East and North Hertfordshire NHS
NHS Trust

Quality Account
2016-17

DRAFT FOR STAKEHOLDER COMMENT

To be amongst the best

Contents

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We always appreciate feedback from members of the public. If you'd like to tell us your thoughts on the Quality Account or suggest ideas for items to focus on in the future please let us know. We can be contacted by email ftmembership.enh-tr@nhs.net

Part 1

1a Statement on quality from the Chief Executive

2016/17 marks the year of a strong focus on partnerships. Creating a NHS that is sustainable in the future requires flexibility and the drive to optimise care and treatment through working alongside partners in the community, with academic establishments and industry. Our staff are working hard to streamline services and are being assisted by industry experts to become more efficient by cutting out unnecessary steps or actions. Alongside this 2016/17 has seen significant investment in information technology, cutting out paperwork and ensuring we're working towards having systems that 'talk to each other' wherever healthcare needs are provided. This is difficult work but ultimately our patients should see the benefit as information becomes more readily available and people will have better access to help manage their own care.

The Trust continues to make progress with improving patient outcomes. Over 97% of patients staying overnight have consistently reported in the Friends and Family Test that they would recommend the Trust for care or treatment. Mortality rates are lower than ever and the care of patients suffering from stroke continues to improve. The falls rate continues to be low amongst our peers and the Trust has been chosen to support Dementia UK by becoming a host organisation for an Admiral Nurse initiative.

Staff are key to being a successful organisation delivering high quality care. With this in mind I am really pleased about the staff development opportunities that have been introduced during the year. A new cultural programme supported by a variety of leadership and development opportunities available to all staff will assist in their personal and professional development, which in turn will translate into better patient care. I am also pleased that staff say they feel engaged in the work they do and feel they are involved in developments as the organisation goes through considerable change.

As we enter 2017/18 there are challenging yet exciting times ahead. I am confident of our staff's ability to be resilient and to embrace the changes ahead. We know that we have more work to do on improving communication and some of the administrative functions. The service developments highlighted within the report will help to address these matters.

Finally I would like to thank our staff for their continued and tremendous dedication towards delivering and improving services. To the best of my knowledge the information in this document is accurate.

Nick Carver, Chief Executive

1b About us

East and North Hertfordshire NHS Trust provides secondary care services for a population of around 600,000 in East and North Hertfordshire as well as parts of South Bedfordshire and West Essex; and tertiary cancer services for a population of approximately 2 million people in Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

The Trust has a turnover of approximately £423m and employs 5,560 whole time equivalent members of staff.

During 2016/17:

		
150,000 people attended the Emergency Department	101,000 people were admitted	604,000 people attended out-patient appointments

Our hospitals

The Trust manages in-patient services at the Lister Hospital; out-patient services at Hertford County Hospital and the new Queen Elizabeth II (QEII) Hospital; and cancer services at the Mount Vernon Cancer Centre. Renal dialysis is provided from four satellite units and the Trust manages a community children's and young people's service.

Therapy services are provided under a service level agreement with Hertfordshire Community Trust and Pathology Services are provided by a consortium arrangement in which the Trust is a partner.

The **Lister Hospital** is a 730-bed district general hospital in Stevenage offering general and specialist hospital services. It provides a full range of medical and surgical specialties together with maternity and children's service . General wards are supported by critical care (intensive care and high dependency) and coronary care units, as well as pathology, radiology and other diagnostic services. There are specialist sub-regional services in urology and renal dialysis; and chemotherapy services are delivered via the Lister Macmillan Cancer Centre.

	Feedback from NHS Choices gives the Lister Hospital 4 stars out of 5 based on 424 ratings.
Requires improvement	Following its inspection in October 2015 the Care Quality Commission rated the hospital as 'requires improvement'

…the Triage nurse made sure I was seen very quickly and then another nurse took great care with me and was so lovely. I had obs, an X ray and a doctor consult and was in and out in 3 hours. The department was clean and I even got a cup of tea. Thank you!

Emergency Dept, March 2017

Had a 24 hour blood pressure monitor fitted and two months later still waiting results? Try and speak to staff but getting nowhere. Very frustrating!

January 2017

I recently saw a doctor in your ENT outpatients clinic after a nasal injury. The doctor was kind, caring and extremely professional. They explained everything thoroughly. At the end of my visit I [felt] confident that everything was healing as it should.

ENT, February 2017

The **Hertford County Hospital** provides outpatient and diagnostic services including:

- Radiology and Pathology
- A range of outpatients clinics
- GP out-of-hours service
- Specialist children's centre
- Physiotherapy and other therapies

	Feedback from NHS Choices gives Hertford County Hospital 3.5 stars out of 5 based on 22 ratings.
Good	Following its inspection in October 2015 the Care Quality Commission rated the hospital as 'good'

… was expecting to have a long wait, I was seen within 10 minutes of arrival, the staff was so helpful and caring, excellent service, thank you.

X-ray, October 2016

… receptionist hardly looked up the entire time and was very rude. The nurse was friendly which was good. I had to change the address on my mother's notes and was told to do that elsewhere downstairs and then the receptionist downstairs told me it wasn't their job and I went back to be told again it was obviously my fault and it was too much trouble. The actual clinical staff were friendly but the clerical staff terrible.

Outpatients, May 2016

The **Mount Vernon Cancer Centre,** based in Northwood in Middlesex, provides tertiary radiotherapy and local chemotherapy services from facilities leased from Hillingdon Hospitals NHS Foundation Trust.

The Cancer Centre offers a comprehensive radiotherapy service via nine linear accelerators and has Cyberknife™ and TrueBeam™ technology. Many patients are involved in clinical trials for both chemotherapy and radiotherapy treatments. There are two inpatient wards and a range of day-case services are offered.

Other services include:

- The Paul Strickland Scanner Centre providing comprehensive scanning services for the diagnosis, treatment, monitoring and research of cancer and other serious diseases, using leading edge PET/CT, MRI and CT scanners
- The Lynda Jackson Macmillan Centre providing support, information and therapies (eg massage) to people affected by cancer
- The Michael Sobell House (MSH) palliative care unit offers hospice services for those at the end of their lives, and their families. MSH has an inpatient unit and a day centre.

The Cancer Centre is supported by a wide range of volunteers easily identifiable by their yellow sashes or badges.

Feedback from NHS Choices specifically for the Cancer Centre is not collected.	
Requires improvement	Following its inspection in October 2015 the Care Quality Commission rated the hospital as 'requires improvement'

The new **Queen Elizabeth II (QEII) Hospital** is located in Welwyn Garden City. It is owned by the East and North Hertfordshire Clinical Commissioning Group, although clinical services are managed by the East and North Hertfordshire NHS Trust.

Opened in June 2015, on the site of the original QEII, the hospital offers a full range of outpatient, diagnostic (radiology, pathology and endoscopy), therapy and ante/post-natal services. It has a 24/7 urgent care centre for adults and children with minor injuries and illnesses and carries out some day case procedures. Pre-operative assessments are undertaken as well as care and treatment offered within The Vicki Adkins Breast Unit.

	Feedback from NHS Choices gives the QEII Hospital 4 stars out of 5 based on 109 ratings.
Requires improvement	Following its inspection in October 2015 the Care Quality Commission rated the hospital as 'requires improvement'

All staff members were very professional and in very good humour considering they were dealing with a human conveyor belt! I was called after a remarkably short time of about 15 minutes by another of the cheerful and pleasant staff, who sat me down, told me we very nearly shared the same birthdate, and took my blood painlessly and unnoticed whilst we laughed! I had such a good time in this spotless department that I want to go back again tomorrow!

Phlebotomy, February 2017

... The person who had originally told us to sit down said they couldn't remember having seen us coming to the desk 45 mins earlier.
…They then told us they will check us in now, so we had been sitting there all that time for nothing, this made us furious
…We got told there was a mix up as we were early
… They then said when we come next time just come to the desk to check in, that's what we did all along.

These two on this desk have no communication going on, and they are letting the patients down…we had to pay more on the parking as a result of them messing us about.

Fracture Clinic, January 2017

Satellite and Community Services

The Trust provides services in renal medicine and has satellite dialysis units at St Albans, the Luton & Dunstable Hospital, Bedford Hospital and the Princess Alexandra Hospital in Harlow.

The Trust offers community services for children and young people.

A strategy for quality

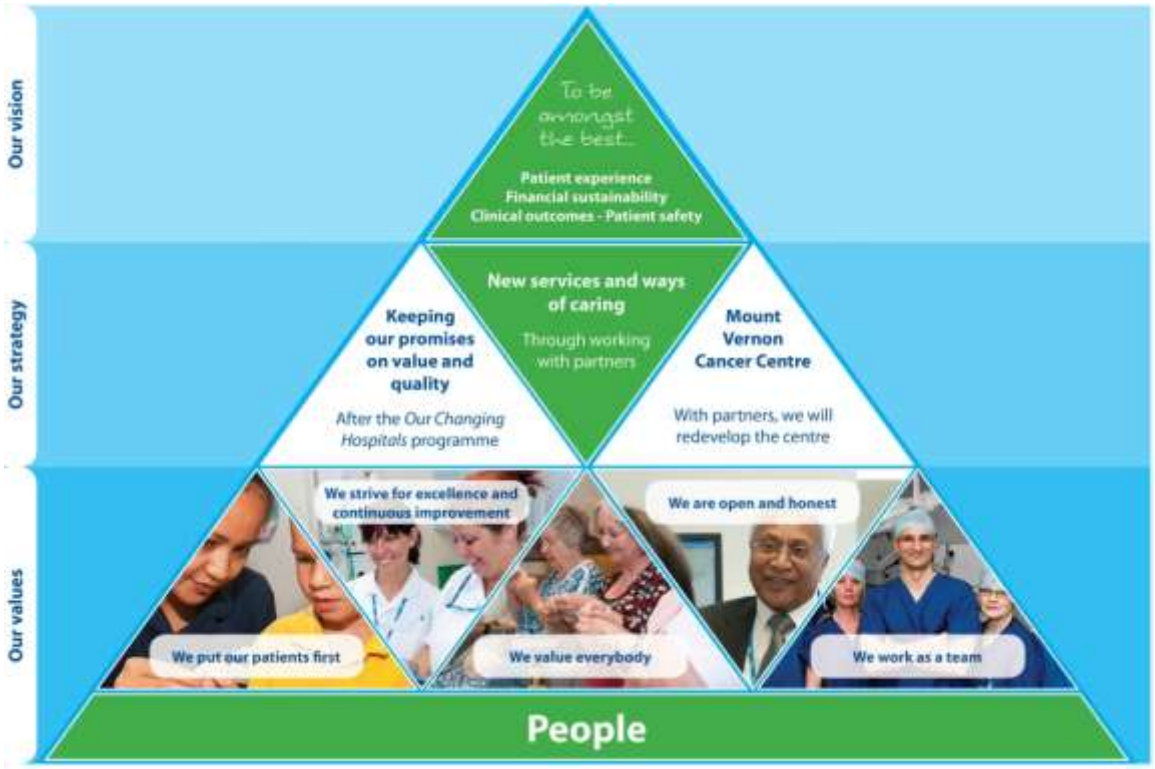
… they made me feel safe and made the whole experience tranquil and special.

… all the staff at the Lister were so reassuring, kind and warm that all my fears melted away.

Every midwife in the maternity unit and every doctor had time to talk to my husband and I, there was no clock watching and nothing was too much. The midwives on Gloucester ward are a credit to the Lister hospital and I will never forget the kindness that the management of Gloucester ward showed me. The management went above and beyond to make sure I was happy and comfortable, this sort of kindness is rarely seen anymore and for this I will be eternally grateful.

Maternity, January 2017

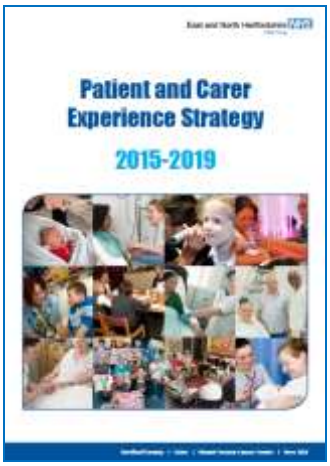
A diagrammatic representation of our quality strategy, with our vision ***"to be amongst the best"*** is shown in the picture below. Supporting the strategy are three strategic aims and the five Trust values. Underpinning the strategy are our staff.



Key to the delivery of the overall vision are a set of core values known as 'PIVOT'.

These values are incorporated into everyday working of staff and the business of the organisation.

The overarching quality strategy is underpinned by a range of supporting strategies, such as those shown below. Further information on the aims of these strategies is given in throughout this report.



Measuring and monitoring improvements

Within the Trust we collect information in a number of ways which can then be used to assess how effective our services are. We can use this information to plan future developments and improvements. Examples of our information collection methods include:

- Routine collection via the Patient Administration System – by inputting information about each individual's episode of care eg. diagnosis or length of stay we can generate a vast range of trends that can help in the future planning of services
- Surveys – results of national or local surveys help us to find out what our service users and staff think of our services
- Feedback from complaints and concerns allows us to rectify things that have not gone as well as planned
- Clinical audits help to assess if we are delivering services according to best practices
- National data collections for specific conditions allow for comparisons with other Trusts where we can learn from those performing better
- Special reviews or service evaluations undertaken by external agencies or partners provide critical appraisal. Results of such reviews are used as the basis for action planning. Service re-evaluation will often happen at a later date to confirm that quality is improved and sustained

Using the data available the Trust's clinical and management teams can measure how well we're performing. They will agree what to aim for in future – the *target or aim* - and a timeframe. Some of the performance measures and aims are mandated by NHS England and others are locally generated. Examples of these are given in section 2d.

Progress towards meeting the aims is routinely presented in reports, dashboards, graphs etc. Some of these are seen throughout this report. They are monitored by various groups, for example:

- Committees, including the Trust Board, who monitor progress
- Departments who review the outcomes and plan changes where necessary
- The executive team who scrutinise information, offering praise or challenge as necessary
- Commissioners (East and North Hertfordshire Clinical Commissioning Group) who purchase the Trusts services on behalf of the local community and scrutinise the outcomes to check that a high quality service is being delivered

By measuring outcomes regularly we can see if we are meeting our aims or not. If we are, then we'll set more demanding aims to raise standards further; if not we'll look at why and change how we do things to meet these aims.

Supporting teams to improve quality

The Trust has five clinical divisions: Medical, Surgical, Cancer, Women's and Children's and Clinical Support Services. Each is led by a Divisional Director and Divisional Chair. The divisions are separated into a number of clinical specialties each headed by a Clinical Director. The specialties are supported by senior nurses and managers. Together they are responsible for quality within their own areas.

The clinical divisions are at the forefront of our hospitals, delivering the care. Helping them to deliver high quality care are teams from the corporate divisions such as:

- Clinical advisors eg infection prevention and control team or the safeguarding team providing specialist advice and support
- Information team supplying data for service evaluation

- Education and Organisational Development teams ensuring staff are up to date with training and have opportunities for personal and career development
- Catering, portering, telephony, estates, supplies and cleaning staff who keep the day-to-day services running so that clinical teams can undertake their duties effectively
- Information technology teams keeping the IT systems running and supporting new ways of working with the increasing installation of electronic systems
- Human resources who support the recruitment and other staff management processes
- Those who support service evaluation and compliance such as the governance teams

The governance teams in particular support the clinical teams in delivering care that is safe, effective and provides a good experience. These teams eg. patient safety, patient experience, clinical audit & effectiveness, complaints and PALS together with those within the Company Secretary's office have a dual role – to support the delivery of optimum quality whilst also supporting staff and managing the effects of something going wrong or where care is sub-standard.

Committee structure

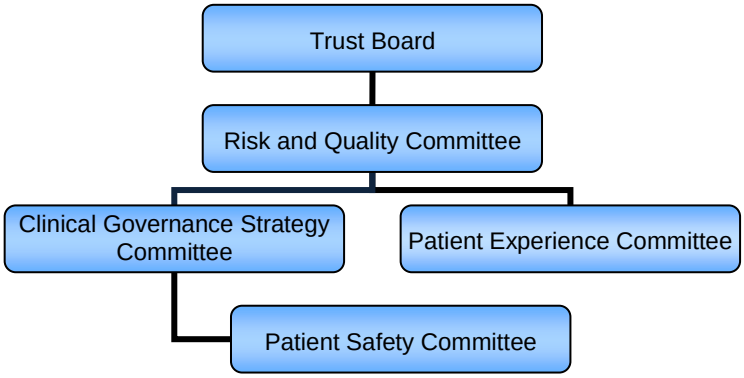
The Trust Board has overall responsibility for the delivery of quality. It scrutinises a range of quality indicators during its meetings which are held in public.

The Risk and Quality Committee (RAQC) has delegated responsibility for oversight of all aspects of quality. The committee holds executive directors to account on relevant aspects of their portfolio.

The main sub-committees for monitoring quality are the:

- Clinical Governance Strategy Committee (Chaired by the Medical Director)
- Patient Experience Committee (Chaired by a Non-Executive Director)
- Patient Safety Committee (Chaired by the Associate Medical Director for Patient Safety)

These each receive scheduled reports from departments, committees or individuals tasked with quality improvement, for monitoring and assurance purposes. Sub-committee membership comprises clinical and managerial staff; and a process of escalation enables significant achievements and any concerns or to be shared with the parent committee.



Performance reviews

Performance reviews are held every month. The executive directors meet formally with Divisional leads and their supporting staff to review all aspects of quality – to praise developments and the achievement of required standards; and to challenge any areas where improvement is required.

Rolling half days (RHD)

Each month (except January and August) all non-emergency activity is suspended for half a day to allow a significant proportion of team members to meet and review their practices. This dedicated time offers an opportunity to review outcomes such as audit findings, care reviews and incident investigations, and where necessary to make plans for improvement.

RHD 'learning points' and divisional reports providing tailored feedback are prepared by the governance teams and are circulated prior to the meetings for discussion. These highlight recent matters of concern or interest for sharing.

Local inspections

A number of inspections are undertaken whereby teams visit wards and departments to observe practices, discuss care with patients and their families and to discuss various aspects of care delivery with Trust staff. Such inspections may be undertaken by Trust staff, the Clinical Commissioning Group staff or members of the public/ patient representatives.

During 2016/17 inspections of the following services were undertaken:

- Emergency Department – safety and compliance teams
- Mount Vernon Cancer Centre – safety and compliance teams
- Ward 9A (Elderly Care) in February 2017 - Clinical Commissioning Group
- Medicines Management across 18 wards in January 2017 - Clinical Commissioning Group
- Emergency Department in November 2016 - Clinical Commissioning Group
- Mount Vernon Cancer Centre in November 2016 - Clinical Commissioning Group
- Ward 8b in October 2016 - Clinical Commissioning Group
- Visits by members of the public as part of a 15 steps challenge (a brief assessment based on initial opinions and observations formed within a few minutes of being on the ward)

These inspections are used to identify areas of good practice and identify where improvements are required. The involvement of clinical staff on an inspection team provides an opportunity for peer review and to share learning. Feedback from the inspections is reported back to staff in the relevant areas.

1c Planning for the future

Partnerships

The Quality Strategy diagram in section 1b shows "New services and ways of caring" as one of our strategic aims. To achieve this aim the Trust is a partner in the Hertfordshire and West Essex Sustainability and Transformation Plan (STP). Working with health and social care partners the Trust is developing new ways of working that will be sustainable in the long term. The plan is outlined in a document called '*A Healthier Future*'.

This sets out four main ways in which health and social care organisations plan to improve health and care in the future:

- Prevention – helping people to live healthier lives and live well with long term conditions
- Primary and community care – supporting more independent living through better coordinated care delivered at home or in the local community
- Acute care – using hospital care for specialist and emergency treatments only
- Improving efficiency – through better use of technology and resources

The acute care workstream aims to ensure that people only attend hospital when they need to ie. for emergency care and specialist care and treatment. The Trust is one of three acute trusts contributing to the STP – the others being West Hertfordshire Hospital NHS Trust (WHHT) and Princess Alexandra Hospital Trust (PAH). Each is working together to support each other where services become fragile. Called 'clinical service consolidation', the development of services across organisations will keep them local and sustainable. Examples of this support include:

- **Vascular surgery and interventional radiology:** The Trust is working with PAH to set up a vascular network covering the eastern area of the STP footprint
- **Paediatric urology:** The Trust will provide one day/week paediatric urology service at PAH to enable the continuity of this service
- **Nephrology:** Agreement in principle for the Trust to be the provider of outpatient and in-reach service at PAH
- **Specialist cancer surgery:** Agreement in principle for the Trust to become the specialist cancer surgery centre for complex urological cancer surgery referrals from PAH, avoiding the need for patients to travel into London for surgery from 2017/18 (subject to agreement with Specialist Commissioners).

In addition partnership working is aiming to:

- Standardise care and treatment to reduce unwanted variation
- Reduce the costs of non-clinical and back-office functions by sharing services where possible
- Develop electronic systems that will support decision making and information sharing, as per *Local Digital Roadmap*

Streamlining services

A team of Lean 6 Sigma specialists is currently employed by the Trust to re-design some processes that are not working as well as desired. The specialists work with clinical teams, managerial teams and external partners where relevant to analyse the current processes, looking at all the component steps and how these can be simplified to become more efficient. Examples of such projects and achievements are given below.

- The handover of patients, within 15 minutes, from ambulance crews to emergency department staff is now achieved in 81% of cases, compared with 10% before the project began. It is also possible to identify the reasons why the remaining cases were not achieved
- The preparation of 'to take out' medications currently takes 2 hours. Working with pharmacy staff the Lean team has redesigned a new process of working which should reduce the preparation time to 30 minutes, thereby potentially reducing discharge time by 90 minutes. Implementation will start once a new IT system change has been completed

- Patient experience and staff efficiency has improved in the Lister Macmillan Cancer Centre due to layout redesign, reduction of overbooking and the elimination of delays or replication of paperwork

The team has trained over 100 staff to date on the use of various Lean 6 Sigma tools and during 2017/18 will be working with the Organisation Development team to deliver a training programme for the whole Trust. Projects that have just started relate to waiting times for patients with cancer and the improvement of catering processes.

A company called Four Eyes Insight have been contracted to support the review of theatre services focusing on theatre productivity eg. improving scheduling and reducing cancellations. The company is currently working with a number of specialties with the improvements in outcomes becoming visible in 2017/18.

Technology

Some fantastic technology is employed for a range of clinical treatments such as robotic surgery and remote monitoring of health conditions. There are also sophisticated systems in use providing services such as access to test results. However the Trust is still largely paper-based and dependent upon systems that do not always 'talk to each other' or do not take advantage of the everyday technology now available.

The Trust's Information Management and Technology (IM&T) Strategy aims to address this imbalance.

"A successful NHS organisation needs up-to-date, trustworthy information and the technology and infrastructure in place to support staff to access the right tools and information as and when they need it."

"This strategy sets out to identify the essential information that the Trust needs to achieve its corporate ambitions at a strategic level and to deliver safe, efficient and effective clinical care."

The IM&T Strategy has six elements:

- Improving patient care by providing the right information at the right time to the right place
- Becoming the hospital of choice through improving patient experience by introducing services such as self check-in
- Delivering digital care through electronic records and prescribing
- Improving the IM&T function through standardization
- Producing an infrastructure fit for future development that is resilient and secure
- Using data to support decision making by improving access to real time information

An Innovation Programme was set up to deliver the objectives outlined within the Strategy, with resource and time assigned to the programme. There are 20 active projects. Most significantly, during 2016/17 staff prepared for the introduction of a system to support electronic observations and escalations (detailed later in the report). The system pilot commenced in March and the full roll-out is expected by July 2017. In addition, the foundations to support electronic prescribing are being put in place and the testing phase for a new patient administration system, called Lorenzo, is underway. Lorenzo is due for deployment in July 2017.

