodical, systematic checks and confirmations prior to the start of any procedures
- Increasing knowledge of situational awareness, using 10,000 feet when an issue requires the team to stop and re assess.
- Improvements to clinical documentation, highlighting the use of abbreviations and the potential to cause errors.

3.3.12 Learning from Deaths

Throughout 2021/22 East Lancashire Hospitals NHS Trust has been using the Structured Judgement Review (SJR) methodology to review clinical care of patients who have died. This

has included deaths of patients with COVID-19 to assure the trust of the quality of care if these patients during the pandemic. 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 round table discussion is held with the clinical team involved and where the SJR concerns are validated 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.

As part of the review of SJRs specific thematic analyses have taken place to look at the management of pneumonia, and the management of COVID-19. In addition, a report on nosocomial Coronavirus has been undertaken which includes learning from SJR analysis. The full report can be accessed on the trust website.

Breakdown of deaths in 2021-22 and number of completed SJR's for this time period.

	Completed	**2021-2022**	
Total number of inpatient deaths 2021/2022	**Q1**	465	
	Q2	538	
	Q3	646	
	Q4	635	
Total		**2,284**	
		SJR 1	**SJR 2**
Number of Stage 1 & 2 SJR's completed 2021/2022 (May contain deaths from current and prior years)	**Q1**	57	10
	Q2	48	5
	Q3	52	10
	Q4	48	10
Total		**205**	**35**

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 senior review
- Good documentation
- Appropriate treatment of patients with coronavirus in line with the latest guidance.

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 complicated by limitations on visiting during the pandemic.

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 and 3.2 of the Quality Account describes what achievements have been made against areas of learning and what future improvement plans the Trust will be focusing on in 2022/23.

Paediatric Mortality

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

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

		In Hospital	At Home	Another Trust	Out of Area
Total number of Paediatric Deaths by Location and quarter the Death occurred 2021/2022	**Q1**	2	0	1	0
	Q2	2	0	2	1
	Q3	4	2	0	2
	Q4	1	1	4	0
Total		**10**	**3**	**7**	**3**
Number of Stage 1 & 2 PMR's completed during by quarter 2021/2022	**Completed**	**PMR 1**	**PMR 2**		
	Q1	5	2		
	Q2	3	6		

And the number which required an RCA	**Q3**	2	0
(May contain deaths from current and prior years)	**Q4**	14	7
Total		**24**	**15**

Over the past 12 months we have seen a decrease in child mortality however the following quality themes and trends have been identified from the primary mortality review process

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

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

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

- End of Life Care and Advance Care Planning should be started at earliest opportunity. This would prevent escalation of care to tertiary centres when the ceiling of care has been reached.
- Discussion of what the ceiling of care is and being clearly documented to prevent invasive interventions should be had early in the patient journey when it is clear that further escalation would not have a positive outcome
- Advance Care Planning should be considered and evidenced even before End Of Life Care in order to ensure child and families wishes are captured and to prevent feeling of panic when difficult conversations need to take place
- Primary care management of acutely unwell child needs to be supported to empower GP's and ensure children get the most appropriate and timely review.
- Childhood suicide has been more prevalent nationally and local trends although low are evident in the reviews.
- As part of the review of child mortality it has become evident that there is a gap in service with the need for a Bereavement/Palliative care nurse based locally to empower families and promote Advanced Care Planning. This discussion is currently taking place with commissioners and has been incorporated as part of the community specialist nursing review.

Learning Disability Mortality Reviews (LeDeR)

In 2021 reviews of patients with coronavirus were prioritised in line with national guidance.

In 2021 the local process was also updated to ensure that all patients with a learning disability undergo both an SJR and an LD nursing review. If concerns are identified, then an RCA will

be requested to review the issues in more detail. The learning disability review is now incorporated into the SJR process rather than a stand-alone review.