Engagement

The Engagement Strategy 2016-19 sets out the ambition and priorities for engagement over the next three years. It ensures we will further build our growing reputation for partnership working and community engagement.

The Strategy outlines our vision for:

- Community leadership
- Member development
- Service delivery, development and transformation
- Clinical engagement

The Engagement Strategy links with the Trust's work with media, MPs, communications, patient experience, workforce and organisational development. Our aim is to work with partners (service users, public, staff and other organisations) to identify our needs and aspirations then to develop and implement the plans to achieve service improvement.

University Trust Status

The Trust is delighted to have achieved University Trust status in early 2017. The Trust already has a successful working relationship with the University of Hertfordshire through its nurse training programme. It also has a shared commitment to research, education, service and teaching.

In future the partnership will provide a number of benefits:

- Quality of Care will be improved through enhanced opportunities in education, training, research and innovation
- Service improvement eg. through use of process engineering
- Public and Patient Engagement will be enhanced by close working with academics from the schools of Health and Social Work and Life and Medical Sciences
- The workforce will be enhanced by improved recruitment and retention and higher levels of knowledge, skills and expertise.

Learning and Development Strategy

The Learning and Development Strategy 2017-20 sets out how the Trust will ensure its workforce has the right knowledge and skills to deliver high quality care and is equipped to meet the challenges of the future.

The Strategy has four strategic goals:

- Create and sustain an educational experience for all learners that inspires them
- Develop a culture that recognises learners as individuals
- Links education to role and career development
- Develop the highest level of technical expertise utilising best practices and latest technology

The strategy outlines the tasks required to achieve the strategic goals such as introducing new roles; working more closely with university partners to support training and embracing technology such as simulation and use of mobile Apps. The strategy also focuses upon improved learning from things that haven't gone as well as intended; and also increases engagement with patients and the public to support self-care.

Part 2

2a Priorities for improvement for 2017/18

In order to seek views about priorities for 2017/18 the following actions were undertaken:

- Existing priorities and indicators were reviewed to ensure they were relevant. This formed the basis of the debate during the consultation stages
- Review of areas of performance where local intelligence monitoring indicates there is further room for improvement eg. PALS concerns, complaints, NHS Choices, national surveys
- Review of the operating plan and workstreams outlined within the Sustainability and Transformation Plans
- Consideration of CQUIN requirements

In addition the opinions of staff and service users were sought from the following committees:

- Involvement Committee
- Patient Experience Committee
- Patient Safety Committee
- Clinical Governance Strategy Committee

The final decision on priorities was determined by the Executive Committee after deliberation of the findings and consideration of existing priorities and their outcomes. The results were presented to the Risk and Quality Committee for final approval.

Patient safety

1. Improve medication management

The pharmacy transformation programme 2017/18 will be introducing a range of medication related improvements.

Leads:
Medical Director
Director of Nursing & Patient Experience

- In-patient survey results of medication purpose >8.4
- In-patient survey results of medication side effects >4.8
- Introduce set of leaflets (subject to funding) for medication group eg painkillers, antibiotics
- Critical medication doses omitted <7% in medication thermometer
- Complete Medicines Optimisation Strategy milestones
- Demonstrate benefits on 3 wards of the hospital pharmacy transformation programme

2. Progress 'deteriorating patient' work

The introduction of electronic observations is intended to help identify and reduce deterioration.

Leads:
Medical Director
Director of Nursing & Patient Experience

- Rollout of Nerve Centre as per plan
- Undertake human factors review in maternity
- Improvement against results of 2015/16 Audit of Unexpected Critical Care admissions
- No. of cardiac arrest calls < 174
- Observation Compliance >=98%
- Identify all cases of poor escalation within SI reports (recorded on Datix)

Clinical effectiveness

3. Further reduce mortality

An on-going priority aiming to reduce mortality through service development and mortality reviews. Recognise the national importance placed on publication.

Lead: Medical Director

- HSMR <95.3
- SHMI 'within normal range' and 'below 110'
- SHMI (inc adjustment for palliative care) <98.5
- Mortality review – areas of concern discussed at each meeting of the Clinical Governance Strategy Committee
- Demonstrate learning from mortality review process

4. Further improve stroke standards

An ongoing priority to monitor the sustainability of changes following service expansion.

Lead: Chief Operations Officer

- 3 hour thrombolysis >=12%
- 4 hours to stroke unit >=90%
- 90% time on stroke unit >=80%
- 60 minute to scan >=90%

Patient experience

5. Improve communication

Communication failure remains one of the most common concerns identified via feedback mechanisms. Continuing service and staff development should reflect in this priority.

Leads:
Director of Nursing & Patient Experience
Chief Operations Officer

- Electronic survey results of involvement in decisions >83%
- National In-patient survey results of consistent information >7.8
- Electronic survey results of providing understandable answers >88% (doctors) and >90% (nurses)
- National In-patient survey results of having point of contact >7.8
- Reduce rate of communication related complaints per bed days <0.144%
- Reduce rate of communication PALS concerns per bed days

6. Improve nutrition and hydration	
To continue oversight of the delivery of the Food and Drink Strategy and evaluate the effectiveness of service redesign. Lead: Director of Nursing & Patient Experience	• In-patient survey results of quality of food >5.2 • In-patient survey results of choice of food >8 • In-patient survey results of help with eating >7.5 • Delivery of strategy milestones • Compliance with nutritional aspect of ward observational tool >=95%

7. Improve patient flow	
A new priority to evaluate the effectiveness of a variety of service transformation processes. Lead: Chief Operations Officer	• Reduce cancellations <504 • Reduce re-admissions <7.75% • Reduce delayed discharges from critical care • Discharge summary to GP within 48 hours • Reduce complaints relating to delays per 100 bed days <0.08%

Progress in delivering these priorities will be monitored by the following means:

- Scheduled reports to the Risk and Quality Committee / Trust Board:
    - Medical Director's Mortality Report
    - Director of Nursing's Patient Safety Report
    - Director of Nursing's Patient Experience Report
    - Chief Operating Officers update reports
- Monthly 'Floodlight' report to the Board
- Medication Forum
- Patient Safety Committee
- Monthly reviews of mortality concerns and quarterly thematic reviews at the Clinical Governance Strategy Committee
- Patient Experience Committee
- Nutrition Group

Trust Board papers are published on the Trust's website.

2b Review of quality performance in 2016/17

In the 2015/16 quality account a list of priorities for delivery during 2016/17 was stated. Progress against each of these priorities is given in the sections below.

Improving safety

Priorities	What success will look like
1. Improve medication management Medication audits show that initiatives to improve medication management are working. We wish to make further improvements in this area.	• In-patient survey results of medication purpose >8.4 • In-patient survey results of medication side effects >4.8 • Reduction of medication incidents resulting in harm <10% • Critical medication doses omitted <7% in medication thermometer • Complete Medicines Optimisation Strategy milestones • Medicines reconciliation within 24 hours of admission >80% • >90% administration of antibiotics within 1 hour of prescription for septic patients in the emergency department
2. Introduce Human Factors[1] There is increasing emphasis placed on this developing area nationally. It is also a priority identified within the Improving Patient Outcomes Strategy	• Deliver a new style serious incident investigation training >=4 times during 2016/17 • Undertake a human factors review of 2 clinical areas • Identify all cases of poor escalation within SI reports (recorded on Datix)

[1] 'Human factors' examines the interaction between a person and their working environment (team, organisational culture,

Priority 1: Medication management

		13/14	14/15	15/16	16/17	Aim for 16/17	Met
1.1	Inpatient survey: - medication purpose	8.2	8.4	8.2		>8.4	
1.2	Inpatient survey: - side effects	4.4	4.8	4.8		<4.8	
1.3	% medication incidents leading to harm	11.96	11.76	10	**11.62**	<8.8	✘
1.4	% critical medication does omitted		21.92%	5.31%		<7	
1.5	Medicines Optimisation Strategy milestones		115	125		>125/144	
1.6	% medicines reconciliation within 24 hours of admission			76.1%	**84%** **(2016)**	>80%	✓
1.7	Admin of antibiotics within 1 hour of prescription for septic patients in the emergency department			Q3 60% Q4 56%	**47%**	>90%	✘

Priorities 1.1 & 1.2 - Inpatient survey

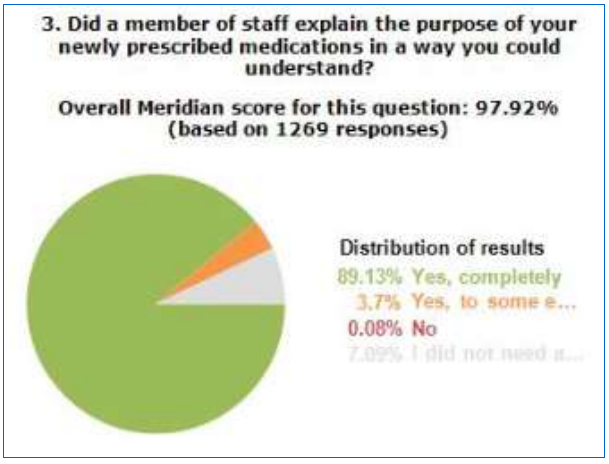
The national in-patient survey measures two important aspects of medicines management:

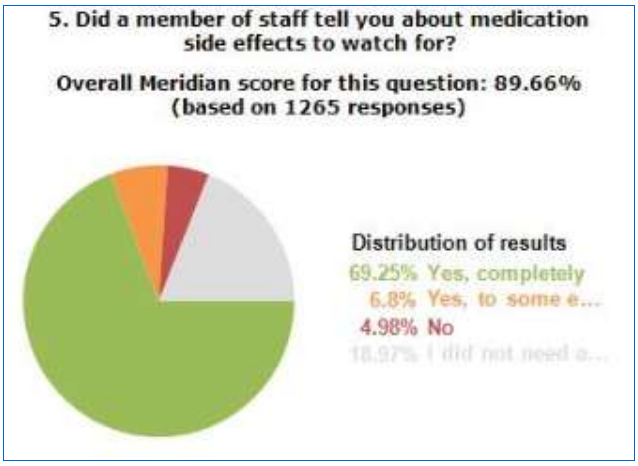
- staff explained the purpose of medications in a way a patient could understand
- staff explained about medication side effects to watch out for at home

The results from the 2016 survey are shown below.

Awaiting result – due May

Almost 1270 people contributed to the Trust's electronic pharmacy survey during 2016/17 whereby two of the questions asked replicated those of the national survey. The results are shown in the pie charts below.





Priority 1.3 - Medication incidents leading to harm

1033 medication incidents were reported by staff during the year, the vast majority causing no harm.

The data below looks at harm rates. However, caution must be applied as the numbers are very small and this information is only reliable if all medication incidents are reported; and also. The aim was to reduce the rate of harm by 10% compared to the previous year ie 8.8% of all medication incidents.

Although not meeting the overall aim the number of harm-related incidents is small. During the year 2.9% of medication incidents led to significant harm.

	16/17	Aim	Met
No. harm incidents	**120**	-	-
% harm incidents (all harm incidents)	**11.62**	<8.88	✘
No. moderate & severe harm & death incidents)	**30**	-	-
% incidents (moderate, severe & death incidents)	**2.9**	<2.56	✘

Of greater importance is the learning that has occurred as a result of these incidents. Some examples include:

- Change in process in the delivery of chemotherapy
- Recording of first antibiotic doses on the 'give now' section of the medication chart
- Enhanced education
- Changes in identification markings on insulin pens

Priority 1.4 - Medication omission audit

Medication is considered to be delayed if it is administered more than 60 minutes, but less than 2 hours late. An omitted dose is defined as one either not given or given more than 2 hours late.

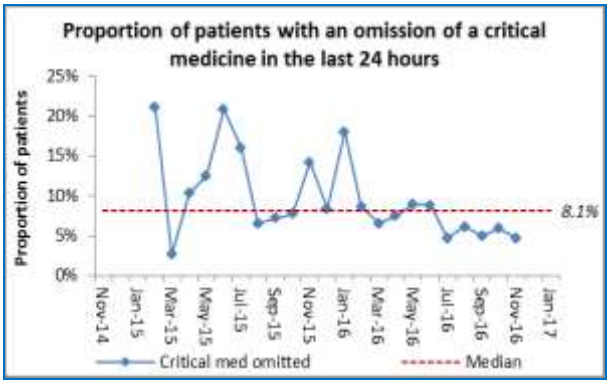
Some medications are known as 'critical' where delay or omission may have a significant impact upon a person's health or wellbeing. Examples of such medications are insulin for diabetes, anti-Parkinson's drugs and anticoagulants.

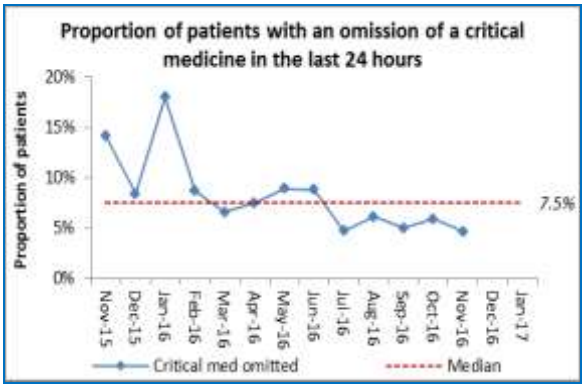
The annual audit of delayed or omitted critical medication shows the following (add once analysed):

	May 2014	January 2015	December 2015	January 2017
Total no. of critical drug doses	1432	2547	6236	
% of doses given correctly	76.75%	89.16%	92.67%	
% of doses omitted	**21.92%**	**10.33%**	**5.31%**	
% of doses delayed	1.33%	0.51%	2.02%	

The Medication Safety Thermometer is a national standardised audit tool that measures medication-related errors. Data is collected by nurses and pharmacists on one day each month on 100% of patients present on six medical wards, five surgical wards and two wards at the Cancer Centre. The data collected is entered onto the national thermometer web-tool. This generates charts summarising ENHT results and compares the results with data from other Trusts.

Results of omitted critical medications for the last two years, and for the last year are shown in the charts below. These show an improving picture from a 2 year median of 8.1% to a 1 year median of 7.5%. There is also a reduction in variation indicating that quality improvement methods are becoming embedded.





Although data continues to be collected each month a change to the national web-tool means that more recent graphs are not yet available.

To help reduce medication omissions the Trust has:

- increased to three the number of wards offering self-medication, with self-medication offered to patients with Parkinson's Disease on a further two wards
- fitted patient-own-drug lockers with each nurse having their own key to retrieve medication thereby saving time taken by nurses searching for keys

- taken a focused approach on critical medications such as anticoagulants and insulin working with staff on targeted projects

The Trust is increasing the number of non-medical prescribers, such as specialist nurses. Such staff can prescribe and administer specific medications in the absence of a doctor thereby streamlining care delivery.

Weekly drug chart reviews have been piloted on four wards. Pharmacy staff join medical and nursing staff to look at prescribing quality with the emphasis on learning and accurate prescribing. This practice will be extended to other wards during 2017/18.

Priority 1.5 - Implement Medicines Optimisation Strategy

The Trust's Medicines Optimisation Strategy was published in July 2014. It was based upon a national framework which helps Trusts to evaluate practices and identify areas of good practice and where development is required. Year on year actions have been implemented to continuously improve upon the original baseline score of 115/144. Actions undertaken in 2015/16 increased the score to 125/144 and actions undertaken in 2016/17 have resulted in a score of xxx/144.

Some achievements in the last 12 months include:

- More than 85% of outpatient prescriptions at the Lister site are dispensed within 15 minutes; and more than 95% within 30 minutes. Overall patient satisfaction for the pharmacy outpatient prescription service is above 96% month on month
- The Lister dispensing service is available 7 days per week (reduced hours at weekend)
- A clinical pharmacy service is provided at the weekend to five wards where there is a high turnover of patients or a most pressing need for support. This service provides enhanced services such as patient counselling and efficient dispensing of discharge medications at a ward level

A new pharmacy stock control system will be introduced in June 2017. It will ultimately form the platform to develop electronic prescribing in the future. The Hospital Pharmacy Transformation Programme Plan was approved at Trust Board and will inform the medicines optimisation strategy in the future.

Priority 1.6 - Medicines Reconciliation

Medicines Reconciliation ensures that medicines prescribed on admission correspond to those taken before admission. Matching such records helps to reduce medication error. Pharmacy staff discuss medications with patients/ carers and use records from primary care (eg. Summary Care Records) to help ensure this match.

The Trust aimed to complete medicines reconciliation on more than 80% of patients within 24 hours of admission. For January 2016 - December 2016 Medicines Reconciliation was completed as follows:

	Target	Achieved	Met
Within 24 hours	80%	84%	✓
Within 48 hours	90%	95%	✓
Within 72 hours	95%	96%	✓

The targets for 2017 have increased and data for January to March against these targets is shown below.

Clearly the targets are more challenging with March data showing compliance in all areas.

	Target	Jan	Feb	Mar
Within 24 hours	85%	82%	82%	92%
Within 48 hours	95%	97%	94%	99%
Within 72 hours	100%	99%	99%	100%

In Quarter 3 (2016/17) 461 medicines reconciliations were completed within 24 hours of admission on the five wards mentioned in priority 1.5 above. This equates to 34 per weekend who would otherwise have had to wait until Monday morning for a pharmacy review. Such weekend working supports the delivery of accurate medications and therefore safer and efficient care.

Priority 1.7 - Sepsis – antibiotics within an hour

"If your immune system is weak or an infection is particularly severe, it can quickly spread through the blood into other parts of the body. This causes the immune system to go into overdrive, and the inflammation affects the entire body. This can cause more problems than the initial infection, as widespread inflammation damages tissue and interferes with blood flow. The interruption in blood flow leads to a dangerous drop in blood pressure, which stops oxygen reaching your organs and tissues."

NHS Choices, April 2017

Recognition of sepsis and prompt action is vitally important to prevent further harm or death as deterioration may be rapid. Data available in April 2017 shows sepsis mortality at 87 (HSMR) and 107 (SHMI) for the period Jan-Dec 2016. [Please see priorities 3.1 & 3.2 for an explanation of mortality].

New NICE guidance was released in 2016 which resulted in the revision of policy and the development of sepsis proformas (in line with the Sepsis Trust). Teaching and awareness raising continues both around early recognition and appropriate management.

The 2016/17 CQUIN set targets relating to sepsis. These challenging targets aim to promote early screening to identify people with potential sepsis and to start treatment within the hour. The achievement against these targets is shown in the table below.

	2016/17	Aim	Met
Screening of all ED patients	**92.5%**	≥90%	✓
Administering antibiotics within 1 hour to ED appropriate patients	**45%**	≥90%	✗
72 hour review of ED patients	**91%**	≥90%	✓
Administering antibiotics within 1 hour to appropriate ward patients	**47%**	≥90%	✗

To support delivery of improved sepsis management a wide range of initiatives are being implemented:

- Permission granted for certain groups of nurses to give antibiotics without prior prescription by doctors to support the delivery of antibiotics within one hour (via the recently approved Patient Group Direction)
- Collaboration with the NerveCentre project group to develop an automated sepsis tool on the electronic observations system, prompting early response when sepsis is suspected
- Prompt action in the Emergency Department is being supported with the provision of a Sepsis trolley containing all relevant information and supplies
- 3 month trial of a neutropaenic sepsis alert card for cancer patients

- The appointment of an additional Sepsis Nurse (bringing the complement to three) to support educational initiatives
- Provision of e-learning

The Lean 6 Sigma team are working with emergency department staff to triage patients with suspected sepsis and initiating treatment within one hour. The team has examined the current process and are now at the point of trialling a new way of working.

Priority 2: Introduce Human Factors

Human Factors is being used increasingly to understand the complexity of healthcare and to identify both causes of error and ways to eliminate the potential for error. It is described by leading international expert as:

> "enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings"
>
> Dr Ken Catchpole

This is a new priority for the Trust and one which has little previous history with which to compare.

	Human factors	15/16	16/17	Aim for 16/17	Met
2.1	Deliver a new style serious incident investigation training >=4 times during 2016/17		**4**	>=4	✓
2.2	Undertake a human factors review of 2 clinical areas		**1**	2	=
2.3	Identify all cases of poor escalation within SI reports (recorded on Datix)	14 (calendar year 2015)	**22** (calendar year 2016)	Identify	✓

Priority 2.1 - Training

Root cause analysis training has been undertaken for many years but during 2016/17 the incident investigation training has been modified to include human factors.

The training:

- uses everyday examples of humans interacting with their environment
- focuses on a true story where greater attention to human factors may have saved a life
- helps staff to see the importance of their role within their environment and how they can make it safer
- focuses on the system and not individual blame

During 2016/17 four training sessions were held attended by 11 consultants and 40 senior nurses/ managers. Many of these staff are now able to participate in serious incident investigations.

Priority 2.2 - Human Factors Review

It was intended that two comprehensive reviews would be completed during 2016/17. One has been completed comprehensively and the Trust is progressing a series of other workstreams with human factors elements.

A full human factors review was undertaken within the Theatres department by national human factors expert Dr Jane Carthey. Observations of twenty-five different operating lists were carried which found some reassuring aspects:

> "The majority of theatre teams observed are exemplary"
> Dr Jane Carthey

- Surgeons, anaesthetists and senior theatre nurses who are really good at flattening the hierarchy
- Well-structured team briefs

Other areas were identified where improvements were required.

Action	Improvement
Ensure team briefs are carried out on the Emergency List in main theatres	All emergency operations are now detailed on a white board which is updated throughout the day as necessary. This supports the delivery of the team brief, particularly where there is a change of operating team
Team briefs should start with all team members being present	Theatre staff have been instructed to ensure all staff are present before undertaking the team brief
Verbal confirmation that the swab and instrument count is correct at the end of the procedure should be given	The verbal swab and instrument count is confirmed prior to the scrub nurse completing the last part of the theatre checklist.

The maternity team bid for funding to "Introduce Human Factors to improve our safety culture particularly in relation to working in teams, critical language and working in a culture of psychological safety and situational awareness to reduce harm".

The team was successful in securing over £80,000 to train 114 staff members in human factors. The actions to implement this work will be undertaken during 2017/18.

Procedures undertaken in the cardiac catheter laboratory were reviewed to ascertain compliance with a national safety standard on interventional procedures. The review confirmed that the procedures were undertaken in line with guidance but required some updates to policy and documentation.

Priority 2.3 - Serious Incidents (poor escalation)

The Trust's electronic incident management system has been tailored to capture themes common within serious incidents. Such themes include patient factors, staff/ team factors, education, equipment or organisational factors. One theme relates to poor escalation – where a patient shows signs of deterioration but has not been escalated to a more appropriate or senior member of staff for action to be taken in a timely way.

The Trust uses the National Early Warning Score (NEWS) where each observation eg. pulse rate is assigned a score between zero (no concern) and three (serious concern). Adding up all the scores gives an overall score which is used to make a decision about escalation – whether it is needed; and if so to whom.

During 2016 (calendar year) poor escalation featured in 22 of 62 serious incidents. This compares with 14 in the previous calendar year. Once the electronic observations system is

introduced in all areas by July 2017 the automatic escalation function will be enabled. This means that any concerns will be communicated automatically to relevant doctors and critical care outreach staff. Meanwhile work is ongoing around raising awareness about escalation.

Improving clinical outcomes

Priorities	What success will look like
3. Further reduce mortality This is a significant priority for the Trust. Whilst the HSMR remains better than national average the SHMI still remains a concern	• HSMR <95.3 • SHMI 'within normal range' and 'below 110' • SHMI (inc adjustment for palliative care) <98.5 • Improvement against results of 2015/16 Audit of Unexpected Critical Care admissions • No. of cardiac arrest calls < 174 • Observation Compliance >=98% • Mortality review – areas of concern discussed at each meeting of the Clinical Governance Strategy Committee
4. Further improve stroke standards There remain delays in transferring people to the stroke unit. Additionally the Trust wishes to evaluate the impact on standards of the increased activity associated with acceptance of patients from the Harlow area	• 3 hr thrombolysis >=12% • 4 hrs to stroke unit >=90% • 90% time on stroke unit >=80% • 60 minute to scan >=90%

Priority 3: Further reduce mortality

		13/14	14/15	15/16	16/17	Aim for 16/17	Met
3.1	HSMR (3 month arrears)	88.96	92.31	93.31	**95.18**	<=95	=
3.2	SHMI	111.76	112.9	109.7	**105.61**	<=108	✓
3.3	SHMI (adjusted for palliative care)	100.43	100.51	98.69	**95.5**	<=98.5	✓
3.4	Unexpected admissions to critical care	Audit completed	Audit completed	Audit completed	**N/A**	Complete audit	-
3.5	Cardiac Arrests	174	203	208	**127 YTD**	<174	
3.6	Observation compliance	95.88	95.49	93.61%	**96%**	>=98%	✗
3.7	Mortality review	N/A	N/A	Undertaken	✓	Undertake	✓

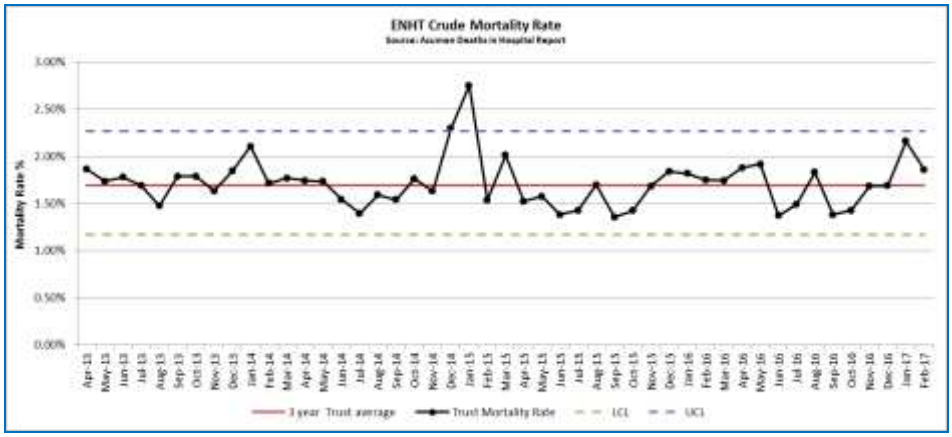
There are three main types of mortality indicator:

- Crude Mortality
- Hospital Standardised Mortality Ratio
- Summary Hospital Mortality Index

Crude mortality is a simple analysis of the percentage of patients who die in hospital against the total number of discharges from hospital. It makes no adjustment for patient acuity (how unwell they are).
Recently introduced benchmarking data shows the average national crude inpatient mortality is 1.4%; and is 1.5% within the East of England region. The Trust has a slightly higher rate at

1.7% as shown in the table below although this is against an expected 1.8% and reported as “significantly better than expected”.

Time period	Crude mortality rate
3 year average rate	1.67%
2016/17 year to date (March 2016-February 2017)	1.7%



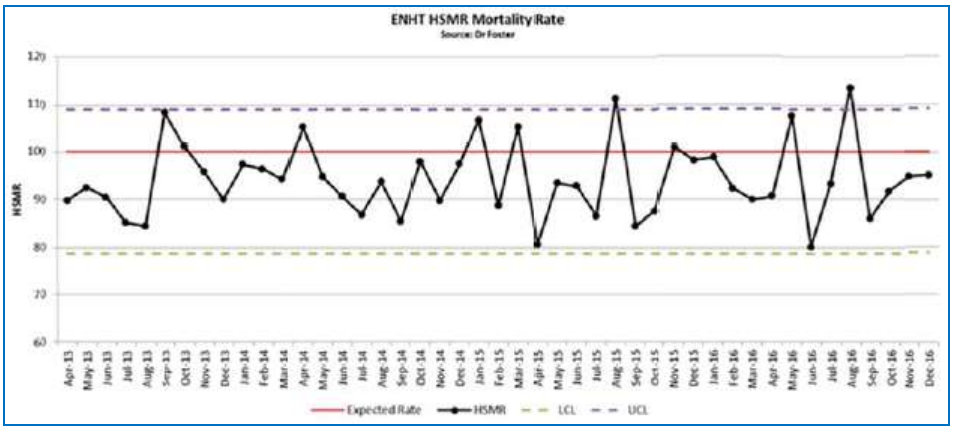
Changes in clinical pathways, where patients are seen via ambulatory routes (walk in day care) and where ‘hospital avoidance’ initiatives become more prevalent, may lead to a rise in crude mortality in the future as only the sickest people are admitted.

Priority 3.1 - Hospital standardised mortality ratio

The Hospital Standardised Mortality Ratio (HSMR) measures in-hospital mortality for 80% of the most common diagnosis categories resulting in patient deaths.

It is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die on the basis of local adjustments (eg patient age and patient acuity). This adjustment allows comparisons to be made with other trusts. HSMR can also be adjusted to account for the impact of palliative (end of life) care. The England average is always 100 (red line in the graph below). A lowering number indicates an improving position and a number below 100 is better than average.

The Trust’s HSMR position for the twelve months to December 2016 was **95.18** and is rated statistically as “as expected”. The Trust’s position relative to its East of England peers is 6th of 17.



HSMR can be used to calculate mortality in a number of ways such as for particular diagnostic groups eg. heart attack or asthma. It is therefore possible to see which conditions result in higher than expected mortality enabling staff to explore why this might be the case.

Priority 3.2 - Summary Hospital-level Mortality Index

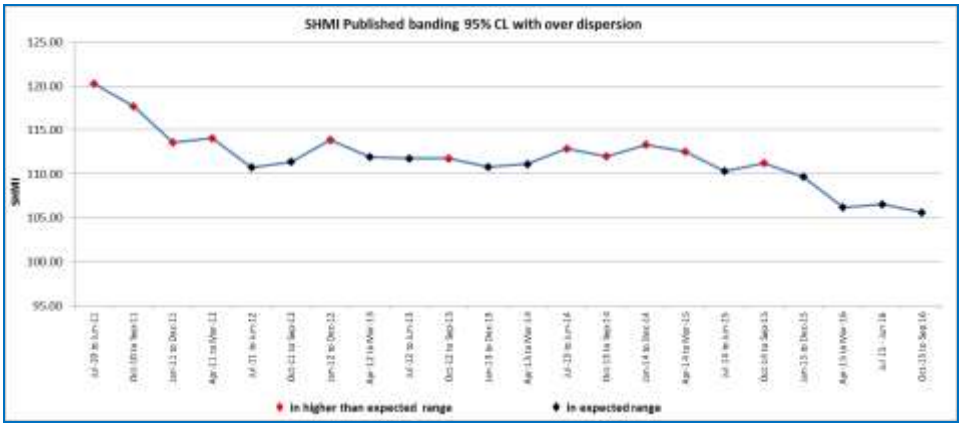
The Summary Hospital Mortality Index (SHMI) measures hospital mortality outcomes for all diagnosis groups along with deaths in the community up to 30 days after discharge. SHMI data is 7-9 months in arrears and is not adjusted for palliative care.

Whilst the Trust performs better than average using the HSMR it performs worse than average when measured using the SHMI methodology. The discrepancy is partly accounted for by 7-day provision of palliative care services in the Trust and the provision, as with a small minority of other trusts, of hospice services. For these reasons the Trust also reports SHMI that has been adjusted for the palliative care influence.

It is notable that the Lister Hospital has a significantly higher proportion of patients with end-stage respiratory and cardiac diseases who are admitted to die in the Trust compared to the norm in England.

The SHMI for the period October 2015 to September 2016 is **105.6** and is within the 'as expected' range. This sees the Trust ranking 10th out of 17 across the East of England.

The graph below shows the improvements in SHMI over the last five years.



Within the Trust we use two approaches to identify areas for investigation into potential mortality problems:

- diagnosis groups with the highest number of deaths as small improvements in care could benefit a large number of patients
- diagnosis groups with high 'excess' deaths - the actual number of deaths over the expected number for our population

The two tables below show:

- five diagnoses resulting in the highest number of deaths
- five diagnoses with the highest number of "excess" deaths

CCS Group	Number of spells	Observed deaths	Expected deaths	SHMI Oct15-Sep16	SHMI performance change
Pneumonia	1,766	377	328.49	114.77	▼
Acute Cerebrovascular Disease	783	130	136.64	95.14	▲
Urinary Tract Infection	1,746	101	109.52	92.22	▲
Acute Unspecified Renal Failure	439	87	72.93	119.29	▼
Congestive Heart Failure, nonhypertensive	512	77	76.14	101.13	▼

Diagnosis group	Number of spells	Excess deaths	SHMI Oct15-Sep16	SHMI Jul15-Jun16	SHMI performance change
Pneumonia	1,766	49	114.77	113.7	▼
Acute Bronchitis	1,148	17	136.83	143.4	▲
COPD	925	16	126.99	108.4	▼
Acute Myocardial Infarction	633	14	130.40	122.3	▼
Acute Unspecified Renal Failure	439	14	119.29	112.2	▼

Clinical and managerial staff work together and with community partners to improve the management of patients with these conditions.

Pneumonia, Acute Bronchitis & Chronic Obstructive Pulmonary Disease (COPD)

- Progress continues on the joint actions agreed with the CCG following receipt of a report from the Royal College of Physicians Review
- Telephone community consultations continue providing a point of access for GPs to engage respiratory consultants regarding management of complex conditions in the community
- The Community team continues to establish itself, working with GPs to highlight frequent attenders and support early discharge from hospital
- Continuation of the Acute Chest Team
- 7 day respiratory service
- Implementation of best practice care bundles for the management of COPD and pneumonia

Patients from other medical specialties who deteriorate and require respiratory support are transferred to the respiratory service. Any deaths are therefore assigned to the respiratory service. So despite improvements within the respiratory services the mortality rate has not fallen at a pace to reflect this work. Consideration of how this may be better managed in the future is underway. It is also noteworthy that over 200 patients per annum are treated on an ambulatory basis when previously they were admitted so the 'least ill' patients, who are likely to survive, are no longer included within the data collection.

Acute Kidney Injury (AKI)

Recent developments of note include:

- ICE (pathology reporting system) now has electronic AKI alerting functionality and will be used later in the year with Lorenzo (new patient administration system) implementation to support early identification
- Policy change regarding gentamycin (antibiotic) following evidence of increased incidence of AKI with a single dose

Acute Myocardial Infarction (Heart attack)

HSMR for Acute Myocardial Infarction has reduced to 130.1 falling within the “as expected” range for the rolling 12 months to December 16.The Cardiology team is in the process of investigating the details of the deaths underpinning this data.

The service is also looking at accuracy of primary codes and depth of coding to ensure the deaths are correctly assigned with the correct codes.

Priority 3.3 - Adjusted SHMI

Priority 3.2 referenced the fact that the SHMI value includes those patients who have died following a stay in the Trusts hospice or after receiving palliative care. This partly accounts for a higher than average SHMI rate.

To understand the SHMI without the effect of the hospice or palliative care an adjusted SHMI can be calculated which allows for a more fair comparison with other organisations.

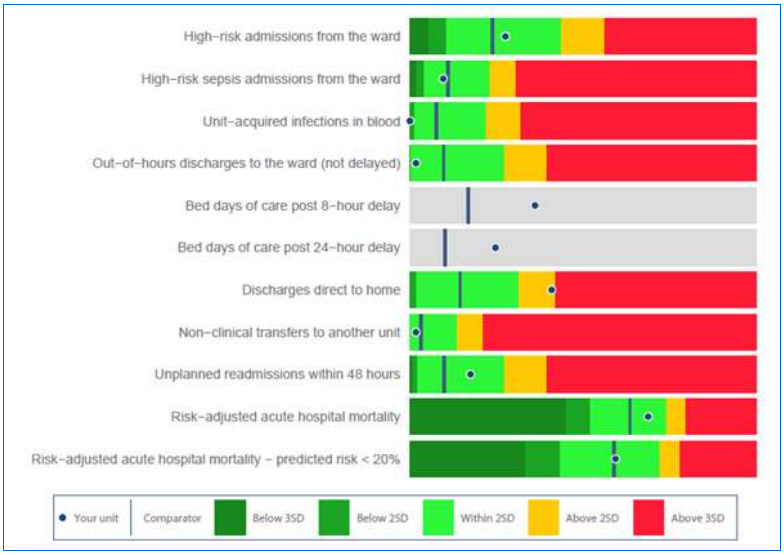
The latest data for an adjusted SHMI shows its value to be at 95.5 surpassing the aim of below 98.5.

Priority 3.4 - Unexpected admissions to critical care

If a patient deteriorates to the point where treatment or care ordinarily available on the ward is insufficient to cope with the patient’s needs the patient will be admitted to the Critical Care Unit. This may be as a result of either rapid deterioration or a failure to act upon the earlier signs of the patient deteriorating, ie worsening clinical observations as described in Section 2.3.

In 2016/17 229 patients were admitted from the wards to critical care. This compares to 233 in the previous year. It is difficult to tell from the data whether these admissions result from unexpected and rapid deterioration or whether the deterioration could have been prevented through earlier intervention.

Despite having a number of unexpected admissions the critical care unit delivers good outcomes. The Intensive Care National Audit and Research Centre (ICNARC) report, which covered admissions to the critical care unit between April and September 2016, provides benchmark data on the performance of the unit. The outcomes of patients admitted to critical care were favourable with four of eight indicators showing performance better than comparative units; and a further four within the ‘as expected’ range. The mortality rate is the same as the national average.



The area of concern is the number of people being discharged home directly from critical care rather than attending a ward for step-down care and rehabilitation. A lack of beds readily available on the wards means that it is sometimes challenging to transfer a patient from critical care as soon as they are well enough. Recent policy has placed transfers from critical care as a bed management priority.

An audit of unexpected admissions to critical care was not undertaken during 2016/17 but will be repeated during 2017/18.

The Trust's Deteriorating Patient Action Plan is a multifaceted set of actions to help identify and reduce the number of patients who deteriorate. The plan is complex and addresses:

- Observation competencies
- Management of patients who are dying
- Use of checklists and common communication to share concerns promptly
- Compliance with surgical checklists
- Clarity over the management of patients receiving care from multiple teams
- Identification and management of sepsis
- Acting early on test results

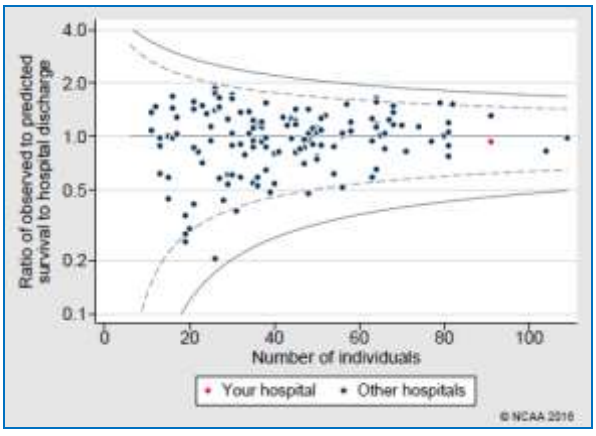
Progress with implementing the plan is monitored by the Patient Safety Committee with the results ultimately measurable using the mortality indicators but supported by a range of other indicators such as ICNARC.

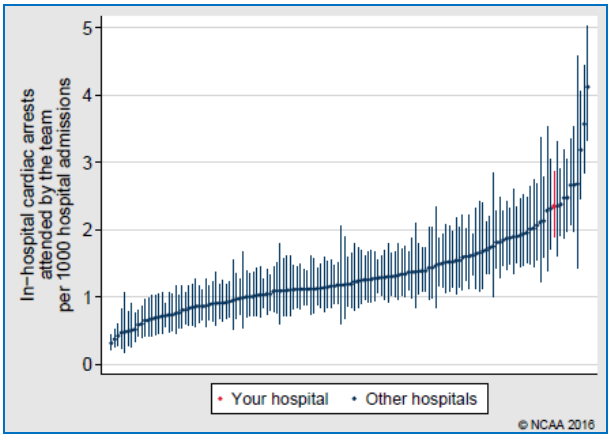
Priority 3.5 - Cardiac Arrests

If deterioration is not acted upon quickly the patient's survival may be compromised potentially leading to a cardiac arrest.

During 2016/17 127 (YTD) cardiac arrest calls were made (excluding those from the Emergency Department).
The National Cardiac Arrest Audit (NCAA) data for April – September 2016 show that the cardiac arrest team attended cardiac arrests of 92 patients.

44 survived the cardiac arrest and ultimately 21 (22.8%) survived to discharge. This is very slightly less than predicted although NCAA data does not take account of the risk factors associated with the local population group.





The attendance by the resuscitation team at cardiac arrests, per 1000 hospital admissions, is high compared to other organisations. This demonstrates a commitment to supporting clinical teams.

Actions undertaken by the resuscitation team include:

- Commencement of a 10 minute team brief commenced in November 2016 to discuss all arrests and assign any outstanding audit documentation
- Implementation of the new RESPECT form in January 2017, working closely with the End of Life team. Trust statistics show we have more arrests in the 85+ age range suggesting that further work is required on the use of do not resuscitate orders where applicable

Priority 3.6 - Observation compliance

Effective identification and management of deteriorating patients requires strict adherence to undertaking timely and complete observations eg. blood pressure measurement; and prompt escalation to senior staff to instigate actions where deterioration is recognised. This was described in more detail in sections 2.3 and 3.4.

Compliance with completing observations fully is measured routinely through a records audit. During 2016/17 the average compliance rate based on 8068 observation charts reviewed was 96%.

The Trust introduced NerveCentre in March 2017.

Observations are recorded on this electronic system which enables remote view so doctors and senior clinical staff can review observations and advise staff/ prioritise their work accordingly. Starting with paediatrics the system will be rolled out to all areas by July 2017. Once rolled out the automatic escalation alerts will commence.

This is a really exciting development and the outcomes relating to deterioration, cardiac arrests and unexpected admissions to critical care will be closely monitored.

Priority 3.7 - Mortality Review Process

The Trust has an established mortality review process:

- Details of deaths are captured via the bereavement service
- Health records are transferred to the mortality review office
- A reviewer, not involved in the patients care, reviews the notes and completes an electronic mortality review questionnaire identifying whether there were any concerns (eg gaps or omissions in care) or not
- Where a potential area of concern is identified the reviewer asks the deceased patient's consultant to review the care and treatment given. This is undertaken as a discussion amongst senior and junior staff during their specialty's Rolling Half Day session. An opinion is provided and if appropriate actions to rectify any shortcomings
- Discussion of any areas of concern and the findings following specialty review by the Clinical Governance Strategy Committee on a scheduled monthly basis. Likelihood of death is considered and an opinion made as to whether further action is required
- Learning is shared via the Rolling Half Day learning points or as deemed appropriate by the committee

A central database holds the details of the reviews and the process is coordinated via the Clinical Audit and Effectiveness Office.

Oversight and challenge is undertaken via Mortality Review meetings with the Clinical Commissioning Group and NHS Improvement. These meetings monitor not only the findings of the review process but also progress in reducing mortality overall.

The mortality review process is closely linked with the incident management process with some deaths being investigated as serious incidents where more in-depth investigation is required. This also ensures that the Duty of Candour is met.

The Trust has 32 trained mortality reviewers in place. All are consultants from the clinical divisions. Reviews of 1295 case notes of people who died in our hospitals have been undertaken during the year representing 84% of total recorded deaths from 1 April 2016 to 31 March were reviewed. This is a vast improvement compared with 45% in the previous year. Whilst striving to meet the >=95% target this remains challenging for the consultants given the multitude of calls on their time coupled with additional winter pressures.

At the time of writing the report the Trust is awaiting information regarding the implementation of the national standardised mortality review methodology.

Priority 4: Further improve stroke standards

		13/14	14/15	15/16	16/17	Aim for 16/17	Met
4.1	60 minute to scan	87.77%	82.89%	89.2%	**92.7%**	>=90%	✓
4.2	3 hour thrombolysis for stroke	10.08%	7.36%	7.47%	**6.1%**	>=12%	✗
4.3	Admission to stroke unit within 4 hours of arrival	66.25%	51.89%	62.33%	**78.6%**	>=90%	✗
4.4	90% time in dedicated stroke unit	72.71%	73.87%	82.12%	**87.3%**	>=80%	✓

Priorities 4.1-4.4 - Stroke

A stroke is caused by a lack of oxygen to the brain. This may be due to a bleed (haemorrhagic stroke) or a clot (ischaemic stroke). Only those who have had an ischaemic stroke can be treated by thrombolysis (an anti-coagulant delivered via a drip). Giving an anticoagulant to someone who has had a haemorrhagic stroke is inappropriate so it is important that patients are scanned soon after arrival to the emergency department to see which type of stroke they have had. Thrombolysis must be given within three hours of the onset of symptoms.

In an ideal situation the process for managing strokes is as follows:

- an ambulance is called as soon as symptoms suggest a stroke
- the ambulance arrives quickly and alerts the hospital that a person with a suspected stroke is due to arrive
- The stroke team will be waiting for the patient's arrival and will quickly assess them and arrange for a scan
- Scan is completed quickly, within 60 minutes of arrival
- Once an ischaemic stroke is diagnosed the thrombolysis will start (within 3 hours of onset of symptoms)
- The patient will be admitted to the stroke ward for intensive treatment and rehabilitation.

✓ 92.7% of patients were scanned within one hour of arrival. There is a well-established process to ensure this is undertaken.

✗ 6.1% of patients received thrombolysis within 3 hours. Achievement of the 12% target was met during only one month in the year.

An audit was undertaken of a sample of patients to understand why there were delays in thrombolysis. The results found:

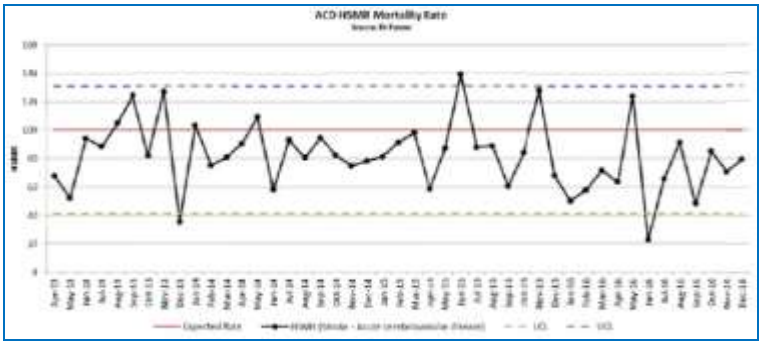
- Only one quarter of patients arrived within the 'thrombolysis time window' due to significant delays in patients calling for an ambulance and delays in the ambulance transfer
- It was not possible to thrombolyse 30/65 patients because the time of onset was unknown
- During the day 73% of those who received thrombolysis did so within 1 hour (average 38 minutes); out of hours this fell to 25% with delays due to other operational pressures
- No patients were missed that should have been treated

A number of actions have been identified such as a patient campaign to raise awareness of symptoms; pre-alert via GPs; better access to blood analysers for immediate test results and improved liaison with the stroke telemedicine service.

✘ 78.6% of patients were admitted to stroke unit within 4 hours of arrival. Since September 2016 the standard of reaching 90% has not been achieved. The number of patients attending the ED suffering a stroke has increased, largely due to accepting patients from West Essex. Together with challenges within the ED to manage an increasing workload it has not been possible to deliver this four hour initiative. The Trust produces a report each month of the patients who do not meet this target and work is underway to understand where the problems are in order to rectify them.

✓ 87.3% of patients spent more than 90% of time admitted on the stroke unit. Stroke services are centralised on 2 wards where staff and facilities are optimised to care for patients with strokes. All efforts are undertaken to ensure patients who have suffered a stroke are admitted to these wards.