All deaths of patients who had a Learning Disability are routinely uploaded to the National LeDeR data system and an external LEDER review completed. The process is monitored through East Lancashire CCG and the Trust has remained an active partner in the regional LeDeR steering group. To date the trust has not received feed back from LEDER in relation to any local actions required. However the learning disability nursing team are responding to national recommendations for service improvement in their 3 year service improvement strategy.

From 2022, LEDER have requested that all deaths of people who have autism are also reported and that an SJR is completed. Mortality steering group have been informed of this and it has been requested that autism be added to the notification of death. The learning disability nursing tam will continue to validate the requests and complete a review of the SJR when completed.

Breakdown of Learning Disability deaths in 2021/22 and number of completed LeDeR's for this time period by financial quarter:

		2021/2022
Total number of Learning Disability deaths 2021/2022	**Q1**	11
	Q2	10
	Q3	7
	Q4	8
Total		36

		2021/2022
Number of LeDeR's completed 2021/2022 (May contain deaths from current and prior years)	**Q1**	13
	Q2	11
	Q3	13
	Q4	12
Total		49

3.3.13 Seven Day Service Meeting the Clinical standards

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

- Consultant job plans enable the review of delegated review of patients by a consultant within 14 hours of acute admission in all specialities 7 days a week.

- Consultant led Board rounds and ward rounds take place on all inpatient units 7 days per week. This enables prioritisation of patient reviews based on severity of need, and delegation of review or need for the review for each patient.
- All diagnostic services for acute admissions are available for patients 7 days a week either within ELHT or in an arrangement with a regional provider
- NEWS2, or maternity and paediatric equivalents are used across the trust to measure patient illness and risk of deterioration, so that assessments can be escalated if the patient deteriorates or is at risk of deterioration 7 days a week, and 24 hours a day
- Patient flow facilitators and discharge coordination team works over 7 days per week to ensure timely progress of the patient's care including discharge in collaboration with system partners
- Multidisciplinary team members including pharmacists, therapists and advanced and specialist practitioners work across the 7 days of the week where this is required in acute care.
- Shift handovers occur throughout every day of the week in all specialities to ensure continuity of care.

Our electronic patient record which will be implemented in November 2022 will enable us to measure and audit against the timed standards in a comprehensive and efficient manner.

3.3.14 Staff can speak up (Freedom to speak up)

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

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

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

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

An online tele-rehabilitation initiative has been piloted at East Lancashire Hospitals NHS Trust to help support survivors of stroke and brain injuries, meaning they can access help in their own homes rather than having to attend hospital.

N-ROL (Neuro-Rehabilitation Online) was funded by an ongoing campaign run by actress Emilia Clarke's charity, SameYou, in collaboration with University College London (UCL). The service enables additional online group-based neurorehabilitation to people in their own homes during the Covid-19 pandemic. The Trust was chosen by the charity to run the service due to their commitment to providing high quality rehabilitation and their improvement of clinical services through research.

The scheme is run by ELHT's specialist stroke and neuro-rehabilitation team, which already uses some remote interventions as part of their service. It is supported by the clinical academic partnership with the University of Central Lancashire, who are undertaking an evaluation of the pilot.

ELHT is a key member of the Lancashire and South Cumbria Integrated Stroke and Neurorehabilitation Delivery Network, which forms part of the NHS national stroke strategy. Following the pilot scheme, their plan is to use a network approach to deliver the service in the Northwest of England.

3.4.2 ELHT staff well-being initiative influences national CQC and NHS England safeguarding policy

East Lancashire Hospitals NHS Trust is proud to be leading the way on workforce wellbeing and safeguarding after being asked to showcase one of their initiatives to the National Care Quality Commission (CQC) Safeguarding Board in April 2021.

The Chaplain at ELHT, and the National Deputy Head of Safeguarding at NHS England, met with the CQC's Safeguarding team in April 2021 to explain all about ELHT's 'Listening Lounge's', where staff can access individual and group support sessions with the Trust's therapy dog, Jasper.

The 'Listening Lounge's' have been running at the Trust now for nearly two years, and staff describe them as a lifeline that have helped them openly discuss their fears and experiences during what has been an extremely challenging years. The sessions provide an open forum to talk with the Chaplain and their colleagues, and staff are guided through the hour-long sessions with questions and opportunities to share their feelings.

The pair were invited by the CQC Safeguarding Board to share some of these lived experiences of staff over the last year and to advise on how they could implement a similar framework for CQC hospital inspectors who visit Trusts across the country. The 'Listening Lounge's' have also been recognised by NHS England.

3.4.3 Our Maternity Services are gold standard, again!

ELHT's Maternity Services have maintained their UNICEF UK Baby Friendly Initiative (BFI) accreditation, which they first achieved in 1998. The team were the first to receive the

'Achieving Sustainability' BFI GOLD award in 2017 and the first to revalidate in both 2018 and 2021.

The GOLD standards are designed to help services to embed Baby Friendly care long-term over four GOLD themes.
To achieve BFI GOLD accreditation and revalidation, the Trust has made a range of developments and innovations within the service, including:

- Appointing a BFI Guardian and establishing a BFI Gold Leadership Team, with representatives from all areas of maternity services.
- Monitoring the culture of kindness is strong and monitored via staff surveys, staff 'listening roadshows', parent audits and parent feedback. When carrying out audits, parents are also asked 'Is there anything else you would like to feed back?', 'How kind and considerate were the staff?' and 'How can we do better'.
- Designing a 'BFI data dashboard' to allow ongoing monitoring, examining all the data in one place and 'rag' rating it each month. This allows the team to develop interventions to support improvements.

3.4.4 Pennine Lancashire Covid Service wins top national award

The Trust working with a team of health professionals for NHS organisations in Pennine Lancashire and in partnership with the voluntary sector have achieved national recognition and a top award for their response to the covid pandemic. The top team created a new service called the Pennine Lancashire Virtual Covid Ward.

The virtual covid ward was quickly established when local health professionals from primary and secondary care services worked together to create it as the covid pandemic began to take hold. It has helped over 2,000 people from becoming seriously ill or hospitalised with severe COVID-19 or worse.

The Pennine Lancashire CCGs, with local GPs, East Lancashire Medical Services (ELMS), Burnley, Pendle and Rossendale CVS, East Lancashire Hospital NHS Trust and Lancashire, South Cumbria Care Foundation NHS Trust worked together at breakneck speed to deliver the "at home" service to respond to the big numbers of people seriously affected by COVID-19.

The Covid Virtual Ward supports clinically vulnerable patients to stay in their own homes when they had a positive COVID-19 test result, or doctors thought they had COVID. In doing so the service provides patients with physical and psychological support through regular contact, as well as ensuring that the patient's own GP is engaged to help with continuity of care. However, if and when patients require further treatment, they will be rapidly admitted to hospital if needed. Patients on the 'ward' are kept in touch with daily by health care professionals, either by phone, video consultation or if required a home visit. Patients have been able to remain at home near loved ones and in their own environment. They were regularly contacted by phone, video consultation or if required, a home visit, and were provided with pulse oximeters for free, so that they could monitor their breathing symptoms. If patients required further treatment, the service was able to rapidly admit them to hospital. The home system of close monitoring has helped avoid many hospital admissions and kept people safe and supported their recovery too.

As well as being recognised nationally by the Health Service Journal (HSJ), the service was one of the first services of its kind in the country and as such has influenced and been adopted by other areas. The award-winning team who work across organisational and professional boundaries believe that in building this service at scale, quickly and effectively, they have created a design prototype for services that will benefit patients in the future.

3.4.5 New urgent treatment streaming tool a success at Burnley General Teaching Hospital and Accrington Victoria Community Hospital

Patients attending the Urgent Treatment Centre at Burnley General Hospital and the Minor Injuries Unit at Accrington Victoria Community Hospital are now reaping the benefits of using a new streaming tool to help ensure they get the right treatment at the right time.