Mortality (HSMR) remains very good at 67.8 (lower than expected) for the 12 month period to December 2016.



The latest SHMI release for the 12 month period to September 2016 has seen a significant improvement with SHMI falling to 95.14.

A variety of changes have taken place in Stroke care to improve outcomes for patients. The success of these has been evidenced by obtaining a high rating of the service in the quarterly Sentinel Stroke National Audit Programme report produced by the Royal College of Physicians (Aug- Nov 2016).

Current on-going initiatives include:

- Recruitment of two clinical fellows (doctors) and a Stroke Matron
- Development of a Thrombolysis action plan to fine tune internal processes and improve the thrombolysis pathway, including the pre- hospital Pathway

- Collaboration with external providers, eg Charing Cross to formalise a Thrombectomy (clot removal) pathway. This pathway supports transfer of suitable patients for further treatment
- Increase by 6 of the number of stroke beds available over the winter
- Introduction of a Stroke care bundle

I was seen by the consultant who I saw originally on the date of my stroke - it is always preferable to see the same consultant throughout as they are familiar with your history.

Stroke Clinic, Lister Dec-16

Improving patient experiences

Priorities	What success will look like
5. Improve communication Communication failure remains one of the most common subjects identified via feedback mechanisms. As the culture programme strengthens we wish to evaluate the impact upon user feedback.	• In-patient survey results of involvement in decisions >6.8 • In-patient survey results of consistent information >7.8 • In-patient survey results of providing understandable answers >8.1 (doctors) and >8.0 (nurses) • In-patient survey results of having point of contact >7.8 • Reduction in rate of communication related complaints per bed days <0.144% • Reduction in rate of communication PALS concerns per bed days (from Q1 to Q4) • Implementation of the Accessible Information Standard milestones
6. Improve nutrition and hydration The Food and Drink Strategy was launched in 2015. Improving nutritional care is the first ambition	• Obtain feedback from patients about new menus • In-patient survey results of quality of food >5.2 • In-patient survey results of choice of food >8 • In-patient survey results of help with eating >7.5 • Delivery of strategy milestones • Compliance with nutritional aspect of ward observational tool >=95% • Delivery of the Healthy Food CQUIN

Priority 5: Improve communication

		13/14	14/15	15/16	16/17	Aim for 16/17	Met	Meridian
5.1	Survey - involved in decisions	6.8	7.3	6.8		>6.8		83.75%
5.2	Survey - consistent information	7.7	7.7	7.8		>7.8		
5.3	Survey - understandable answers (doctors)	7.8	7.8	8.1		>8.1		88.36%
5.4	Survey - understandable answers (nurses)	7.8	8.3	8.0		>8.0		90.91%
5.5	Survey- point of	7.6	7.8	7.8		>7.8		

		13/14	14/15	15/16	16/17	Aim for 16/17	Met	Meridian
	contact							
5.6	Complaints about communication (per 100 bed days)*	*0.16%* *FCE**	*0.19%* *FCE**	0.32%	0.21% (Q1-3)	Improve[Ψ] (<0.144%)	✓	
5.7	PALS concerns - communication (per 100 bed days)	*0.28%* *FCE**	*0.48%* *FCE**	0.57%	0.21% (Q1-3)	Improve	✓	
5.8	Accessible Information Standards					Implement		

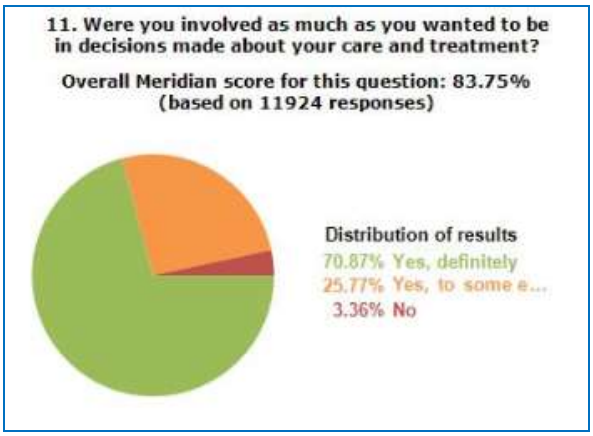
*Bed days - number of beds occupied at a particular point in the day.
FCE – Finished consultant episode
[Ψ]The aim for 2016/17 was inaccurately stated in the 2015/16 report. Indicators measured since 2013/14 show complaints with communication as an element whereas the aim to reduce complaints to <0.144% was based on communication being a primary subject

Priorities 5.1- 5.5 – Inpatient survey scores

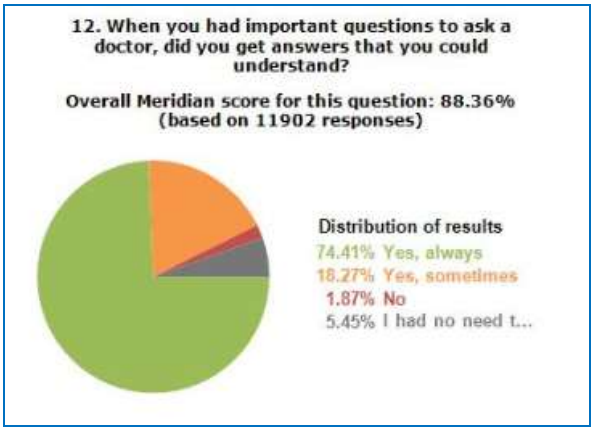
Five questions in the national in-patient survey relating to communication have been monitored over a number of years. These are weighted scores with a maximum score of 10.

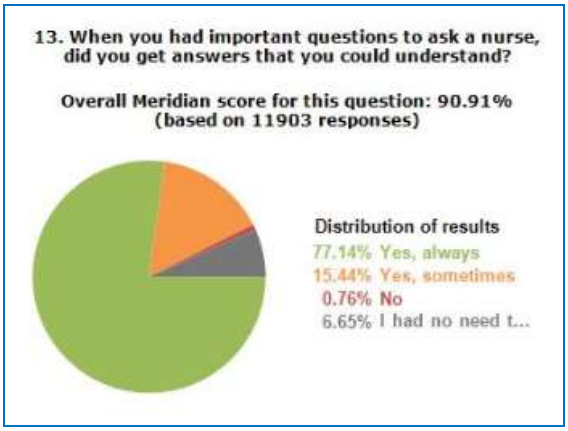
The results are shown in the table above where it can be seen that…due May

Three of these questions are also asked routinely using the electronic survey system Meridian. During 2016/17 almost 12,000 patients participated in the survey and the results are shown in the three pie charts below.



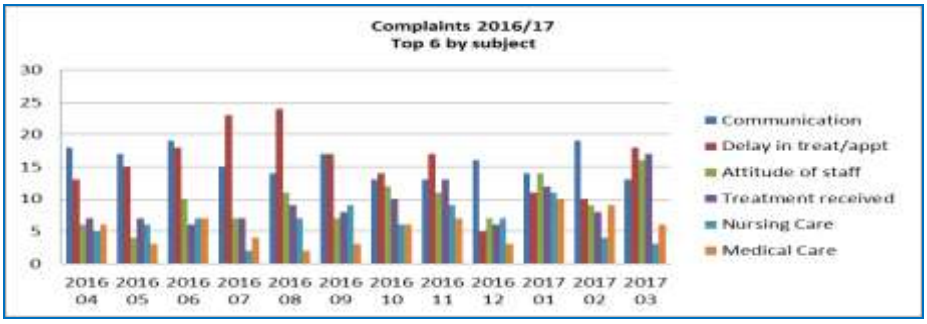
Add commentary comparing with national scores once released





Priority 5.6 & 5.7 – Complaints and PALS concerns about communication

The graph below shows the categories accounting for the greatest number of complaints for 2016/17, by primary subject.



…we understood the reasons for the delays, which were due to emergency cases parachuting in, and the staff were very communicative about what was happening - they kept us updated and did their very best to squeeze her [daughter] in that day, managing to fit her in at about 3pm in the end. The nurse on the ward was unfailingly kind and helpful, plying us with drinks, keeping us updated and bringing toys/dvds to occupy our daughter during her long wait. The surgical team were also very good with her and communicated well with us both before and after the operation.

Day Surgery, March 2017

i have already emailed but had no reply, not even an acknowledgement, approximately 2-3 weeks ago. Living a distance from the hospital we only get feedback from family nearby. We have heard reports of our relative being seen and then left with sheets off and curtains open-on view to all who walked past! A request to speak to Doctors about the diagnosis/ condition and plan of care has not happened. The on time a doctor did speak to us whilst we were visiting, they were abrupt and impatient. As the patient now has a terminal diagnosis, it would be nice if the family could talk to the teams involved in his care?! it would be nice, as we are visiting this weekend, for someone to be around to talk to us,,,,but i am guessing this is unlikely to happen,,,,not impressed.This has been happening at 2 locations: ICU, and the ward he is on at the moment which i am unsure of which it is.

January 2017

Although the number of complaints and concerns needs to be acknowledged it is more useful to measure the rate of complaints and concerns per activity level to get a better understanding of whether the proportion of complaints or concerns is changing.

The rate of formal complaints and concerns reported to the complaints service and to the Patient Advice and Liaison Service (PALS) regarding 'communication' is given below (please note this is where communication features within the complaint, not just as the primary subject).

	No. of complaints & PALS (communication) per 100 bed days				
	2015/16	**2016/17**			
		Q1	**Q2**	**Q3**	**Q4**
Complaints	0.32%	0.21%	0.23%	0.19%	
PALS	0.57%	0.18%	0.16%	0.29%	

✓ An improvement of complaints and PALS relating to communication per bed days can be demonstrated compared with 2015/16 figures (0.32% & 0.57% respectively)

✓ When analysing complaints where communication was a primary subject this has reduced per 100 bed days from 0.144% to 0.08%

Trying to reduce complaints is a challenge because of the wide ranging concerns. Whilst each complaint or concern is dealt with individually the larger picture is about preventing them in the first place. Work described throughout this report such as streamlining processes, developing staff and the culture in which they work and enhancing technology will all support more efficient working in the future. This should therefore promote getting things right in the first instance.

Priority 5.8 Accessible Information Standards

A group oversees the review of practices and implementation of initiatives to comply with the NHS Accessible Information Standard. The standard aims to ensure information is available in a variety of formats to meet the needs of our patients and the public. The following have been put in place this year:

- A list of 'mandatory demographics' has been set up on Lorenzo to include hearing, sight and speech in preparation for the go-live
- The mapping of services is underway within the divisions to understand the full implications of the standards and actions required
- Awareness of the Standard has been raised and the National e-learning module is available on the intranet
- Agreement that a dot is to be put on the front of the patient's health records to show that there is an information requirement
- A sentence has been added to appointment letters to ensure patients/ carers are prompted to inform the Trust if they have any information or communication needs. This is being piloted at MVCC
- Disabledgo have assessed all areas with hearing loops
- The Lorenzo team is working with outpatients staff on letter templates.
- Communication books are available on all wards
- Outpatient clinic appointments can be extended if requested by a clinician
- A Patient Information Leaflet production and review process in place

Priority 6: Improve nutrition and hydration

The Catering Team have been recognised nationally by "Food for Life" and have been awarded the bronze standard. The Trust is one of only fifty-five "in house" hospital catering departments to have received this award. The Catering Mark awarded reflects removal of harmful additives and trans-fats from menus, and that the majority of food available is prepared freshly. Assurance is in place that meat is traceable and from farms that adhere at least to minimum standards of animal welfare.

		13/14	14/15	15/16	16/17	Aim for 16/17	Met
6.1	Feedback from patients about new menus				Received	Obtain feedback	✓
6.2	Survey - Quality of food	4.8	4.4	5.2		>5.2	

6.3	Survey - choice of food	8.3	8.4	8		>8	
6.4	Survey - help with eating	7.4	6	7.5		>7.5	
6.5	Delivery of strategy milestones				Delivered	Deliver	✓
6.6	Compliance with nutritional aspect of ward observational tool			95.25%	96.52%	>=95%	✓
6.7	Delivery of the Healthy Food CQUIN				Delivered	Deliver	✓

Priorities 6.1– Patient feedback & 6.5 Food & Drink Strategy milestones

The catering team is constantly working to receive feedback from which to improve their services. At the same time staff continue to develop choices and services to improve meals and mealtimes in line with the Food and Drink Strategy.

The Food and Drink Strategy was developed in 2015 by the Nutrition & Hydration Steering Committee. Progress is monitored at bi-monthly meetings attended by a multi-disciplinary team consisting of medical, nursing, catering and allied health professionals.

The strategy's ambitions cover 3 areas:

1. Providing good nutritional care for our in-patients
2. Promoting healthier eating for patients staff and visitors
3. Supporting sustainability and reducing food wastage

Protected mealtimes are embedded across the organisation, ensuring that patients receive the help they need to eat and drink. Two Housekeeping Training Co-ordinators have been appointed to support ward housekeepers by ensuring a patient has the correct meal. These staff members have knowledge of all special menus and have direct access to the chef should any changes be required. They are also able to support the food service if required.

Examples of service developments include:

- Expansion of the range of patient menus to meet the therapeutic, religious and cultural needs of our patients to improve patient choice. This includes an a la carte menu for patients requiring a texture modified diet and an option for vegans
- The catering team are working with paediatric staff to review portion sizes and the type of food available that appeals to young people. A young person's menu is being considered which will also be available for young people being cared for on adult wards
- Review of the provision of meals for our patients with dementia, providing finger foods, and supporting Trust wide initiatives for carers at ward level
- John's Campaign has been introduced which encourages carers to remain with their loved ones in hospital to provide help with care such as feeding. In return support such as reduced car parking and discounts on food etc. are being made available
- Carers of patients with a learning disability are encouraged to stay and this has been shown to lead to a shorter length of stay for the patient
- Sandwiches are available at lunch-time and in the evening and snacks are available between meals
- Snack bags are available for carers which has received great praise
- Milk is delivered to the discharge lounge area for patients to take home with them so they can have a hot drink when they go home

- Provision of information for patients and staff at ward level that includes patient bedside menu booklets and a ward level catering services directory
- Piloting of a new nutrition care plan for use at ward level

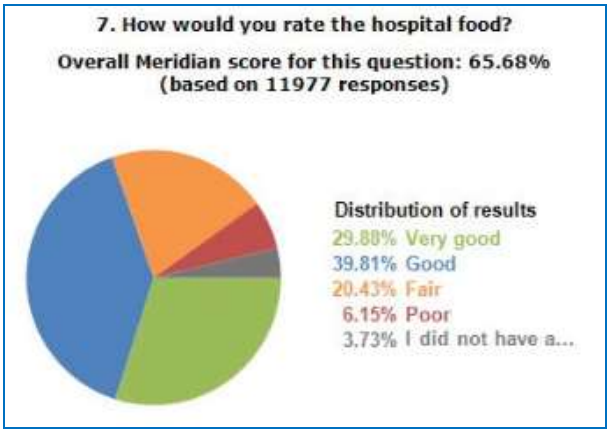
Developments have also been made which support staff, for example:

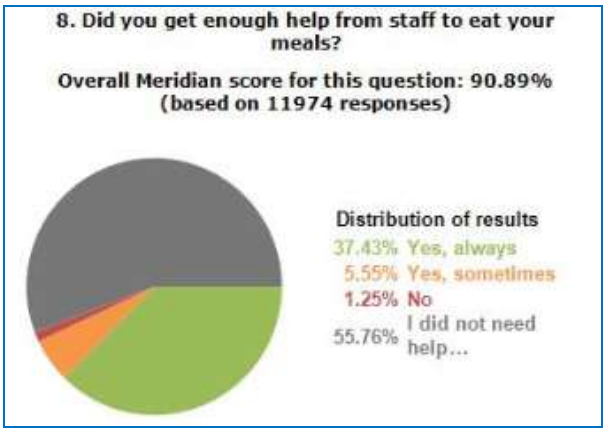
- Provision of a range of education and training opportunities for staff working across the Trust. This includes Hospitality Operating Standards Training (HOST) for housekeeping staff, food and nutrition awareness training for catering staff, and e learning opportunities managed through the Electronic Staff Record (ESR);
- Developed a new Nutrition and Hydration page on the Trust intranet for staff to access information

Priorities 6.2-6.4 – Survey results

Awaiting national survey results – due May.

A number of national survey questions are included within the Trusts standard electronic surveys. Almost 12,000 responses regarding food rating and assistance to eat meals is given in the pie charts below.





Priority 6.6 – Assessment

The Trust measures a number of matters relating to nutrition on a monthly basis. One of these measures is completion of the Malnutrition Universal Screening Tool (MUST). This assessment tool looks at the patient's height, weight, recent weight loss and illness to identify an overall risk of malnutrition. This score then determines the action to be taken eg. referral to a dietician.

✓ The assessment tool was completed for 96.52% of patients on admission (against a plan of >95%).

Other assessments recorded show that there has been an improvement in all the areas measured compared to the previous year.

Question	**2015/16 (5910 responses)**	**2016/17 (8450 responses)**
Was the patient weighed (or upper arm circumference measured) on admission	91.09%	93.95%
Was the patient weighed at least every 7 days	88.51%	92.09%
Was the screening tool updated every 7 days	92.06%	94.16%
Were food charts accurately completed	87.67%	89.7%
Was assistance to eat given where indicated	89.88%	90.96%

Was a nutritional care plan documented for those at risk of malnutrition	85.74%	88.99%

Priority 6.7 – Healthy Food CQUIN

The healthy food CQUIN aims to promote and provide healthy food options for staff, visitors and patients. It involves a number of initiatives:

- The banning of:
    - price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS)
    - advertisement on NHS premises of HFSS
    - sugary drinks and HFSS from checkouts
- Ensuring that healthy options are available at any point including for those staff working night shifts

A project plan is in place with coordination overseen by the Food and Nutrition Group. Some of the actions completed are as follows:

- Two thirds of catering staff have received the healthy eating awareness training
- All meals are evaluated to determine the fat, sugar and salt content – with information displayed in staff restaurants
- All meals advertised are under 500 calories
- There are no advertisements of HFSS foods
- HFSS foods and sugary drinks are no longer sold at checkout points, and have been replaced by fruit
- Baked crisps have been introduced as a healthier options – these are selling well
- New menus are approved by dieticians
- Nutritional information cards are available at cold food self-service cabinets
- Lower calorie sandwich options are available
- An agreement has been reached between WHSmith's and NHS England to ensure the hospital outlets are CQUIN compliant (changes implemented by 23rd February)
- All fronts to drinks vending machines, except one have been changed, with healthier drinks at the top and full sugar at the bottom on the selection area
- The Health@Work service can refer eligible members of staff for a free 12 week referral to Weight Watchers or Slimming World

2c Statements of assurance from the Board

This section contains the statutory statements concerning the quality of services provided by the Trust.

Review of services

During 2016/17, the East and North Hertfordshire NHS Trust (ENHT) provided and/or sub-contracted 32 relevant health services. The ENHT has reviewed all the data available to them on the quality of care in 100% of these relevant health services. The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant services by the ENHT for 2016/17.

Participation in clinical audits

During 2016/17 45 national clinical audits and 9 national confidential enquiries covered relevant health services that ENHT provides.

During that period ENHT participated in 43 (96%) national clinical audits and 9 (100%) national confidential enquiries of the clinical audits and national confidential enquiries which it was eligible to participate in.

The two tables below show:

- The National Clinical Audits and National Confidential Enquiries that ENHT was eligible to participate in during 2016/17
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2016/17, and for which data collection was completed during 2016/17, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

National Audits	Eligible	Participated	% Cases Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	93.71%
Adult asthma (BTS)	Yes	Yes	100%
Adult Cardiac Surgery	No	Services not undertaken	
Asthma in Emergency Departments	Yes	Yes	100%
Bowel Cancer Audit Programme (NBOCAP)	Yes	Yes	80% (last report)
Cardiac Rhythm Management (CRM)	Yes	Yes	92%
Chronic Kidney Disease in primary care	No	Not applicable	
Congenital Heart Disease (CHD)	No	Not applicable	
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	The database is still open (it closes on the 30th of April). We are currently approx. 99% but will be 100% compliant
Diabetes (Paediatric) (NPDA)	Yes	In progress	tbc
Endocrine and Thyroid National Audit	Yes	Yes	tbc
Falls and Fragility Fractures Audit programme (FFFAP) – Fracture Liaison Database	No	No Fracture Liaisons Service	
Falls and Fragility Fractures Audit programme (FFFAP) - Falls	No	Audit starts May 2017	
Falls and Fragility Fractures Audit programme (FFFAP) – National Hip Fracture Database	Yes	Yes	100%

National Audits	Eligible	Participated	% Cases Submitted
Head and Neck Cancer Audit (DAHNO)	Yes	Yes	tbc
ICNARC Case Mix Programme	Yes	Yes	100%
Inflammatory Bowel Disease (IBD) programme	Yes	Yes	0% due to lack of resource
Learning Disability Mortality Review	No	Audit starts in 2017/2018	
Major Trauma (Trauma Audit & Research Network) (TARN)	Yes	Yes	61%
National Audit of Dementia	Yes	Yes	100%[1]
National Audit of Pulmonary Hypertension	No	Not a specialist pulmonary hypertension centre	
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	No	Audit starts in 2017/2018	
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery - Use of blood in Haematology	Yes	Yes	100%
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery - Audit of Patient Blood Management in Scheduled Surgery	Yes	Yes	78%
National Diabetes Foot care Audit – Adults (HSCIC)	Yes	No[2]	
National Diabetes Inpatient Audit – Adults (HSCIC)	Yes	Yes	100%
National Pregnancy in Diabetes Audit – Adults (HSCIC)	Yes	Yes	100%
National Diabetes Core Audit – Adults (HSCIC)	Yes	Yes	In progress
National Emergency Laparotomy Audit (NELA)	Yes	Yes	83%
National Heart Failure	Yes	Yes	98.8%
National Joint Registry	Yes	Yes	99.8%
National Lung Cancer Audit (NLCA)	Yes	Yes	tbc
National Neurosurgery Audit Programme	No – not undertaken within the Trust		
National Ophthalmology Audit	Yes*	No[3]	
National Prostate Cancer	Yes	Yes	tbc
AAA Repair (National Vascular Registry) -	Yes	Yes	tbc
Carotid Endarterectomy (National Vascular Registry)	Yes	Yes	tbc
Lower Limb Amputation (National Vascular Registry)	Yes	Yes	tbc
Lower Limb Angioplasty/Stenting (National Vascular Registry)	Yes	Yes	tbc
Lower Limb Bypass (National Vascular Registry)	Yes	Yes	tbc
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
Nephrectomy audit	Yes	Yes	100%
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	tbc
Paediatric Intensive Care (PICANet)	No	Do not have Paediatric Intensive Care	
Paediatric Pneumonia	Yes	Yes	In progress (data entry closes 30th April)
Percutaneous Nephrolithotomy	Yes	Yes	100%

National Audits	Eligible	Participated	% Cases Submitted
Prescribing Observatory for Mental Health	No	Not relevant	
PROMS (Patient Reported Outcomes Measures) Elective Surgery	Yes	Yes	tbc
Radical Prostatectomy Audit	Yes	Yes	100%
Renal Replacement Therapy	Yes	Yes	100%
Rheumatoid and Early Inflammatory Arthritis - Clinician/Patient Follow-up	Yes	Yes	100%
Rheumatoid and Early Inflammatory Arthritis - Clinician/Patient Baseline	Yes	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	97%
Severe Sepsis and Septic Shock – care in emergency departments	Yes	Yes	100%
Specialist rehabilitation for patients with complex needs	No	Service not relevant	
Stress Urinary Incontinence Audit	Yes	Yes	100%
UK Cystic Fibrosis Registry	No	Do not treat patients	

[1] The Trust submitted 40 cases to the National Dementia audit which is the recommended minimum for national audits. The original target was 50 but was reduced following consultation with the national body due to lack of resources.
[2] National Diabetes Foot Care audit did not take place as the specialty did not have the required input from the community podiatrists
[3] National Cataract audit - we did not take part due to the lack of funds available to purchase & install the audit software.

National Confidential Enquiries	Eligible	Participated	% Cases submitted
NCEPOD Child Health Clinical Outcome Review Programme – Chronic Neurodisability	Yes	Yes	100%
NCEPOD Child Health Clinical Outcome Review Programme – Young Peoples Mental Health	Yes	Yes	In progress
MBRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	Yes	Yes	100%
MBRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	Yes	100%
MBRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	Yes	Yes	100%
MBRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance	Yes	Yes	100% (no maternal deaths)
NCEPOD - Medical & Surgical Clinical Outcome Review Programme - Acute Pancreatitis	Yes	Yes	100%
NCEPOD - Medical & Surgical Clinical Outcome Review Programme – Cancer in Children and Young People	Yes	Yes	100%
NCEPOD - Medical & Surgical Clinical Outcome Review Programme - Non-invasive ventilation	Yes	Yes	In progress
NCEPOD - Mental Health Clinical Outcome Review	No	Not applicable	

National Audits

The reports of 18 national clinical audits were reviewed by the provider in 2016/17 and the following are some of the actions ENHT intends to take to improve the quality of healthcare provided.

National audit	Actions to be taken
National Pregnancy in Diabetes	• Improve pre-conception care. Educate GPs, Practice nurses, Diabetes Nurse/ Midwives • Enhance resources (esp Specialist Midwife hours) in joint antenatal clinic (Med and Obstetrics)
National Neonatal Audit Programme	• Improve compliance with observations and documentation • Monthly audit by band 6 nurses and data manager • Check delivery room (including theatres) temperatures and transfer preterm babies using transport incubator
National Hip Fracture Database	• Improve liaison with anaesthetic department • Full physiotherapy staffing and a Sunday service to be available
RCEM Mental Health: care in emergency departments	• Develop a Mental Health Risk Assessment Triage proforma • Review findings and proposed re-audit with the Mental Health Team

Local audits

The reports of 122 local clinical audits were reviewed by the provider in 2016/17
and the following are some of the actions ENHT intends to take to improve the quality of healthcare provided.

Local audit	Actions to be taken
Audit of palliative care triage tool	• Establish possible reasons why the referral proforma is not being completed in all cases and ways in which this usage can be increased • Establish possible reasons why the RAG rating tool is not being completed. This should include discussion as to the possible re-design of the form (e.g. Colour printing to highlight the RAG rating section). • Identify on Infoflex the reasons why there may be delays to patients being seen.
Adherence to Hertfordshire Medicines Management Committee (HMMC) Recommendation in 2015	• Review ordering process for NFDs with procurement team • Send copy of Rifaximina and Dapagliflocin HMMC recommendations to Gastroenterologists and Endocrinologists
DNACPR – Elderly Care	• Reiterate the need to file DNAR forms in the front of the notes • Clinicians should review DNAR forms daily on ward rounds
Measure Vitamin D levels at diagnosis in all people with melanoma per NICE recommendation	• Ensure that the Plastic surgery team and the Multi-Disciplinary Team requests a measurement of Vitamin D for any newly diagnosed patient with Melanoma
Perineal Trauma	• Remind staff to give advice on perineal care for all women who have perineal trauma including those who do not require suturing

Research and development

The number of patients receiving relevant health services, provided or sub-contracted by the ENHT in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 2715.

During 2016/7 the Trust introduced a new Research Strategy which aims to enhance patient experience and outcome by offering research opportunity for all patients and staff. During its first year research participation has increased by 30% compared with 2015/16.

The Trust has a long history of being research-active as we seek to "enhance patient experience and outcome through research and innovation". We are part of the National Institute for Health Research (NIHR) therefore support health and care research which translate into new products, treatments and procedures. We work with charities and the life sciences industry to help patients gain earlier access to breakthrough treatments and we train and develop researchers to keep the nation at the forefront of international research.

Trust staff are supported to apply for external research funding. Recent success includes:

- The Gynaecology Cancer Team has been granted an award to study to demonstrate that circulating tumour cells and lymphocytes in various solid tumours can be identified, quantified and used to monitor ongoing metastatic disease
- The Cardiology team has been awarded a grant for a project "*Assessing the effect of apixaban on endogenous fibrinolysis in patients with nonvalvularatrial fibrillation*"
- One of our Urology / Haematology Research Nurses won a place on the Clinical Academic Internship Programme), funded by Health Education England, which will provide a practical skills to undertake a research project

The Trust publishes research and for the period Jan 2016 – Dec 2016 produced at least 199 publications in peer-reviewed journals. Examples of how research and innovation at the Trust has had a positive benefit for patients are:

- The Renal Team has established a shared care space in haemodialysis. Some patients were trained to set up their own dialysis machines in the renal unit, self-needle, put themselves on the machine and take themselves off.
- The Respiratory Team contributed to the *Cancer Diagnosis in the Acute Setting (CaDiAS) Lung and Colorectal Research Study*. This study is important because a high proportion of lung and colorectal cancer patients are diagnosed after presenting as an emergency rather than after primary care referral
- The Radiotherapy Team, with support from the Bioengineering team, have developed an innovative 'fixation template device' for the delivery of high dose radiation (brachytherapy) in prostate cancer treatment. The Trust has worked with Health Enterprise East to review options to make this available on a commercial basis to other organisations

Central to the research activity are our patients. We have worked with patients to create videos that share their research experience to use as part of our training for research.

In November and December 2016 a hundred research participants were asked to rate their experience of taking part in research. 69% of participants rated their experience as excellent (10/10), and 29% rated the experience at 9/10. One participant commented:

"My research nurse has always been supportive, kind and caring and has always listened to my thoughts, doubts and concerns and has always put my mind at ease. She makes my two week treatments bearable."

Goals agreed with commissioners

A proportion of the ENHT's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the ENHT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

CQUIN is a way of improving quality by providing a financial incentive. The Trust receives either a full or part payment depending upon the results it achieves. In 2016/17 £x.xx million of income was dependent upon achieving CQUIN targets. During the year we secured xx% of the CQUIN target generating £x.xx million of income.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at www.enht-tr.nhs.uk

The Trust main CQUINs for 2016/17 are set out in the table below, together with their full monetary value and details of whether or not these quality improvements were met.

	CQUIN	Weighting (%)	Value awarded (£000s approx)	Achievement (%)
1a	Staff health & wellbeing initiatives	10		
1b	Healthy food for NHS staff, visitors and patients	10		
1c	Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff	10		
2a	Timely identification and treatment of Sepsis – emergency department	5		
2b	Timely identification and treatment of Sepsis – in patient setting	5		
3a	Reduction in antibiotic consumption per 1,000 admissions	8		
3b	Empiric review of antibiotic prescriptions	2		
4	7 day pharmacy service	10		
5	Improving Patient Experience in out-patients	10		
6a	Increase in ambulatory care capacity (at Lister only)	10		
6b	Improved patient flow and reduction in patient delays	2.5		
7	Digital technologies - Pilot Phase of tele-monitoring for kidney disease patients on renal replacement therapy	5		
8a	Improved turnaround times for access to and reporting of outcomes from urgent radiology diagnostics for Patients attending ED requiring CT.	6.25		
8b	Improved turnaround times for access to and reporting of outcomes from urgent CT scans for Patients referred on the lung cancer pathway.	6.25		
		100%		

Statements from the Care Quality Commission

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is registered with some conditions. The Trust has the following conditions on registration.

Regulatory Activity	Lister Hospital*	New QEII	MVCC	Hertford	Bedford Renal Unit	Harlow Renal Unit
Treatment of disease, disorder or injury	Registered with conditions	Registered	Registered with conditions	Registered	Registered	Registered
Surgical Procedures	Registered	Registered	Registered with conditions			
Maternity and midwifery services	Registered with conditions	Registered		Registered		
Diagnostic and Screening procedures	Registered	Registered	Registered with conditions	Registered	Registered	Registered
Termination of Pregnancies	Registered	Registered				
Family Planning Services	Registered	Registered		Registered		
Assessment or medical treatment of people detained under the Mental Health Act 1983	Registered	Registered	Registered			

* Lister Hospital's registration includes the registrations for renal satellite units in St Albans Hospital and Luton and Dunstable Hospital.

The Care Quality Commission has not taken enforcement action against ENHT during 2016/17.

The ENHT has not participated in any special reviews or investigations by the CQC during 2016/17. However the Trust underwent a follow-up inspection as part of the overall inspection programme of all Trusts with the details reported in section 3e.

Data quality

The ENHT submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and the patient's valid General Medical Practice Code is given in the table below.

	Included valid NHS Number	Included valid General Medical Practice Code
Admitted patient care	99.7%	99.7%
Out-patient care	99.9%	99.9%
Accident & Emergency care	98.7%	98.4%

Information Governance

The ENHT's Information Governance Assessment Report overall score for 2016/17 was 75% and was graded 'satisfactory' (green).

Clinical coding error rate

The ENHT was subject to the Payment and Tariff Assurance Framework (previously *Payment by Results* clinical coding audit) during the reporting period by NHS Improvement (previously by the Audit Commission then Monitor) and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

	Monitor
Primary diagnoses incorrect	5%
Secondary diagnoses incorrect	1.57%
Primary procedures incorrect	5.04%
Secondary procedures incorrect	0.54%

Following the new Head of Coding's review of the Trust's coding position a number of areas have been identified for initial focus. The Information Governance Audit has improved from Level 1 (fail) to Level 2 (managed) for clinical coding. ENHT will be taking the following actions to improve data quality and to support coding improvements:

- Coders have been linked with divisions to work with assigned teams for accurate coding and to promote learning. All Coding staff have a Divisional Lead Mentor, All Divisional Leads are Mentored by the Head of Coding
- Audit, including baseline audit for all specialties, is planned together with participation of coders on ward rounds
- Progress in clearing the coding backlog has been made. It is intended that 85% of records are coded by the first day of the month following discharge [There will always be a coding backlog as coding takes place after patients have been discharged]
- Clinical coding reports are being developed to support service improvement
- Data Quality review is undertaken and amendments made to capture accurate data
- Ward Clerk awareness raising to reduce variation of data entry across wards
- Standardisation of the ward clerk role to reduce variation of data entry across wards

2d Performance against national core indicators

In this section the outcomes of nine mandatory indicators are shown. This benchmarked data is the latest published on the NHS Digital website.

For each indicator the Trusts performance is reported together with the national average and the performance of the best and worst performing Trusts, where applicable.

Indicator 1 - Summary Hospital Mortality Index

		ENHT Previous Periods		ENHT Current Period	National Current Period
		Apr 15- Mar 16	Jul 15 – Jun 16	Oct 15-Sept 16	
a	Summary hospital-level mortality indicator ("SHMI") value	1.062	1.065	**1.056**	1
	SHMI banding	2 As expected	2 As expected	**2** **As expected**	-
b	Percentage of patient deaths with palliative care coded at diagnosis or specialty level	45.3%	45.8%	**44.19%**	29.75%

(Source: NHS Digital SHMI data)

The Trust considers that this data is as described for the reasons given in Part 2b, priority 3 of this report.

The ENHT has taken a number of actions to improve the SHMI rate, and so the quality of its services. These are detailed in Part 2b, priority 3 of this report.

Indicator 2 - Patient Reported Outcome Measure

Patient Reported Outcome Measures (PROMs) compare the outcomes relating to four procedures. These are measured by questionnaires both before and 6 months after surgery, to measure the extent of improvement. The measure given is an overall weighted assessment relating to function and feeling. The measure ranges from -0.594 to 1 where 1 is the best possible state of health.

		ENHT Previous Periods		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		2014-15 (final)	2015-16 (provisional)	Apr 16-Sept 16 (provisional)			
a	Groin hernia surgery	0.073	0.093	0.077	0.089	0.161 Countess of Chester NHSFT	0.016 Dudley Group NHSFT
b	Varicose vein surgery	N/A	0.061	Insufficient data	0.099	0.152 Heart of England NHSFT	0.016 Kings College Hospital NHSFT
c	Hip replacement surgery	0.438	0.419		0.449	0.522 Northern Devon Healthcare NHST	0.329 Western Sussex NHSFT
d	Knee replacement surgery	0.302	0.315		0.337	0.430 Royal Devon & Exeter NHSFT	0.260 Royal United Hospitals Bath NHSFT

(Source: NHS Digital PROMS data)

The ENHT considers that this provisional data is as described for the following reasons. The Trust ensures the first questionnaire is provided to patients at the pre-operative screening stage. After this the patient's surgery may be outsourced to a different provider, hence insufficient data for assessment.

The ENHT has taken the following actions to improve these scores, and so the quality of its services, by reviewing data that is available and ensuring the process is followed as appropriate.

Indicator 3 - Readmissions

a	% patients aged 0-15 readmitted within 28 days of discharge	The national data set has not been updated since 2011/12 and was reported in previous Quality Accounts. Future releases have been suspended pending a methodology review
b	% patients aged 16 or over readmitted within 28 days of discharge	

(Source: NHS Digital Indicators/NHS Outcomes Framework 3)

More recent Trust data since 2012 is given below in the table.

Emergency readmissions to hospital within 30 days of discharge				
12/13	**13/14**	**14/15**	**15/16**	**16/17**
11%	10.52%	10%	8.54%	8.3%

The ENHT considers that this data is as described for the following reasons. The Trust is working with community partners to enhance care within the community settings and ensure information provided at the point of discharge supports ongoing care, therefore helping to prevent readmission.

The aim for 2016/17 was to reduce readmissions to 7.75%. The ENHT has taken the following actions to improve the score, and so the quality of its services by continuing the admission avoidance initiatives and auditing readmissions to identify the causes to see if anything should have been done differently.

Indicator 4 - Responsiveness to Personal Needs

This indicator is the average weighted score of 5 questions relating to responsiveness to inpatients' personal needs as measured in the national in-patient surveys. The measurement is based upon patients reporting they are involved adequately in decisions about their care; they have privacy and understand their medications; they know who to contact after discharge if there is a problem or if they have any worries.

	Responsiveness to Personal Needs	**ENHT Previous Period**		**ENHT Current Period**	**National Current Period**	**Best Performer**	**Worst Performer**
		2013/14	2014/15	2015/16			
a	Responsiveness to the personal needs of patients	64.9	67	**66**	69.6	86.2 Royal Marsden NHSFT	58.9 Croydon Health

(Source: NHS Digital Indicators/NHS Outcomes framework/Domain 4.2)

The ENHT considers that this data is as described for the following reasons. The Trust is implementing the initiatives outlined within the Patient and Carer Experience Strategy and a range of pharmacy-related activities.

The ENHT has taken the following actions to improve the score, and so the quality of its services by:

- Continuously taking action in response to feedback
- Implementing local initiatives within the clinical divisions in light of local feedback

Indicator 5 - Recommending the Trust (Staff)

The Trust participates in the annual national staff survey where staff are asked "*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*"

69% of staff surveyed 'strongly agreed' or 'agreed' with this statement.

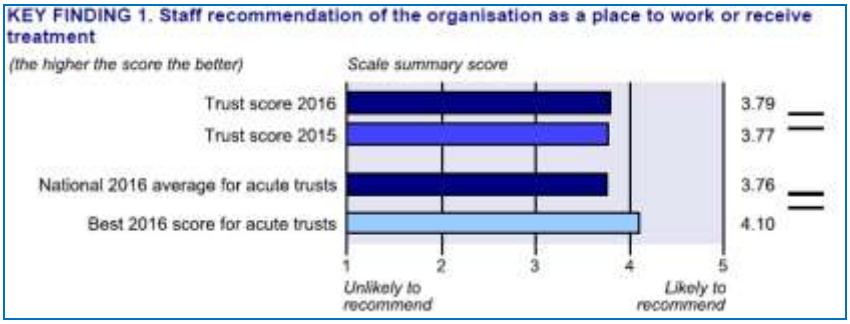
	Recommending the Trust	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		2014	2015	2016			
a	% of staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends	67%	67%	**69%**	69% Acute Trusts	95% Liverpool Heart and Chest Hospital NHSFT	45% North Essex Partnership University NHSFT

(Source: National Staff Survey 2016)

The ENHT considers that this data is as described for the following reasons. The Trust continues to engage, develop and recognise staff as described in Part 3, section 3f, of this report.

The ENHT has taken the following actions to improve this score, and so the quality of its services, by implementing the initiatives outlined in the People Strategy and engaging staff through its culture programme. Section 3f describes some of the initiatives underway to increase staff involvement, wellbeing and development thereby supporting improvements to patient care.

The National Staff Survey report presents data so that it is possible to view the Trust scores compared with the previous year and against other Trusts. It can be seen in the chart below that the Trust score slightly improved compared to 2015 and is slightly higher than the national average.



Indicator 6 - Family and Friends Test (Patients)

After completing treatment or being discharged from a service, patients will often be invited anonymously to complete the Family and Friends Test (FFT). This is a single question "*How likely are you to recommend our service to friends and family if they needed similar care or treatment?"*

Five options are given:

Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely

Responses are grouped as follow:

Would recommend = % of 'extremely likely' and 'likely' responses
Would not recommend = % of 'unlikely' and 'extremely unlikely'

The information is collected via paper/ electronic surveys or text messages. The results are shared amongst Trust staff and uploaded into the national data collections for publication on NHS Choices. During 2016/17 105,636 FFT responses were received and the monthly responses are displayed on each ward for patients and the public to see which brings about local ownership.

	Family and Friends Test	**ENHT Previous Period**		**ENHT Current Period**	**National Current Period**	**Best Performer**	**Worst Performer**
		Dec 2016	Jan 2017	Feb 2017			
a	Friends & family test—score of inpatient	96%	97%	97%	96%	100% Various	76% Sheffield Childrens NHSFT
b	Friends & family test—score of patients discharged from the accident & emergency department	81%	82%	83%	87%	100% Liverpool Womens NHSFT	48% North Middlesex University NHST

(Source: NHS England, Friends & Family Test data)

Very impressed with the dedication, professionalism and general friendliness of the nurses despite pressures in staffing and challenges they face on the ward daily. The nursing staff are also caring and very supportive and they would go out of their way to accommodate any request from family members to listen sympathetically and ease my concerns.
Barley Dec-16

Having to wait less time to get through all the doors so we can spend more time with the little one. Less time for handover or handover being done in another room.
Neonatal unit Dec-16

Inpatients & Day Case

97% Recommend the Trust (NHS England, Feb 2017)	In February 2017: 1,743 in-patients said they would be extremely likely to recommend the Trust 11 in-patients stated they would be extremely unlikely to recommend the Trust The England average for recommending the Trust during this time was 96% (excluding independent sector providers).

Accident and Emergency

83% Recommend the Trust (NHS England, Feb 2017)	In February 2017: 1,103 emergency department attendees said they would be extremely likely to recommend the Trust 111 emergency department attendees stated they would be extremely unlikely to recommend the Trust The England average for recommending the Trust during this time was 87% (excluding independent sector providers).

The FFT score of 83% reflects the challenges faced by the Trust in delivering emergency services at a time of severe demand. However the slight improvement compared with the score in 2015/16 reflects some of the improvements made to expedite flow through the department from arrival to discharge or admission.

The place was clean, the staff were wonderful, kept me up to date with what was happening and told me what was wrong with my daughter, and even had cups of tea, which is a lovely touch when you haven't been able to sleep for a few days; it's not normally available unless you go out to find a machine. Well organised, relaxed staff and very helpful. Thank you.

ED, Lister Dec-16

Not enough seats, I was involved in a car accident, had nowhere to sit. Only one doctor on for everyone. Got seen quickly for an x-ray but very long and painful wait for the results.

ED, Lister Dec-16

The ENHT considers that this data is as described for the following reasons. The Trust is implementing the initiatives outlined within the Patient and Carer Experience Strategy and is working with community partners to improve the flow of patients through the emergency department.

The ENHT has taken the following actions to improve the score, and so the quality of its services by:

- Developing staff as per the culture programme, as research shows that happy staff deliver better services
- Continuously taking action in response to feedback
- Revising care pathways and processes, such as in the Emergency Department, so that patients have an even better experience

Maternity & out-patients

The family and friends test is also undertaken within maternity and the out-patients department. Results are given below.

	Would recommend				
	Antenatal	Birth	Post-natal	Community Midwifery	Outpatients
Trust target	93%	93%	93%	93%	94%
Q1 Apr--Jun-16	93.79	95.41	87.14	100.00	95.44
Q2 Jul-Sept-16	93.06	96.95	89.77	83.33	95.38
Q3 Oct-Dec-16	94.16	94.79	86.06	100.00	94.69
Q4 Jan-Mar-17	96.61	97.41	89.35	80	95.75

Indicator 7 - Venous Thromboembolism

Thrombosis is a blood clot occurring inside a blood vessel. A venous thrombus is a blood clot that forms within a vein. A deep vein thrombosis (DVT) is a blood clot in the deep veins of the leg. Occasionally a small segment of this clot may break and travel in the blood stream to the lungs where it may lead of a pulmonary embolism (PE). Such clots may develop for a number of reasons eg. being still in bed. All in-patients should be assessed for their risk of VTE and where necessary be prescribed an appropriate anti-coagulant (blood thinning drug).

	Venous Thromboembolism (VTE)	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		July-Sept 2016	Oct-Dec 2016	Jan-Mar 2017			
a	% of patients who were admitted to hospital and who were risk assessed for VTE	96.57%	98.01%	Due May			

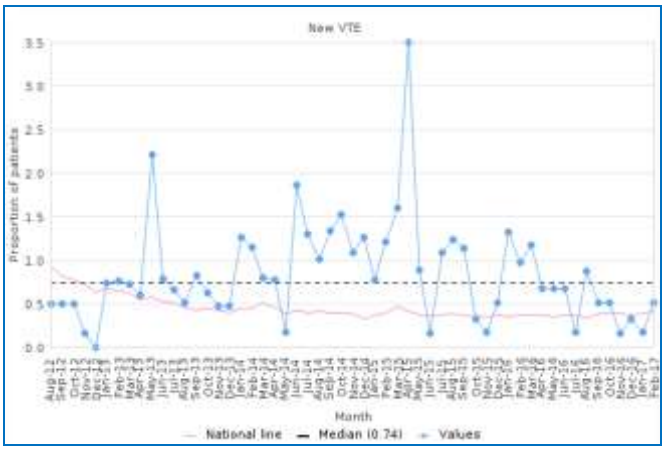
(Source: NHS England, VTE risk assessment data)

The ENHT considers that this data is as described for the following reasons. There is a robust data collection process which ensures completeness of data. Pharmacy staff are fully engaged in working with doctors to promote the assessments being undertaken.

The ENHT has taken the following actions to improve this percentage, and so the quality of its services, by:

- Ongoing instruction / training on VTE assessment
- Making results available for specialty level review
- Monitoring the completion of assessments at ward level with compliance information displayed on ward boards

The NHS safety thermometer shows that the incidence of new (hospital acquired) VTE has been below the median throughout the year (except August) with incidence either slightly above or below the national line.



Throughout the year the Thrombosis Committee has overseen actions aimed at reducing the incidence of hospital induced blood clots. This work has centred around education, production of guidance, review of medications and changing practices in light of learning from those who have acquired a hospital acquired blood clot. The medication chart, which contains the risk assessment, has been revised to simplify its completion.

Indicator 8 - Clostridium Difficile

Clostridium difficile is a bacterium that can affect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, but can spread easily to others. C. difficile infections are unpleasant and can sometimes cause serious bowel problems, but they can usually be treated with another course of antibiotics.