The Clinical lead for Emergency Medicine Department explains more: “The streaming tool helps us to ensure that everyone receives the treatment they need without lengthy waits in the department. Upon arrival at the Urgent Treatment Centre or the Minor Injuries Unit, patients are asked to input some details into the tool via a smart device. The tool will guide the patient through a series of questions in order to assess and prioritise their condition.

Once the information is gathered, we are then able to determine whether a patient needs to be seen immediately or if they can be asked to return at a later, appointed time. This helps reduce crowding in the waiting areas making it much safer for patients and colleagues.

The Trust are already seeing the benefits to patients as in the first week of implementation at the Urgent Treatment Centra alone we saw 682 complete the tool and out of these, 630 were given an allotted appointment time. Alongside this, the average time to triage each patient was 15.5 minutes, with time waiting to see a clinician averaging at 46 minutes. Our performance against the National 4-Hour Standard met the target at 95% for that first week. This is a really positive step forward in urgent and emergency care.

3.4.6 New home-based Urgent Community Response Service for Blackburn with Darwen

People requiring medical assistance in Blackburn with Darwen could now be cared for in their own home thanks to an expansion of a two-hour Urgent Community Response pathway which aims to reduce admissions and wait times.

The service, already available for East Lancashire residents, is now being offered to Blackburn with Darwen residents attending the Emergency Department, identifying those who are able to be assessed and treated at home, all within a two-hour time frame. This new innovation will be managed through a Single Point of Access for both East Lancashire and Blackburn with Darwen patients, enabling them to receive the care they need quickly at home rather than at hospital, if appropriate.

3.4.7 East Lancashire Hospitals NHS Trust celebrates at prestigious national awards

East Lancashire Hospitals NHS Trust was shortlisted for two awards and invited to attend the highly acclaimed Health Service Journal but sadly, were not winners on this occasion but the Trust was delighted to be recognised for its achievements.

First up, was the innovative Enhanced Respiratory Unit, shortlisted in the Patient Safety Award category. The Unit, which was developed by the Trust's Critical Care Outreach Team, was created to increase capacity to care for Covid-positive patients and improve their treatment outcomes during the second wave of the Covid pandemic.

In the months before the second wave, the Trust had been developing a plan for an Enhanced Care Area, which acts as a middle ground between the traditional ward and the Critical Care Unit, but it was still in planning phase when the Unit reached full capacity.
Within 10 hours the Outreach Team opened the Enhanced Respiratory Unit, enabling them to manage the increasing number of critically ill patients who needed much more care than could be delivered on the ward.

The Unit made a huge difference to patient care – in 40 days the unit saw 67 patients and so saved 247 Critical Care bed days. Without the unit, critically ill patients would have had to stay on wards without access to the higher level of oxygen available on the Enhanced Respiratory Unit, the expert interventions or specialist drugs.

The ELHT team has shared the results of the work of the Unit with the Trust's across the North West, as an example of good practice.

Second up was the Trust's Black, Asian and Minority Ethnic (BAME) network group which was shortlisted for their work towards racial equality. The network, which is run by colleagues from various roles across the Trust, recognises initiatives which identify and tackle ethnic health inequalities for patients and communities and promotes race equality and inclusion within the workplace.
Since its formation, the BAME network has actively listened to the concerns of BAME staff and has worked with Executive Directors at the Trust to reboot the conversation around Race and Ethnicity to influence and set the tone with managers to reshape thoughts and cultures.

This new leadership team of BAME network Co-Chairs has now transformed ELHT into a truly inclusive, active and representative network advancing race equality across the Trust – all of it voluntary and done on top of their demanding day jobs.