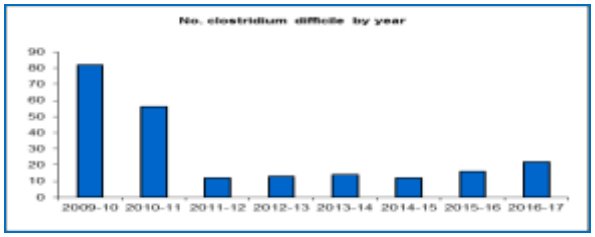
(NHS Choices)

	Clostridium Difficile	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		2013/14	2014/15	2015/16			
a	The rate (per 100,000 bed days) of cases of C.difficile infection reported within the Trust in patients aged >= 2	6.2	5.7	**7**	14	0 Various hospitals	66 Royal Marsden Hospital

(Source: www.gov.uk statistics/C difficile)

More recent data from Public Health England (PHE) for 2016/17 to March shows the rate of reported infections per 100,000 bed days as 10.27 (based on reporting 22 cases by this point). This is the 6th (of 19) best performing Trust in the East of England (average 12.39) and lower than the England average at 11.06.

During 2016/17 there were 22 reported cases of hospital acquired C.difficile in the year, ten of which have been successfully appealed, and a further under discussion.



The ENHT considers that this data is as described for the following reasons. The Trust continues to promote high standards of hygiene and appropriate antibiotic usage. There have been reported delays in taking stool samples for testing.

The ENHT has taken the following actions to improve this rate, and so the quality of its services, by:

- Strict hand hygiene control (96.26% compliance) and adherence to infection control care bundles
- Application of the antibiotic stop policy
- Undertaking root cause analysis investigation of each case to identify causes and use this information for learning and sharing across the organisation
- Focusing upon timely collection of stool specimens

Careful antibiotic prescribing must be undertaken to help prevent the incidence of clostridium difficile. The Trust participated in a CQUIN scheme to reduce antibiotic use by 1% (measured by daily dose per 1000 admissions); and a scheme to review antibiotic usage 72 hours after initial prescription.

✓ Compared to baseline data 2013/14 antibiotic usage in 2016/17 reduced by 18%.
✓ 93% of antibiotics reviewed in quarter 4 (against a plan of 90%), with the aims of all other quarters also met

A new antimicrobial stewardship ward round started in February, focusing on patients with gastroenterology conditions where there is a high use of certain antibiotics.

Indicator 9 - Number of Patient Safety Incidents

A patient safety incident is an unintended or unexpected incident which could have or did lead to harm for one or more patients. Common examples include falls and pressure ulcers.

	Number of Patient Safety Incidents	**ENHT Previous Period**		**ENHT Current Period**	**National Current Period**	**Highest Performer**	**Lowest Performer**
		Apr – Sept 15	(Oct 15-Mar 16)	(Apr 16-Sept 16)			
a	The number of patient safety incidents reported within the Trust	2799 *(2961)*	3968 *(4176)*	3446 *(3527)*	-	-	-
b	The rate of patient safety incidents reported within the Trust (per 1000 bed-days)	26.61 *(28.15)*	36.41 *(38.32)*	31.76 *(32.51)*	-	71.81 North Devon Healthcare	21.15 Luton & Dunstable Hospital
c	Number of severe harm or death (Acute Trust – non specialist)	17 *(18)*	23	27	-	4	92
d	Percentage of severe harm or death (Acute Trust – non specialist)	0.6%	0.6%	0.8%	0.4%	0% Thameside Hospital	1.7% United Lincolnshire Hospitals

(Source: NHS Digital Indicators/NHS Outcomes framework/Domain 5)

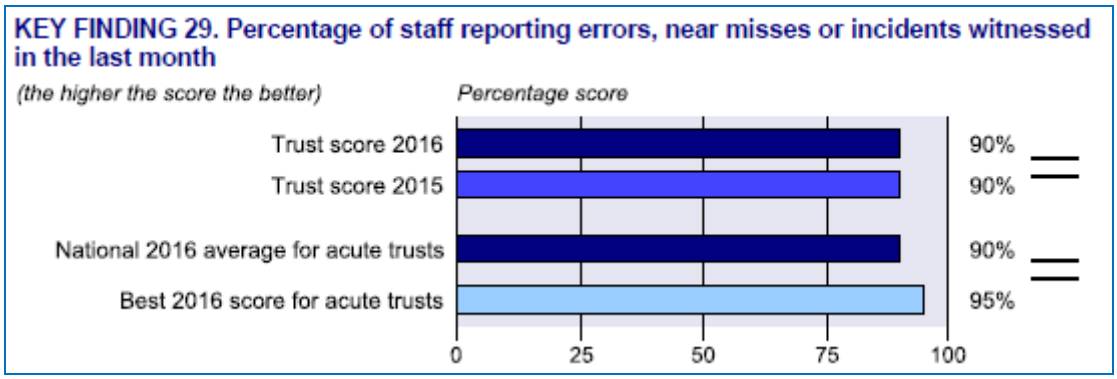
Staff report patient safety incidents via an electronic reporting system. Managers review the incidents detailing the action taken where relevant. Trend data can be extracted from the electronic system which is used to target preventative initiatives or to identify wards or departments where more support is required to address any emerging problems.

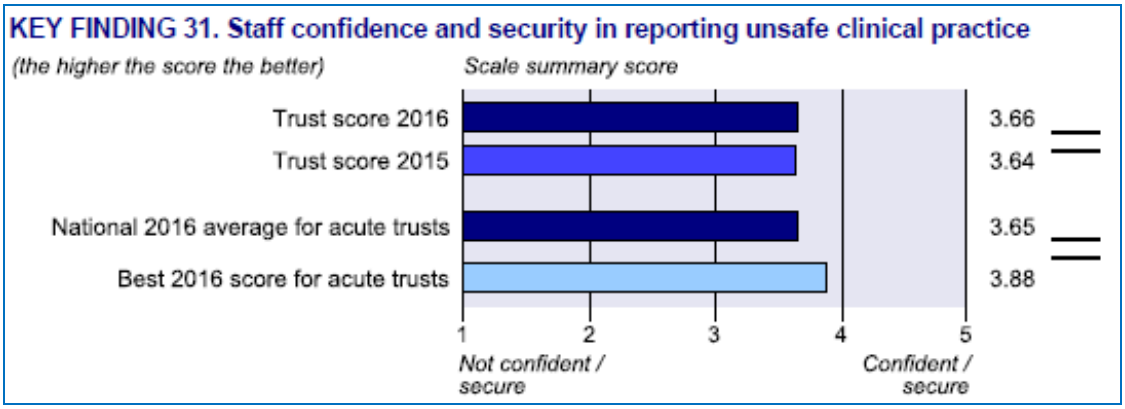
The ENHT considers that this data is as described for the following reasons. Staff report incidents on an electronic system and whilst surveys indicate staff are confident to do so there is an ongoing concern about signing incidents off in a timely way. This causes a delay in sending data to the national system hence a lower reporting rate is shown than is actually the case. The number of incidents reported are shown in brackets () but not all signed off in time to meet the national capture deadlines.

The ENHT has taken the following actions to improve these scores, and so the quality of its services, by:

- Continuing to support staff in dealing with any concerns
- Providing ongoing training
- Providing monthly reports to divisions about the sign-off status

The national Staff Survey (2016) indicates that staff report incidents in line with national averages and feel confident to do so.



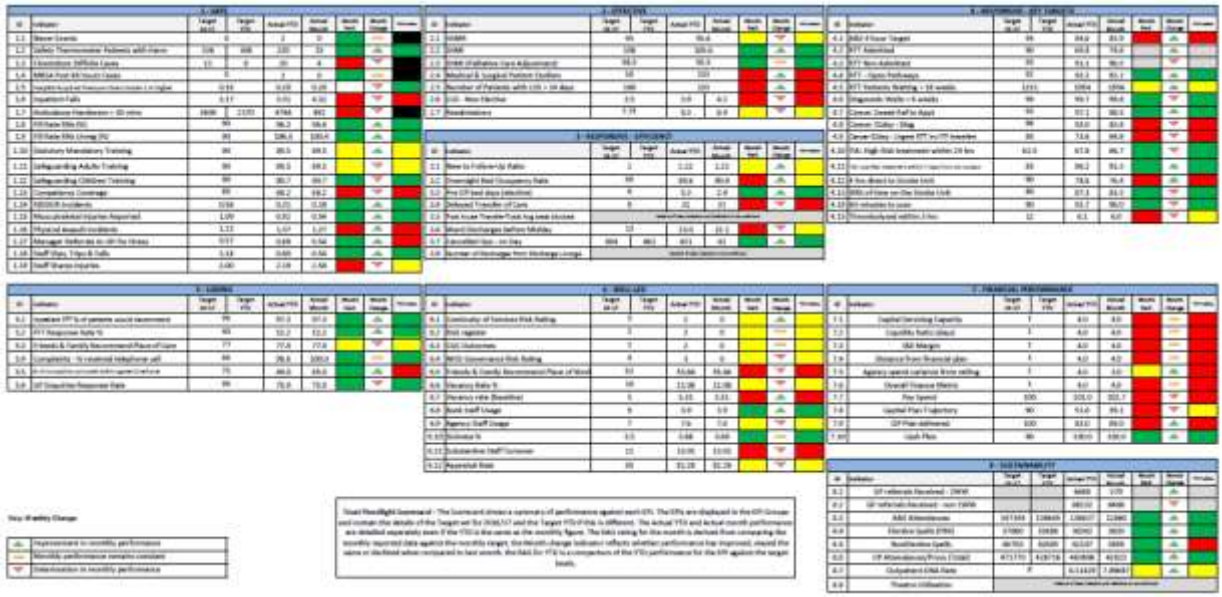


Part 3

3a	Review against selected metrics • Safety • Clinical effectiveness • Patient experiences
3b	Duty of Candour
3c	Sign up to Safety
3d	Staff survey
3e	Care Quality Commission inspections
3f	Our staff
3g	Performance against national requirements

3a Review against selected metrics

The Trust Board routinely reviews a selection of metrics at each of its meetings. An overview, known as the Floodlight, is given below for illustrative purposes.



This shows the ‘at a glance’ performance in relation to five areas which includes the components of quality – safety, experiences (caring) and effectiveness.

The metrics include national and local indicators, some of which have ‘stretch targets’. Such stretch targets aim high to force the organisation to make big improvements. Although desired, it is not always possible to reach these targets which is why a number of indicators above are shown as ‘red’.

Patient safety

Indicator	13/14	14/15	15/16	16/17	Aim for 16/17	Met
Never events	1	1	4	**2**	0	✖
MRSA Bacteraemia	2	5	0	**2**	0	✖
Number of inpatient falls	988	919	861	**867**	<818	✖
Number of in-patient falls resulting in serious harm	16	14	13[1]	**15**	<=24	✓
Number of preventable hospital acquired pressure ulcers	45	54	26	**27**	<=36	✓

In the 2015/16 report this figure was reported as 11
Source: Datix internal incident reporting & information held by local teams

Never events

A never event is an incident that should never happen if the correct procedures are in place and being followed to prevent an occurrence.

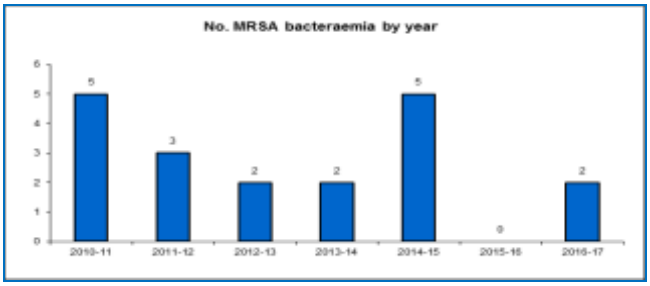
In 2016/17 the Trust reported 2 never events:

- A wrong side bearing was placed into a knee during surgery. A failure to realise the bearings were 'sided' coupled with inadequate checks prior to placement meant that surgery was completed before the error noted. The department has introduced specific checking responsibilities and reviewed the role of company representatives within the theatre environment.
- A patient fell out of a window despite restrictors being in place. The restrictors were compliant with regulations but could not withstand the force applied against them.

MRSA

Methicillin Resistant Staphylococcus Aureus (MRSA) is a type of bacteria that is resistant to many widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections resulting in patients staying in hospital for a long length of time.

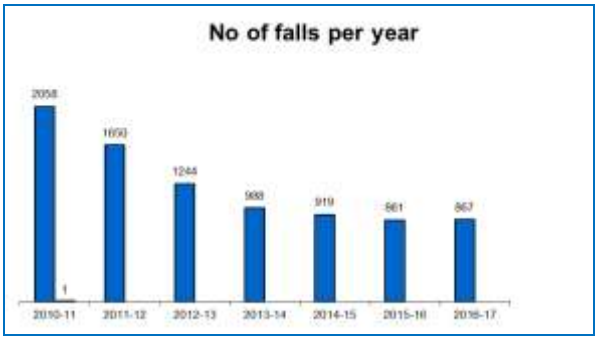
In 2016/17 the Trust had a target of achieving zero avoidable MRSA Bacteraemias. These are bloodstream infections from the MRSA bacterium. There have been two hospital associated MRSA bacteraemias in the year including one pre-48 hour case which was found to be a contaminant.

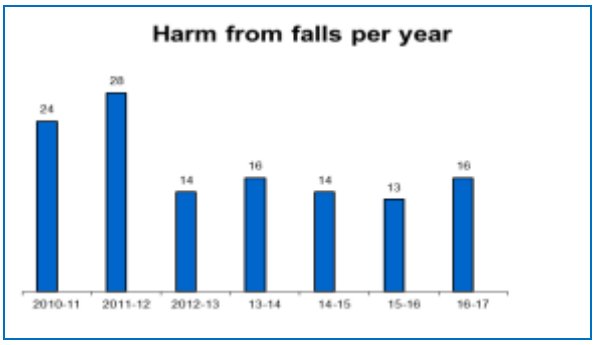


Actions underway are the same as those described in the section on clostridium difficile.

Falls

A 5% falls reduction target was planned against the 2015/16 figure. During the year 867 patients fell. This represents a 0.69% increase compared with 2015/16 and an increase per 1000 bed days by 0.12.





There were 152 falls that resulted in harm representing a 7.31% reduction when compared to 2015/16. Of these 15 patients suffered severe harm and one patient died as a result of a fall. Upon investigation it was identified that the patient who died had a severe blood coagulation abnormality which increased the risk of bleeding into the brain following trauma.

Actions underway to help prevent falls include:

- Baywatch system of observing cohorted patients at high risk of falls
- Safety huddles which facilitate staff to identify and manage key patient risks on a daily basis
- Participation in a falls collaborative organised by NHS Improvement, starting with pilots on a small number of wards and focus on an improvement plan

Where a patient has fallen and this has resulted in severe harm such as a fractured hip or head injury the incident is investigated as a serious incident. The findings from the investigations are routinely shared amongst the clinical teams to ensure that risk mitigation measures are put in place. All falls-related serious incidents are discussed routinely at the bimonthly Falls, Fragility and Bones Group to decide whether the findings/learning from individual investigations warrant an amendment to the trusts falls prevention strategy.

Pressure Ulcers

There have been 15 grade 2 and 12 grade 3 unclassified avoidable hospital acquired pressure ulcers reported during 2016-17. The majority of these (13/27) relate to heels.

Actions underway to help prevent pressure ulcer development include:

- Pressure ulcer prevention study days
- Production of a film to promote use of the intentional rounding tool
- Review of equipment available in relation to heels
- Alteration and re- launch of the heel care flowchart

Also relating to patient safety…

Safeguarding Adults

- ✓ A ‘flag’ on the patient administration system helps to identify patients with a learning disability so they can be supported more effectively during their attendance or admission
- ✓ 90.9% (March) of all Trust staff were compliant with Adult safeguarding training, surpassing the 90% aim
- ✓ QEII, Hertford County Hospital and Ophthalmology continue to work with the Health Liaison Team towards achieving Purple Star accreditation

Safeguarding Children

✓ 91.2% (March) compliance with child protection training (aim >=90%)

✓ Processes implemented and plans to improve data collection for referrals to mental health services and children's services to inform service

Electronic referrals

✓ Radiotherapy referrals are paperless thus ensuring robust audit trails and reducing the chance of error

Clinical effectiveness

Indicator	13/14	14/15	15/16	16/17	Aim for 16/17	Met
Length of stay (non-elective)	3.91	3.53	3.50	**3.9**	<=3.5	✗
Number with length of stay > 14 days				**145**	<100	✗
Cancelled operations (on the day)	0.62%	1.41%	1.71%	**467**	<=504	✓
Medical and surgical outliers (PCM)				**115**	<50	✗

Source: Information accessed from local teams

The indicators described in this section are all inter-related whereby improvements in one are required to support improvements in the others. For example a reduced length of stay will increase the bed availability for those requiring surgery, thus reducing on the day cancellations due to a lack of beds.

Length of stay

Length of stay is optimised when care pathways and care bundles are introduced so that care is given in a prescriptive manner aligned with best practices.

A care pathway, also known as an Integrated Care Plan, is a plan of optimum care to be delivered from arrival to discharge. It describes the tests, treatments and monitoring to be undertaken at certain points during the admission; and by whom. It aims to standardise care where possible so people routinely receive the same optimum treatment and staff become familiar with delivering it.

A care bundle is a specific group of actions that need to be undertaken within an agreed timeframe to maximise chance of survival or to optimise treatment. An example is the Sepsis care bundle – known as the sepsis 6 – where 6 aspects of care must be delivered together within one hour of suspected diagnosis. The omission of one aspect will reduce the chance of overall success.

Care Bundles, either standalone or as part of an Integrated Care Plan, are now in place for the following diagnostic groups:

- Pneumonia
- COPD
- Congestive cardiac failure
- Stroke
- Acute MI
- Decompensated cirrhosis.

The newest care bundle is that for Decompensated Cirrhosis which is a medical emergency with a high mortality rate. The care bundle comprises a practical, evidence-based guideline designed to be used from the point of admission (within 6 hours), including a checklist of important aspects of Chronic Liver Disease management.

Within Respiratory services the use of the COPD care bundle continues to be encouraged and data is now submitted as part of a national real-time audit. As part of the STP project the Trust is working with WHHT and PAH to agree a standard pathway for pneumonia to reduce the variation in management.

Trust discharge planning teams are also actively working with community health and social care partners to support the needs of those requiring additional help after discharge.

Cancelled operations

The number of 'on the day' cancellations that have occurred during 2016/17 is 467 against a plan of below 504.

Hospital initiated cancellations are due to a failure of the hospital's infrastructure such as a lack of beds, equipment failure, missing medical records, sterile services issues or staff absence. Patient cancellations are where it is not possible to operate on a patient as they have failed to attend, have cancelled at short notice or are not medically fit for surgery.

The theatre process redesign work is intended to improve theatre efficiency thereby maximising the use of theatre time. In addition better bed management and the prevention of admission and re-admission will all help to reduce the number of cancellations.

Outliers

Patients are admitted ideally on a ward where their care and treatment can be provided by specialists with expert knowledge of their condition. For example the needs of a patient with heart problems is best cared for in the coronary care unit. Where a patient is placed on a ward within a different specialism this is known as 'outlying'. Although care and treatment is still provided the specialist teams are not as readily available so patients potentially may not receive the most timely or optimum care.

The Trust is committed to reducing the number of outliers; and to support this the number of outliers is now tracked on a monthly basis. The data available is still in its infancy and developments during 2017/18 will help to ensure the data is robust and meaningful.

All outlying patients are reviewed by a dedicated medical outlier team within the Trust although more therapy support will be required in the future. It is the aim of the team to review the patients daily before 12 Noon and to ensure discharge planning and multidisciplinary teamwork is maximised.

Outlier medical patients get similar medical input to patients on medical wards, i.e. consultant ward rounds Monday – Thursday with Friday covered by physician of the day rota. Specific additional support is provided by support teams such as those providing diabetes and dementia care. Heart failure and acute kidney injury teams actively support patients throughout the Trust.

Also relating to effectiveness of care…

- ✓ The Trust continues to work towards 7 day working, aiming to comply with the four national priorities by March 2018. These are: Time to Consultant Review; Access to Diagnostics; Access to Consultant-directed Interventions and On-going Review.

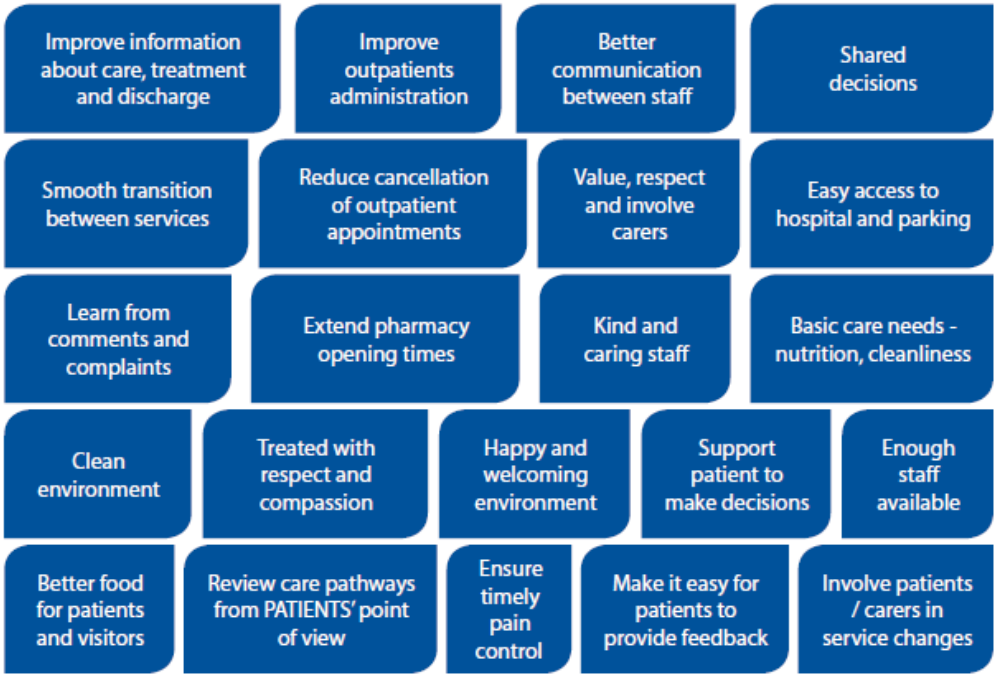
✓ Patients who have Robot Assisted Radical Prostatectomy were found to have better treatment when compared with patients undergoing Open Radical Prostatectomy and that the cost of treatment was less.

Patient experiences

The Trust's Patient and Carer Experience Strategy (2015-19) has three ambitions:

- To improve the experience of our patients and carers from their first contact with the Trust, through to their safe discharge from our care
- To improve the information we provide to enhance communication between our staff, patients and carers
- To meet our patients' physical, emotional and spiritual needs while they are using our services, recognising that every patient is unique

A summary of the strategy is represented in the diagram below.



Patient experiences indicator set

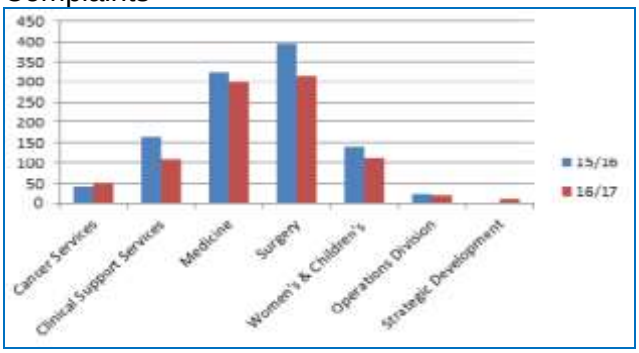
Indicator	13/14	14/15	15/16	16/17	Aim for 16/17	Met
Number of complaints	864	1181	1095*	**924**	<previous year	✓
Number of PALS concerns	1728	2306	3279	**3195**	N/A	-
Complaints per level of activity - per 100 bed days (Before 2015/16 this was per finished consultant episode)	0.9%	1.32%	0.5% (New methodology)	**0.41% (Q1-3)**	N/A	-
Complaints – response within agreed timeframe	49%	59%	54%	**48%**	>75%	✗

*The 2015/16 report stated 1072 complaints were recorded. This has been revised in light of supplementary information.
Source: Datix internal system & Information held by local teams

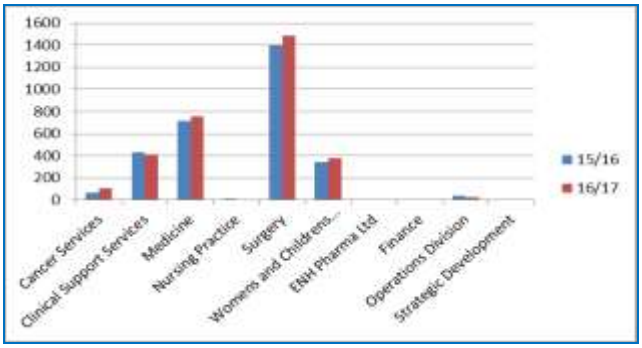
Complaints and PALS concerns

The number of complaints and PALS concerns is showing a reduction compared with the previous year.