3.4.8 New digital record system to revolutionise maternity care for East Lancashire families

In November 2021 East Lancashire Hospitals NHS Trust, who provide maternity care across Blackburn, Burnley, Accrington, Clitheroe, Darwen, Rossendale, the Ribble Valley and Pendle, has rolled out a new digital system for parents-to-be to register their pregnancy and access their care notes.

The new system is called BadgerNet and is provided by a company called Clevermed LTD. BadgerNet is a full electronic patient record, which supports clinical and administrative management of the woman's whole maternity journey. This has replaced the paper-based records.

From the 9 November 2021 the way that women access and book into the maternity service was changed. Expectant parents are now able to self-refer directly into the service, via an online booking form, where they fill in their details, are assigned to a midwife and an appointment generated. This removes the need for women to get an appointment with their

GP before being referred through to the service and ensures that they are is seen by a midwife as soon as possible. Women who do not have digital access, are able to telephone the service to self-refer for their pregnancy care.

As part of this BadgerNet rollout, the service will also launch 'Badger Notes'. Badger Notes is an online portal and app. Badger Notes replaces the traditional women's handheld paper record and allows the parents to have real-time access to their maternity care record, which is populated with the information from the hospital maternity records. It is a secure system requiring a log-in, which allows parents-to-be to see updates to their notes in real-time, as well adding their own information such as birthing plans or preferences and feedback. The portal is connected to the 'BadgerNet' system and used by maternity staff to record notes following appointments and consultations.

Records can be easily updated at each maternity visit or appointment and midwives do not have to double enter data onto paper handheld notes, allowing them more time to focus on delivering the best care.

3.4.9 Pancreatic Cancer Rapid Diagnostic Service wins top Macmillan award

East Lancashire Hospitals NHS Trust Pancreatic Cancer Rapid Diagnostic Service (RDS) has kickstarted November's Pancreatic Cancer Awareness month with a win at the Macmillan Professionals Excellence Awards, as recognition of their outstanding contribution to cancer services.

The service is part of a Lancashire and South Cumbria wide initiative designed to support earlier diagnosis in pancreatic cancer and came out top in the 'Integration Excellence' category. The award recognises teams who have improved the coordination of services and enabled integration across settings such as acute, primary, social and voluntary services to provide a seamless experience for people living with cancer.

The ELHT Cancer Services Team was nominated for their collaborative working with colleagues including diagnostic specialists, biomedical scientists and clinicians. They also work closely with representatives from the Lancashire and South Cumbria Cancer Alliance, Primary Care Networks and 3rd sector organisations, Pancreatic Cancer Action and Pancreatic Cancer UK.

The successful collaborative work has meant that an average wait time for a patient to be diagnosed with pancreatic cancer has reduced considerably following GP referral.

3.4.10 Hip-Hip hurray! ELHT performs its first ever day case hip replacement

A Burnley man was the first to undergo day case hip replacement surgery at East Lancashire Hospitals NHS Trust, an exciting new development as the Trust progresses in its aim to reduce patients' length of stay following their operation.

ELHT's Orthopaedic team have been focussing on reducing length of stay for hip and knee arthroplasty patients and the majority of patients are now staying in hospital for less than 3 days. Day case surgery for hip and knee replacements is a massive challenge and not many patients that the service lists would be appropriate for this.

With the first case now a success, the outcomes and learning can be shared with the lower limb team in the hope of offering day case surgery to more patients who fit the criteria.

3.5 Statements from Stakeholders

3.5.1 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 2021/22 Quality Account for East Lancashire Hospitals NHS Trust (ELHT) as Quality continues to be at the heart of commissioning and provider processes.

The CCGs would like to thank all members of staff at ELHT for their hard work and dedication, both in their response to the Covid-19 pandemic and in continuing to deliver services with a focus on quality, patient safety and patient experience.

Despite the challenges of the last 2 years and the significant impact of the COVID19 pandemic across Pennine Lancashire, the CCGs are pleased to note the progress made against the key priorities identified for 2021/22 and the Trusts approach to continuous learning and improvement. ELHT currently have 451 improvement projects registered as 'live' with 22% currently in the 'test and adapt' stage, and 16% in the final 'sustain' phase. The CCGs are pleased to note the implementation of the 'SPE+ (Safe, Personal and Effective Care) Improvement Practice Training Framework' for all staff including FY1/2, medical students, and trainee advanced clinical practitioners.

The CCGs are proud to work alongside ELHT on their journey as an early adopter of the Patient Safety Incident Response Framework (PSIRF) which supports a culture of learning across the Trust, leading the way for wider implementation across other health care providers. It is pleasing to note how the learning from patient safety events is feeding into the Trust's key priorities to improve the safety culture in line with the National Patient Safety Strategy.

The 2021/22 Quality Account highlights many achievements made by the Trust throughout the year and the CCGs commend ELHT and their staff on their work and determination in relation to the pandemic response and the subsequent restoration of services while continually striving to focus on patient care and key quality and safety improvements.

The CCGs would like to congratulate the Trust on winning multiple awards during 2021/22 for services such as the collaborative work on the Pennine Lancashire Virtual COVID Ward working across organisational and professional boundaries to support clinically vulnerable patients in their own homes. It is wonderful to note that ELHT have also maintained their UNICEF UK Baby Friendly Initiative (BFI) accreditation and BFI GOLD award.
Monitoring of the Commissioning for Quality and Innovation (CQUIN) schemes was paused during 2021/22 and will recommence in 2022/23. The CCGs and the soon to be formed Integrated Care Board (ICB) will continue to work closely with ELHT and the Provider Collaborative in monitoring quality assurance indicators and quality improvement outcomes.

The Trust has participated in 95% of national clinical audits, 100% of national confidential enquiries and 180 local clinical audits in 2021/22 with all activity and lessons learned being presented at multi-specialty forums to provide assurance and support improvement in quality and patient care, demonstrating a commitment to evidence based safe care.

Patient experience and the patient voice continues to be important for the Trust and the CCGs are pleased to note the multiple ways that ELHT actively encourage feedback with patient, carer and staff stories regularly featuring at divisional meetings and the Trust Board. Inpatient survey results remain consistently high and above the national average. The CCGs recognise the challenges around increasing numbers of patients attending Accident and Emergency and the resulting extended waiting times in the department, which is reflective in the falling Friends and Family Test results.

ELHT scored 7.0 for the overall staff engagement score on the 2021 National Staff Survey which is higher than the national average of 6.8 for combined Acute and Community Trusts in 2021. Recommendation scores from staff as a provider of care have decreased in 2021 when compared with the previous data in 2019 (no survey in 2020 due to the pandemic) and the CCGs would recommend that ELHT include the areas for improvement within the Quality Account. However, it is pleasing to note the reduction of staff reporting harassment, bullying or abuse from colleagues at work (14.1%). This indicator has seen a reduction on the previous year of 16.2% and is significantly lower than the national average of 19.5%.

The CCGs continue to sit on the Trust's Mortality Steering Group and are pleased to note the positive reduction into the expected ranges of both the Summary Hospital level Mortality Index (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) following a deterioration during the pandemic. The Trust continue to monitor alerting groups taking appropriate quality improvements as necessary.

Readmission within 28 days of discharge has increased on the previous year to 9.83% but remains below the expected rate of 10.28% and below the national rate of 10.18%. The 0–15 year age group rate of 12.16% is higher than the expected rate of 10.22% and the national rate of 8.93%. However, some of this data is skewed due to the assessment unit readmitting children with a range of issues, which are clinically appropriate. Actions are in place to manage the readmission rate which includes the production of 'common childhood illnesses' guides to support and reassure parents.

The CCGs monitor progress through bi-monthly Quality Review Meetings and continue to sit on a number of the Trusts internal quality groups. As part of a trusted relationship, CCGs also hold informal weekly catch up calls with the ELHT Quality and Safety Team. The CCGs commend the Trust on their approach to collaborative working in an open and transparent way and are assured of the Trusts focus on quality and safety.