Complaints



PALS Concerns



Given that activity has increased over the year it is encouraging that fewer complaints have been received.

✓ Data on complaints per 100 bed days which takes into account changing activity levels suggests an improving picture compared to 2015/16.

Complaints response times

When a complaint is received a member of the complaints team telephones the complainant and agrees an appropriate timeframe within which to complete a response. This is then measured. The timeframe has been met on 48% of occasions against a plan of >=75%.

Investigators are given 15 days to provide a report but often where the complaints are complex or where more than one department or professional is involved the investigation can be very time consuming. Case Handlers within the complaints team meet with key clinical personnel to support the investigation and more recently a standardised report template has been introduced to support obtaining thorough answers.

Each division receives a monthly spreadsheet detailing the number of complaints that are open for each specialty. This supports local ownership and monitoring. In addition, a review of the staff assigned to undertake the investigations has been undertaken to ensure the right people are involved; and a training programme has been delivered to enable ward sisters to more fully understand the process of undertaking a complaints investigation which will help to expedite the investigation and ultimately the response rate.

Below are some examples of what has happened as a result of complaints.

You said…	**We did…**
Delays in medication dispensing meant patient was delayed being discharged.	Apology given that a different way of working at the weekend means that prescriptions are sent to Pharmacy for dispensing. The Pharmacy team are exploring the dispensing prescriptions from the wards at the weekends to minimise delays
Cancellation of procedure / communication concerns.	Apology that family were not told sooner. Explanation given of why it may be necessary to cancel a procedure. As a result of the complaint the procedure for the scheduling of lists will be reviewed.
Complainant queried the refusal of Fentanyl. Concerns over care	Doctor was reluctant to give a controlled drug as the care plan the patient brought to the Emergency

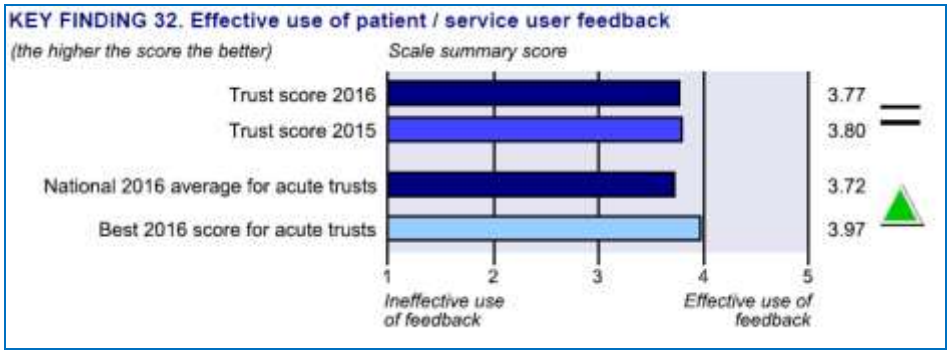
plan not being on patient's file / electronic records.	Department had not been produced on Trust headed paper. The care plan has been re-written, printed on headed paper and laminated. The patient and staff now have copies.
Complaint regarding a delay in the Emergency Department, lack of communication and "unhelpful lazy" staff.	Explanation that many new processes had recently been put in place, including improved staffing due to recruitment, changing processes within the Emergency Department and improving the care pathway to ensure that patients who need to be admitted are given beds sooner, thus freeing up beds and trollies for the patients who need them while they are waiting to be seen. The concerns relating to attitude and behaviour of a member of staff have been discussed with the individual and training has been arranged.

Gathering feedback

The Trust values the views of our patients, their families/ carers and the public to help us better understand what they think about our hospitals, staff and services so that we can make improvements. Examples of how we seek and listen to service users are:

- Local and national surveys (paper and electronic)
- Letters of thanks
- Complaints and Patient Advice and Liaison Service (PALS) enquiries
- Comments posted on the NHS Choices website
- Engagement activities including consultation work on service planning
- 'Patient Stories' shared with the Trust Board

The National Staff Survey (2016) shows the Trust as being better than average in its effectiveness of using feedback from service users.



It was my 2nd time as a day patient from the doorman right the way through to the surgeon there amazing companionate I wish more hospitals were like this I highly recommend this hospital well done to everyone wishing you a great future x

General Surgery, January 2017

Very poor communication no doctor return calls if it wasn't for the nurses we would not know anything about my dad no discussion regarding dads further care about moving him to a care home sister on the ward very un approachable would not talk to us I could go on not acceptable for a NHS hospital.

December 2016

Dementia

A Clinical Nurse Specialist (CNS) oversees the development of services for people with dementia and offers advice and support to staff looking after them. Hospital environments can

increase anxiety for suffers of dementia and the Trust continues to develop its services to care for them:

- A Dementia/Delirium care plan, aimed to identify and meet the care needs of patients with dementia and people suffering from delirium, has been trialled on the elderly care wards. A roll-out to all wards is planned for 2017/18
- The new patient administration system (Lorenzo) has been set up with a specific section for dementia assessments. Once the system goes live in July it will help the CNS to identify inpatients quickly and be able to offer them and staff support
- Dementia Strategy Multi-disciplinary meetings are held every 3rd Thursday of the month. They aim to discuss and implement better patient care and dementia awareness
- Dementia champion meetings are held every three months. It is an opportunity for the CNS to support staff on wards and provide up to date information within the Trust
- A series of educational Student Nurse forums have been held and Student Nurses regularly shadow the CNS to see how dementia patients are supported

✓ It is an exciting time for dementia within the Trust as we've been approached by Dementia UK to become a host organisation for an Admiral Nurse. Admiral Nurses are specialist dementia nurses who work in partnership with people affected by dementia and their families by embracing evidence-based relationship-centred care. With the support of Dementia UK the Nurse can receive up to date training, support and work closely with other Admiral Nurse's in the community. This will help support patients and carers going home in the community and hope to prevent hospital admissions too.

National in-patient survey 2016 (update when available in May)

xxx patients responded to the survey, with a xx% response rate (xx% nationally). The results since 2013 are shown together with how the Trust scores compared with the national averages.

Question group	2013	2014	2015	2016	National range (2016)
Emergency / A&E department	8 =	8.1 =	8.4 =		
Waiting lists & planned admissions	8.6 =	8.6 =	8.6 =		
Waiting to get to a bed	6.9 =	6.9 =	7.1 =		
Hospital & ward	7.8 =	7.7 ↓	8.1 =		
Doctors	8.2 =	8.1 =	8.4 =		
Nurses	8.1 =	8.2 =	8.1 =		
Care & treatment	7.2 =	7.4 =	7.5 =		
Operations & procedures	7.8 ↓	8.2 =	8.1 ↓		
Leaving hospital	6.9 =	6.9 =	6.8 =		
Overall views & experiences	5.1 =	5.4 =	5.3 =		

Electronic surveys

The Trust uses electronic devices, called Meridian, to record the views of patients during their stay with us. Examples of pie charts produced by the Meridian system are shown throughout this report.

In 2016/17 almost 12,000 people undertook the electronic inpatient survey. The scores for each of these questions is shown in the table below with the highest scores relating to privacy

and dignity; the lowest to noise at night and food. The scores can be generated for specific wards and time periods and are used by the relevant departments to make improvements.

Rank	Question No.	Question	Score	Questionnaires
1	20	Did you feel you were treated with respect and dignity while you were in the hospital?	97.01	11919
2	21	During your time in hospital, did you feel well looked after by hospital staff?	96.14	11909
3	18	Do you think the hospital staff did everything they could to help control your pain?	92.82	11878
4	13	When you had important questions to ask a **nurse**, did you get answers that you could understand?	90.88	11863
5	8	Did you get enough help from staff to eat your meals?	90.84	11934
6	6	In your opinion, how clean was the hospital room or ward that you were in?	89.76	11938
7	12	When you had important questions to ask a **doctor**, did you get answers that you could understand?	88.33	11862
8	17	Do you feel you got enough emotional support from hospital staff during your stay?	87.24	11889
9	11	Were you involved as much as you wanted to be in decisions made about your care and treatment?	83.71	11884
10	10	Were you ever bothered by noise at night from hospital staff?	83.67	11910
11	16	Did you find someone on the hospital staff to talk to about your worries and fears?	82.19	11883
12	14	In your opinion, were there enough nurses on duty to care for you in hospital?	80.44	11879
13	15	Do you know which nurse is in charge of looking after you? (this would be a different person after each shift change)	76.11	11860
14	19	How many minutes after you used the call button did it usually take before you got the help you needed?	71.15	11907
15	7	How would you rate the hospital food?	65.62	11937
16	9	Were you ever bothered by noise at night from other patients?	65.01	11899
17	5	As you would not recommend this service could you please tell us why?	N/A	11955
18	4	As you would recommend this service, could you tell us what we did well?	N/A	11955
19	2	What was good about your stay?	N/A	11398
20	3	What would have made your experience better?	N/A	11233
21	1	How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	N/A	11928

You Said… We Did

All wards have a patient experience notice board where they display a range of information about the ward's performance. This includes listening to feedback and acting upon it – so called 'You Said – We Did'. Examples of some actions taken by staff are given below.

Learning From Your Experience - Examples of 'You Said – We Did' Actions

October - December 2016

Ward/Dept.	You Said	We Did
Acute Medical Unit Assessment	We need better communication with the doctors about timings of what is going to happen and when.	Reminded all staff to keep patients and relatives updated on all treatment plans and decisions so everyone is clear what is happening and when.
Short Stay Unit	Patients can get a bit noisy sometimes which is disruptive.	Where possible we will aim to move patients if they are distressed or disruptive to others, although sometimes this is not possible as space is limited.
Short Stay Unit	We would like our families to be able to visit more often.	We are rolling out 'John's Campaign' welcoming visitors on the ward between 9am-9pm and enabling carers to stay with their loved ones at any time. We have two fold up beds available for carers staying overnight on the ward.
Midwife Led Unit	I was kept waiting for a bit on arrival at the MLU.	We try to make everyone on MLU feel welcome as soon as they arrive with us and ensure that they are reviewed as soon as possible. However if there is likely to be a delay we will ensure that women are informed and know when they are likely to be seen.
Midwife Led Unit	Left a bit too long without any information after delivery.	We understand the importance of leaving a new family to bond and rest after birth and we will do our best to support and guide on an individual basis. If women or their partners have any concerns the call bell is available 24 hours a day and staff are happy to answer any questions or give advice.
Consultant Led Unit	A shorter time between triage and transfer to the CLU	We endeavour to ensure that there are no delays in transferring women to ensure they are cared for in the right place. At times, when activity is high there may be a delay in transfer, we will ensure that women are kept informed of what is happening.
5A	Wanted to be kept up to date by doctors.	We endeavour to keep patients informed of their progress and test results. Depending on the type of test, some results can take longer to be processed. We have reminded our staff to keep patients updated on progress whilst in our care.

Also relating to patient experiences…

Purple Star Award

✓ The Trust's diabetic eye screening team has earned a Purple Star for supporting people with learning disabilities. Awarded by Hertfordshire County Council's Purple Star strategy team, it is earned for the delivery of high quality services that have been adjusted reasonably for adults with learning disabilities eg. promotion and use of the Purple Folders, production and use of accessible information and demonstration of awareness of safeguarding concerns.

Patient/Carer Stories

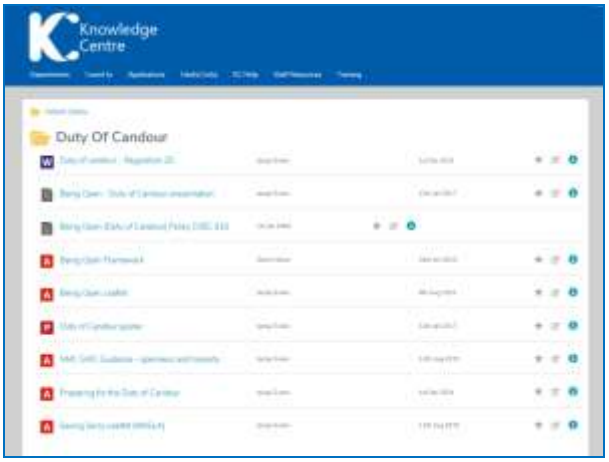
✓ Trust Board meetings start with a patient story, often told by a patient attending the meeting. The Board welcomes such information to understand better what it is like to be a patient/ family member in our hospitals.

3b Duty of Candour

This is the duty to 'be open' with people when something goes wrong leading to significant harm. The duty is to explain what has happened; to offer a sincere apology; and to involve the patient / family in what will happen next.

Some examples of how the Duty is promoted include:

- Training at induction and during mandatory updates for doctors
- Forced fields on the incident reporting system for staff to state how they have been open when things have gone wrong
- Written communication with patients/ families when a serious incident has occurred
- Investigation reports include a specific section on communication with the patient/ family
- Meetings with patients/ families to discuss incidents
- Incident training includes the importance of family discussions
- Liaison with families as part of investigations



Information for staff is available in one place on the Trust's intranet

For many years patients/ families have been offered, and taken up, the opportunity to meet with staff to discuss the findings of a serious incident investigation report.

During 2016/17 a new process was established whereby families are invited to meet with the patient safety and investigation teams prior to the start of a serious incident investigation. This allows patients/ families to be more involved with the investigation and enables their views and concerns to be considered early on. Such an approach is helpful to investigators who can obtain answers to concerns at the earliest opportunity and include them in the report. More importantly, the views of patients/ families are considered early and the meeting offers an opportunity to answer any immediate questions.

The value of these meetings is demonstrated by the views of two families involved:

"I would like to thank you for organising the meeting, which I thought went well. I have come away in the knowledge that by drawing the trusts attention to our own experiences we may help other families in the future. Please extend my thanks once again to Dr Hughes for his honest and thorough report"

"Very soon after the mistake was apparent I was visited by a senior pharmacist and by the young pharmacist involved. I was kept informed of investigation progress whilst still in hospital and a full explanation was also given to my family. Later, after my discharge from hospital, as the investigation progressed I and my daughter were invited to meet with the investigators face to face so that I could express in my own words how I felt at the time of the error and subsequently. It was very important to me that I was allowed to do so. I am fully reassured that a proper investigation was carried out and that measures have been taken to help prevent a similar incident in the future."

3c Sign up to Safety

Sign up to Safety SAFETY LISTEN LEARN ACT	Sign up to Safety is a national initiative to improve safety by identifying improvement projects and implementing them locally; but also sharing learning nationally via web links and conferences. The Trust's safety initiatives are closely aligned with: • The Improving Patient Outcomes Strategy • The Trust's culture programme • Plans to enhance collaboration with partners • Plans to enhance the Duty of Candour

3d Staff survey

Harassment and bullying

Although showing improvements since 2015, the 2016 NHS staff survey highlights a continuing concern with bullying and harassment at the Trust.

Percentage of staff…	Trust 2014/15	Trust 2015/16	National
Reporting they had experienced harassment, bullying or abuse from patients/ relatives/ public	29%	**28%↑**	27%
Reporting they had experienced harassment, bullying or abuse from staff	30%	**29%↑**	25%
Who had experienced harassment, bullying or abuse had reported it	22%	**42%↑**	45%
Who had never suffered violence from patients/ relatives or public	89%	**89%=**	85%
Who had never suffered violence from staff	98%	**97%↓**	98%

Slight improvement in experiencing bullying compared to 2015 but rated in the **worst 20% of Trusts** in 2016

Significant improvement in reporting episodes of bullying compared to 2015 but rated in the **worst 20% of Trusts** in 2016

Source:
National Staff Survey 2016

Below is a summary of the initiatives, as detailed in the staff newsletter *Your Voice* (Sept 2016) to reduce bullying.

We refuse to tolerate any form of Bullying and Harassment from our staff.

The Trust are committed to ensuring that none of our staff experience bullying and harassment at work and that staff have the opportunity to raise concerns as soon as possible through a number of different forums.
(Please see staff support section on page 7)

We have been working over the last year to remove bullying and harassment from the Trust and improve the ways we can support our staff;

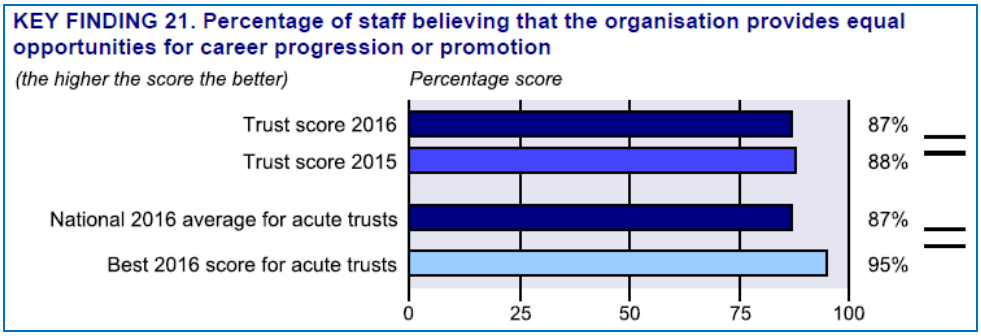
- Zero Tolerance campaign to bullying and harassment
- Staff are encouraged to speak up without fear.
- An anonymous concerns-raising platform – Speak in Confidence
- Employee relations advisory service (ERAS)
- Use early intervention techniques
- Raising the awareness of bullying and harassment
- Educating staff and managers on the impact of bullying and harassment
- Managers using their emotional intelligence when dealing with Bullying and Harassment cases
- Managers encouraged to have difficult conversations with team members when appropriate
- Raising the importance of tackling bullying and harassment with the executive team
- Bullying and harassment survey (Duncan Lewis report)
- CORE management skills training for the Trust's line managers
- Drop-in surgeries run by the ERAS team for staff
- A focus on reducing vacancy rates (which impact on stress and pressure felt by staff)
- Continue to drive improved compliance for new appraisal process which focuses on assessing behaviours and values
- The availability of the employee assistance programme
- Mediation is also used in cases of bullying and harassment. HR staff will be undertaking an intensive training course on mediation skills in September 2016
- We deal with cases informally
- Executive walkabout and Ask Nick sessions

In addition, training programmes offered by the Employee Relations Advisory Service for managers include Difficult Conversations and Dealing with Conflict.

Supported by the culture programme and the initiatives to reduce sickness and vacancies detailed in Section 3f it is intended that staff will work as part of a stable workforce in a culture that is nurturing and developmental. These initiatives collectively aim to reduce the incidence of bullying.

Equal opportunities

The 2016 Staff Survey indicated the Trust has an *average* score at 87% for *staff believing the organisation provides equal opportunities for career progression or promotion.* This is a slight overall reduction compared with the previous year. When looking in detail at the responses by ethnic group we can see there is a disparity felt by staff within the black and minority ethnic (BME) groups albeit to a lesser extent than reported nationally. It is encouraging to note, however, that there has been some improvement in the scores reported by the BME staff groups.



			Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	89%	88%	90%
		BME	81%	76%	79%

The Trust took the opportunity to include additional questions in the national survey on *Leadership & Career Development* and *Organisational values.* As an optional module there are no national comparisons but it does provide some rich data and an opportunity in the future to measure the effectiveness of the LEND leadership model and the Leadership & Management Development Pathway described in Section 3f. Of note:

- Over 70% of staff feel they have the capability to become a leader in their area of work
- 53% of staff feel that the person they report to creates opportunities for their professional growth
- Just under 60% of respondents feel that there are opportunities for them to develop their career in this organisation, and a similar number feel able to access the right learning and development materials when they need to.

The Trust is now engaging staff in developing actions to make further improvements.

3e Care Quality Commission inspections

October 2015

The Care Quality Commission (CQC) carried out an inspection as part of its routine comprehensive inspection programme from 20-23 October 2015.

The Commission rated the Trust as '**requires improvement**' overall but judged Hertford County Hospital and Children's Community Services to be '**good**'. The Bedford and Harlow renal units were inspected but not rated. The Trust was rated '**good**' for caring.

The ratings for the services assessed are given in the tables below.

Our ratings for Lister Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Requires improvement	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for QEII

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Our ratings for Hertford County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Our ratings for Mount Vernon Cancer Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Inadequate	Requires improvement	Good	Inadequate	Requires improvement	Inadequate
End of life care	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Chemotherapy	Good	Good	☆ Outstanding	Requires improvement	Requires improvement	Requires improvement
Radiotherapy	Good	Good	Good	Good	Good	Good
Overall	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community health services for children, young people and families

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Throughout the year staff have continued to progress actions to improve services. Their action plans are reported and monitored via Development Board meetings and updates are routinely sent to the CQC. Some examples of improvements are given below:

- Increased awareness sessions regarding Mental Capacity Assessments
- Risk register reporting and oversight has improved
- Disability Champions have been identified at Mount Vernon Cancer Centre and more appropriate seating for people with disabilities has been purchased
- Strengthening of systems to ensure that patients who require urgent transfer from Mount Vernon Cancer Centre to other hospitals have their needs met to ensure their safety
- Movement of paediatric clinics to ensure they are in child-appropriate environments
- Review of maternity triage so that women requiring the services are seen in a more appropriate and timely way

- Rotation of community midwives to work in the maternity unit to maintain skills and confidence
- Review of the emergency department triage process

May 2017

The CQC carried out an unannounced, focused inspection on 17 May 2016 to review concerns found during their previous comprehensive inspection. The inspection focused on the adult emergency department (ED) and Bluebell Ward, part of the children's and young people's service. Although services were inspected they were not rated.

The CQC saw that significant improvements had been made since the last inspection such as:

- Staff were caring and compassionate towards patients and visitors within the emergency department; and patients and those close to them felt involved in their care
- The new triage process within the ED appeared to be efficient and safe
- Improvements to hand hygiene and overall cleanliness
- Systems were in place to monitor patients at risk of deterioration in the ED and on Bluebell Ward
- The risk assessments reviewed, including falls and pressure area risk assessments, were generally completed appropriately and reflected patients' needs
- Staffing levels met patients' needs at the time of the inspection and there had been an improvement in the number of staff that were trained to care for a child with complex needs

However, further improvements were identified such as meeting targets in the ED around triage and 4 hour waiting times. In addition further improvements were required relating to the knowledge around Duty of Candour, local induction of temporary staff and training around advanced life support. The actions relating to all recommendations have been built into the action plans and monitored as above.

Internal Audit

An audit of Care Quality Commission (CQC) processes was undertaken as part of the approved internal audit plan for 2016/17, particularly focussing on the development and monitoring of action plans following the CQC inspection. The audit noted:

- There is a strategic and tactical overview of the CQC process provided through a senior management structure
- Testing was undertaken on a sample of completed actions in respect of medicine, mandatory training, childrens' and maternity and surgery to confirm that these had been actioned and were supported by appropriate evidence. These were all found to evidence/ support the delivery of the actions and no issues were identified.

It was reported that not all fields within the action plans had been updated fully but otherwise the report stated…

"the Board can take substantial assurance that the controls upon which the organisation relies to manage the identified risks are suitably designed, consistently applied and operating effectively".