ELHT has continued to demonstrate their commitment to Quality throughout 2021/22, putting the patient at the heart in order to deliver safe, personal, and effective care following a period of increasingly challenging times. The CCGs support the key priorities identified for 2022/23 and irrespective of the upcoming place and system changes we must all ensure that the citizen remains at the heart of everything we do.

3.6 Statement of Directors' Responsibilities

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

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

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

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

Signed By Order of the Board:

Chairman: Eileen Fairhurst

Interim Chief Executive: Martin D. Hodgson

Date: 30 June 2022

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
DNACPR	Do not attempt cardiopulmonary resuscitation – this is a treatment that can be given when you stop breathing (respiratory arrest) or your heart stops beating (cardia arrest)
Dr Foster Guide	A national report that provides data on patient outcomes in hospitals in the UK
Duty of Candour	The Duty of Candour is a legal duty on hospital Trusts to inform and apologise to patients if there have been mistakes in their care that have

	led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers.
EQ-5D	Instrument for measuring quality of life
Family Liaison Officer (FLO)	Acts as a single point of contact for the relevant person, patient, next of kin in regards to liaise with on the investigation of a serious incident
Get It Right First Time (GIRFT)	A programme to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improvement patient outcomes
GROW	Gestation related Optimal Weight, used to assess fetal size and growth of baby.
Healthwatch	Healthwatch England is the national consumer champion in health and care and has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.
Health Education England (HEE)	Supports the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.
HCV	Hepatitis-C virus
Hospital Episode statistics	A data warehouse containing records of all patients admitted to NHS hospitals in England
Hospital Standardised Mortality Ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths occurring within hospitals
Indicator	A measure that determines whether a goal or an element of a goal has been achieved
Information Governance Toolkit	An online tool that enables NHS organisations to measure their performance against information governance requirements
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
MSOC	Medicines Safety Optimisation Committee
National Confidential Enquiries (NCEs)	A process to detect areas of deficiency in clinical practice and devise recommendations to resolve them
National Early Warning Scores (NEWS)	A tool to standardise the assessment of acute illness severity in the NHS
National Patient Safety Alerts (NPSA)	National patient safety alerts are issued by NHS Improvement to rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death.
National Reporting and Learning System (NRLS)	A national electronic system to record incidents that occur in NHS Trusts in England

Never Event	Never Event are serious medical errors or adverse events that should never happen to a patient
NHS England (NHSE)	A body that oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and social Care Act 2012
NHS Improvement (NHSI)	A body that supports foundation Trusts and NHS Trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NHS Number	A twelve digit number that is unique to an individual and can be used to track NHS patients between NHS organisations
National Institute for Health and social Care Excellence (NICE)	A body to improve outcomes for people using the NHS and other public health and social care services by producing evidence-based guidance and advice for health, public health and social care practitioners. NICE develops quality standards and performance metrics for those providing and commissioning health, public health and social care services and provides a range of information services for commissioners, practitioners and managers across the spectrum of health and social care
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential survey and research.
Nursing Assessment Performance Framework (NAPF)	Measures the quality of nursing care delivered by individuals and teams and is based on the 6Cs Compassion in Practice values.
Palliative Care	When there is no cure for an illness, palliative care tries to make the end of a person's life as comfortable as possible
Parliamentary and Health Service Ombudsman	A body that investigates complaints where individuals perceive they have been treated unfairly or have received poor service from government departments, other public organisations and the NHS in England
Patient Administration System (PAS)	An electronic system used by acute Trusts to record patient information such as contact details, appointments and admissions
Patient Advice and Liaison Service (PALS)	A service that offer confidential advice, support and information on health-related matters
Patient Safety Incident Response Framework/Plan	New National incident reporting and investigation requirements.
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.