3f Our Staff

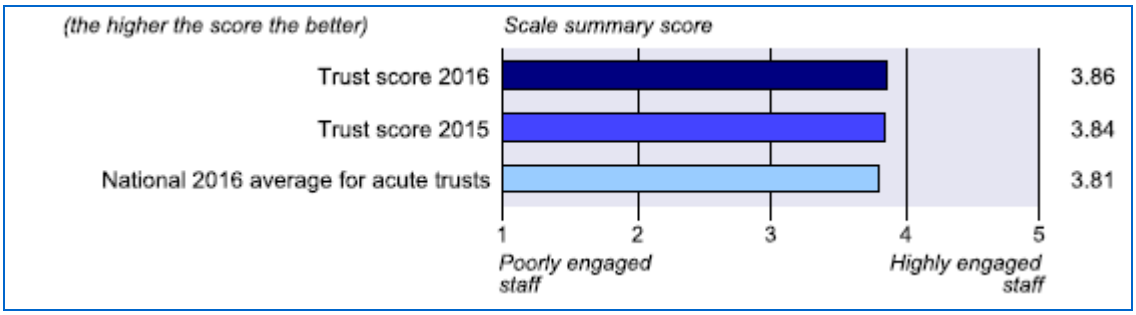
"We want to be known as an organisation where our people feel engaged, valued and supported and empowered to deliver excellent patient care and services they are proud of." *(People Strategy 2014-19, page 3)*

Staff indicator set

Key Indicators	13/14	14/15	15/16	16/17	Aim for 16/17	Met
Staff engagement	3.76	3.71	3.84	**3.86**	N/A	
Appraisal completions	45.33%	68.33%	80.45%	**81.75%**	>=85%	=
Sickness rate (annualised)	3.41%	3.55%	3.55%	**3.65%**	<=3.5%	✖
Turnover	10.71%	12.91%	12.8%	**12.96%**	<=11%	✖
Vacancy rate	5.65%	7.11%	9.72%	**5.42%**	<=5%	✓

Staff engagement

The National Staff Survey 2016 demonstrates that staff engagement has improved further during 2016/17 and is **above average** compared with other Trusts.

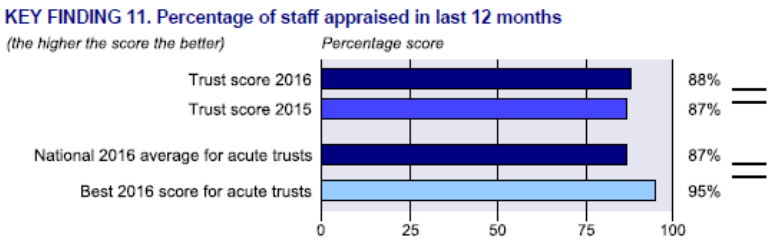


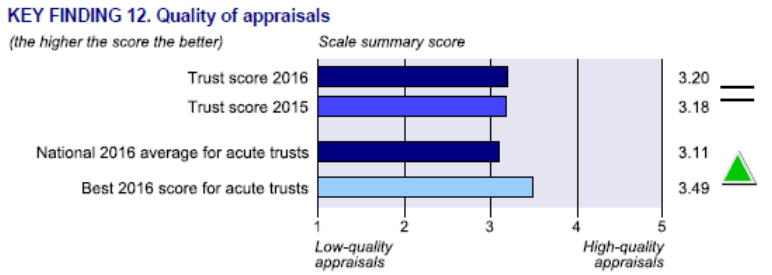
The table below shows how the Trust compares with other acute trusts on each of the questions making up the 'staff engagement' score.

	Change since 2015 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	✓ Above (better than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	• Average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Highest (best) 20%
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	✓ Increase (better than 15)	✓ Highest (best) 20%

These findings reflect the efforts undertaken to involve staff in service development as part of the improvement plans together with the increase in staff development opportunities.

Appraisals
81.75% (March) of staff have received an appraisal against a target of 85%. Appraisals are aligned with incremental dates and staff may not receive their pay progression without being compliant with appraisals and mandatory training. Managers approve the switching off of automatic pay progression for non-compliant staff.





Continued improvement in appraisals conducted compared to 2015 and rated the **same as the national average**

Continued improvement in the quality of appraisals rating **above average**

Source:
National Staff Survey 2016

Sickness Absence
To reduce sickness absence below 3.5% staff and managers are being supported to optimise health at work and prevent work related ill health and injury. Examples of some of the initiatives underway are:

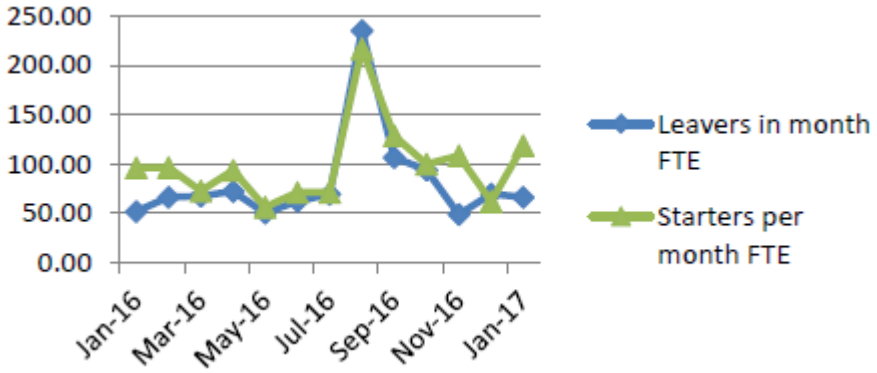
- Absence Assist – liaison service which manages staff absence
- Employee Relationship Advisory Service (ERAS) – in-house team supporting staff when they have matters of concern; supporting the management of staff suffering long term sickness
- Review of nursing absence which makes up the largest percentage of sickness absence and support for ward managers to manage this
- Early access to occupational physiotherapy for staff with musculoskeletal conditions as part of the health and wellbeing plans
- The Health at Work Service has promoted the 'Time to Talk' campaign which is encouraging people to be open about their mental health. Two events were held in February to promote the campaign; encourage use of the ERAS; offer advice on stress management and promote lunch time walks
- The Health at Work team offer mental health first aid lite training

Turnover and vacancies
The Trust aims to reduce the vacancy rate to below 5%. Also, to support the People Strategy and the Safer Staffing agenda a number of innovative attraction, recruitment and retention projects have been established. Examples include:

- Flexible working project commenced in January 2017 with four wards piloting self-rostering as a preferred method of flexible working across clinical teams
- Increased access and opportunity for leadership development (see 'culture programme' below)
- 'Never lose a nurse' campaign with drop in surgery style sessions

- Improving the speed of pre-placement health clearances to expedite the recruitment process
- Cohort recruitment, including international recruitment campaigns for registered nurses
- Continuing to advertise on local radio, social media and e-jobs boards, as well open days and evenings to increase awareness of vacancies
- Launch of the ENHanced Recruitment Campaign to increase awareness of flexible working and pension contribution choices. The pilot scheme which was initiated to attract agency workers back to working for the Trust will continue until 31 July 2017; after which its success will be evaluated
- Conducting exit interviews to understand the reasons for leaving. Analysis of January leavers indicates this is largely related to retirement (32%), relocation (18%), enhanced job opportunity (13%) and family/ personal reasons (8%).

The graph below shows the turnover levels during the year.



The target of achieving the Tust wide vacancy rate of 5%-6% is expected to be achieved in the second quarter of the financial year 2017/18.

Culture Programme

The Culture Programme, known as LEND, aims to improve staff engagement. This is being achieved by embedding a strong leadership culture, leading to improved patient and staff experience and improved customer satisfaction with services.

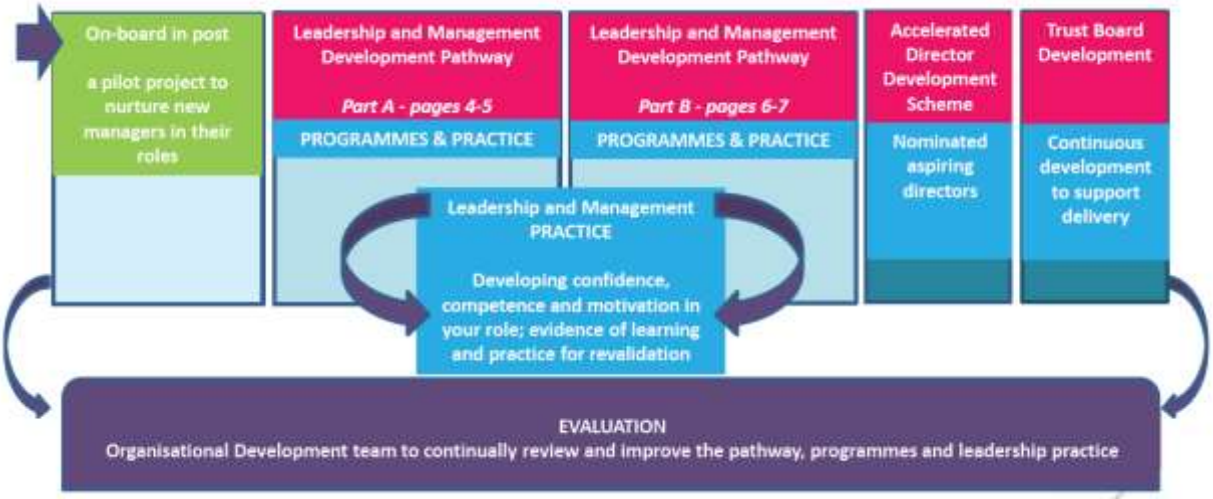
- Quarterly sessions for line managers to explore Trust developments and to consider their role and contributions
- Skills development including the management pathway

Leadership & Management Development Pathway

In January, an expanded pathway was launched. This is a set of programme and practice opportunities for all roles at all levels to develop confidence, competence and motivation to care effectively and compassionately for our community.

The expanded pathway includes programmes such as:

- Skills for Leaders
- Building Effective and Agile Teams
- Quality and Service Improvements



	Aspiring leaders	Leaders		Experienced Leaders	
Who	Non-management roles, interested in developing and becoming future leaders (suggested for Bands 1-5)	Supervises a team, reports to the team /department manager (suggested for Bands 3-5)	Leads a team / department (includes nurse team leaders, managers, doctors / dentists in training) (suggested for Bands 6-7)	Experienced in leading a department or team of people (includes nurse team leaders, managers, doctors / dentists in training) Interested in exploring leadership further and its career-long importance (suggested for experienced Bands 6-7)	
Programmes	**Aspiring Leaders** 1 day course covering the development of your personal leadership skills and leading by example (PIVOT and LEND)	**Effective Supervisor Programme** 3 workshops over 3 months covering key supervisory skills and portfolio of reflections	**Effective Manager Programme Part 1 – Core Management Skills** 3 days for NEW and existing managers covering core management and people skills **Effective Manager Programme Part 2 – In practice** 3 workshops over 4 months PLUS each delegate has: observed appraisal, observation of service, work shadowing	**Coaching - An approach to leadership** 2 day programme introducing the concepts and practice of coaching which will support the establishment of a coaching culture and as an approach to leadership. Strong practical and experiential programme supported by relevant models and concepts.	**Leadership Awareness - You and your approach to leadership** 2 day programme that explores and raises awareness of the concept and challenges of leadership. Interactive and thought provoking, exploring personal ideas of leadership as well as practical techniques - create a career long interest in developing your personal leadership capacity.
On-the-job development and practice	Activities to build experience - e.g. work shadowing, recommended meetings, secondments, follow up learning	Activities to build experience - e.g. work shadowing, recommended meetings, secondments, follow up learning	Activities to build experience - e.g. work outside of specialist area, secondments, involvement in projects, follow up learning	Activities to build experience - e.g. involvement in change and improvement, work shadowing, work outside of specialist area, secondments, follow up learning	
	ENH library services and evidence based resources are free for all Trust staff. Contact librarylister.enh-tr@nhs.net for information on how the library team can support your learning. http://www.enherts-tr.nhs.uk/gps-professionals/library/our-resources/				
Other training development practice	**Additional development - liaise with your manager/mentor to find out what is available for your role and profession**				
	Trust leadership development		**Regional or national leadership development**		
	Appraisal skills for managers - Half day		NHS Leadership Academy programmes, for example - The Stepping Up programme for aspiring BAME leaders, NHS Graduate Management Training Scheme		
	Recruitment and Selection Skills - 1 day				
	ERAS Policy training on: Sickness Absence, Work Life Balance, Capability, Dignity and Respect at Work and Grievance, Dealing with Conflict and more to be released in 2017		Regional Mary Seacole Programme		
	Health@Work Service - Mental Health First Aid Lite training - Half day		1:1 Coaching via NHS Beds & Herts or regional coaching networks		
	LEND Leadership sessions and LEND team updates		1:1 Mentoring via NHS regional mentoring network		
	Bespoke team interventions tools and advice		CPD funded courses at University of Hertfordshire, including Skills for Clinical Leadership		
	Briefing/debriefing - building an organisation				

Next Step - Leadership and Management Development Pathway - Part B on next page

The 2016 Staff Survey indicates that the quality of non-mandatory training offered and delivered by the Trust has improved since 2015 and is amongst the best nationally.

Quality of non-mandatory training has improved since 2015 and is **amongst the best 20%** of Trusts

Source:
National Staff Survey 2016

Staff surveys

Staff surveys are undertaken annually as part of a national programme. A selection of some of the national staff survey results are given below with the position showed compared with the national averages. Findings from the survey are also given later when aligning them to the Trust values. The full set of staff survey results is shown in Appendix 1.

Question	Trust 13/14	Trust 14/15	Trust 15/16	Trust 16/17	Comparison with national	National 16/17
Role makes a difference to patients	90%	92%	92%	**91%**	**Above average**	90%
Level of satisfaction with work and care	81%	77%	4[1]	**4.02**	**Above average**	3.96
Good communication with managers	27%	26%	32	**33**	**Average**	33
Quality of non-mandatory training	Not collected		4.09	**4.12**	**Best 20%**	4.05
% staff experiencing discrimination at work		11%	12%	**12%**	**Below average**	11%

[1] change in measurement

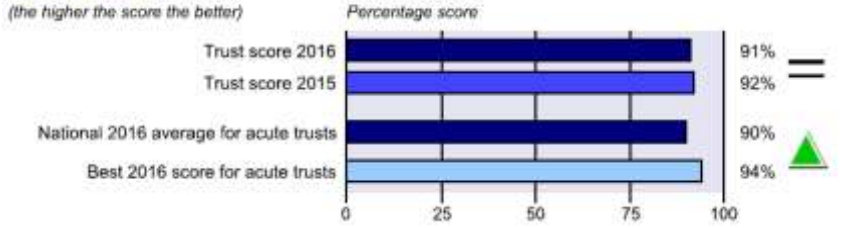
There has been no significant deterioration since the 2015 survey. Significant improvements since the 2015 survey include:

- Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse [note – although improved this indicator remains worse than average]
- Percentage of staff feeling unwell due to work related stress in the last 12 months
- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
- Percentage of staff able to contribute towards improvements at work
- Organisation and management interest in and action on health and wellbeing

Aligning the national staff survey results with Trust values

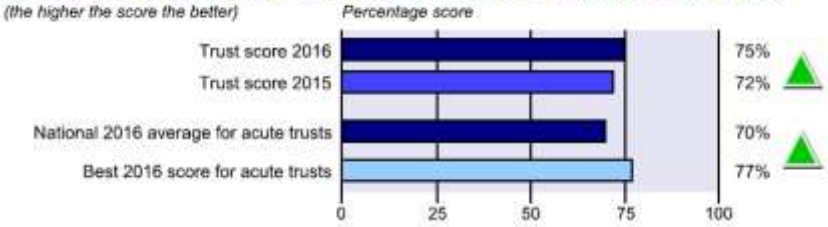
We put our patients first

KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users



We strive for excellence & continuous improvement

KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

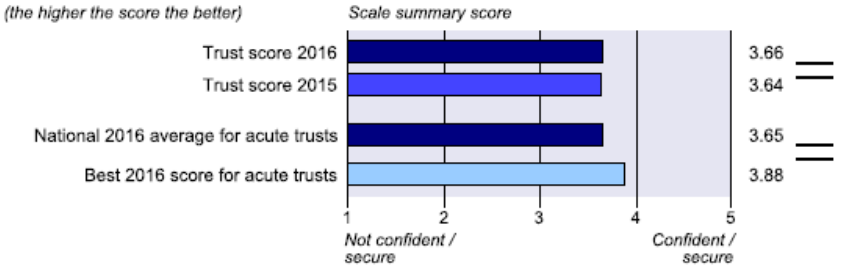


We value everybody

KEY FINDING 5. Recognition and value of staff by managers and the organisation

We are open and honest

KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice



We work as a team

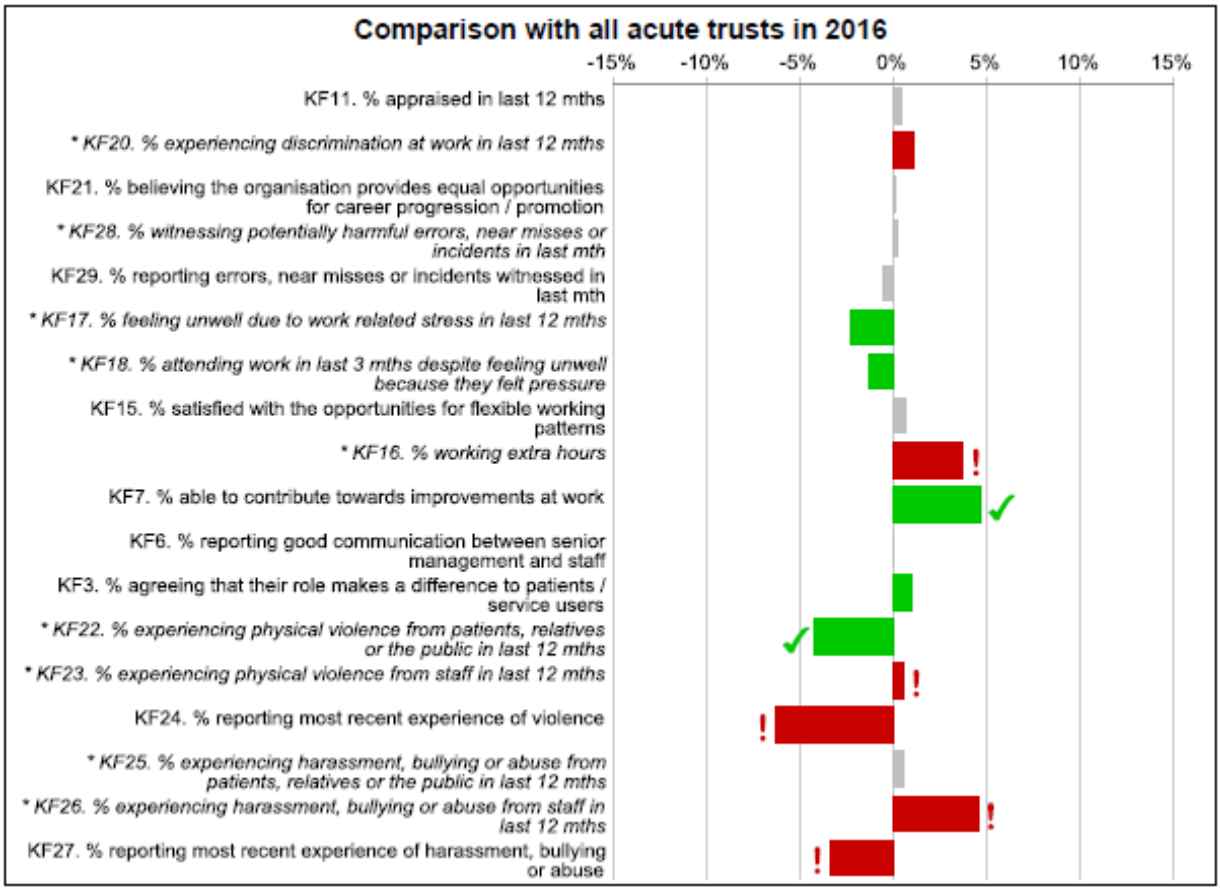
KEY FINDING 9. Effective team working

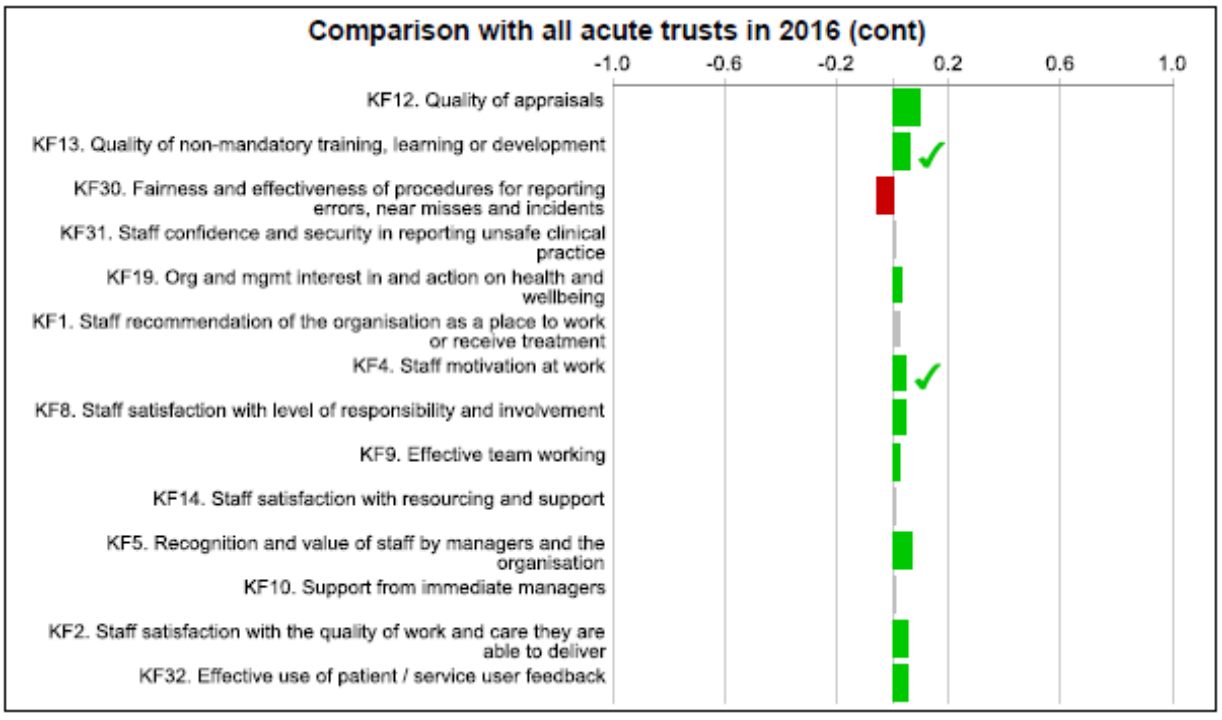
3g Performance against national requirements

		14/15	15/16	16/17 YTD	Plan for 16/17	Met
Referral to treatment times	Max 18 weeks from referral in aggregate – patients on incomplete pathways	94.2%	92.7%	**92.2%**	>=92%	✓
Access to A&E	Four hour maximum wait in A&E	92.3%	85.2%	**84.6%**	>=95%	✗
Cancer access – initial treatment	62-day urgent referral to treatment of all cancers	81.4%	76%	**73.6%**	>=85%	✗
Clostridium difficile	Rate of infection per 100,000 bed days	12	16	**22**[a]	<=11	=

Source: Single Oversight Framework (NHSI), Risk Assessment Framework (Monitor)
[a] 10 cases have been successfully appealed, with one further under discussion

Appendix 1 - National Staff Survey 2016





KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, e.g. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Annexes