Appendix A

East and North Hertfordshire NHS
NHS Trust

Quality Account

2017-18

(for stakeholder review)

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

2017/18 has been a year of challenge, change and celebration.

The challenges posed by increasing demand for NHS services are reported regularly in the media. Managing capacity to meet this demand is complex requiring new or different ways of working. I am pleased that our Trust is participating in the *Model Hospital* program to improve productivity and efficiency, which in turn will improve patients' experiences of care. Our work-streams are aiming to make improvements in out-patients, the emergency department and to the flow of patients as they move around the organisation.

In May the Trust experienced a cyber-attack resulting in complete loss of computer systems and some telephony systems. The major incident plans were initiated and recovery processes undertaken without any compromise to patient safety or patient data. Whilst extremely challenging the response from staff and support from neighbouring organisations was overwhelming and I am very grateful for their contribution. As a result we have strengthened our resilience plans.

In September the Trust introduced two new electronic systems. The first is Nerve Centre for recording clinical observations; and the second a new patient administration system called Lorenzo. The new systems aim to allow staff to have access to real-time patient records and to better support clinical decision making. In future Lorenzo will also support developments towards achieving full electronic records. The changes associated with the implementation have been immense and challenging. Whilst much of the implementation has gone well there are some functions that require further improvement and this work will continue into 2018/19.

Amongst all of these challenges we have a lot to recognise and to celebrate. The Trust has been notified of its success to become a Specialised Vascular Hub and Network lead with West Hertfordshire Hospital NHS Trust and The Princess Alexandra Hospital NHS Trust. This secures the future in providing vascular services to many local patients, but in particular the large number of patients receiving renal dialysis.

We've seen our services recognised regionally and nationally for example:

- The stroke team has received an A-rating in the Sentinel Stroke National Audit Programme, placing them in the top 19% of stroke units in the country
- The Royal College of Physicians rated the Lister's Respiratory Department in the top 5% in the country for reviewing patients after 24 hours and the discharge care bundle they provide
- The Multiple Pregnancy Team has been rated as exceptional by the Twins and Multiple Births Association. The team has worked to reduce significantly the proportion of second twins being born by caesarean section
- Public Health England has rated the Diabetic Eye Screening the best in the country for seeing patients with proliferative diabetic retinopathy within four weeks of receiving their positive screening results

- The 2016 National Vascular Registry report rates the Trust as offering the second fastest service in the country for unblocking carotid arteries to help reduce the risk of further strokes
- The National Institute for Health Research activity report confirms the Trust to be in the top 50 research active hospital groups in the country
- The Acute Stroke Therapy Team won the Excellence in Partnership Working Award at Hertfordshire Community NHS Trust's Leading Lights Awards

These are just some examples amongst many.

I would like to take this opportunity to mention our team of over 600 volunteers, of which 300 are at the Mount Vernon Cancer Centre. Our volunteers play a significant part in supporting patients and staff in so many ways. Amongst them are teams who are paired with renal dialysis patients from the start of their treatment; and the Butterfly volunteer team who provide an invaluable service in supporting people in the last days of their lives.

As we neared the end of the year the Trust welcomed the Care Quality Commission (CQC) who began a routine inspection of services. The inspection is being undertaken during March and April and we look forward to receiving the report in July.

Approximately 97% of in-patients tell us they would recommend us to friends and family. This is testament to the work undertaken by our staff across all of our sites. I would like to thank them for their continued endeavours to deliver safe and compassionate care, particularly during these times of enormous pressure and change. To the best of my knowledge the information in this document is accurate.

Nick Carver, Chief Executive

1b Our vision

Our vision is

to be amongst the best for clinical outcomes, patient experience and financial sustainability

For the next few years the Trust has agreed to focus on three overarching strategic aims. Each of these has associated objectives and a set of priorities for meeting them.

Aim One	Objectives
1. Delivering our promises on value and quality	…by improving patient experiences
	…by improving patient outcomes
	…by securing financial recovery – transforming our services
	…by developing our organisational culture and ensuring our staff are supported and engaged
	…by transforming our services to deliver consistent improvements in access to care and quality of the care that our patients receive

Aim Two	Objectives
2. New ways of caring	…by developing and redesigning our workforce to respond to recruitment challenges and support new models of care
	…by transforming our services to support and deliver STP* plans
	…by developing and delivering sustainable specialist services across the STP

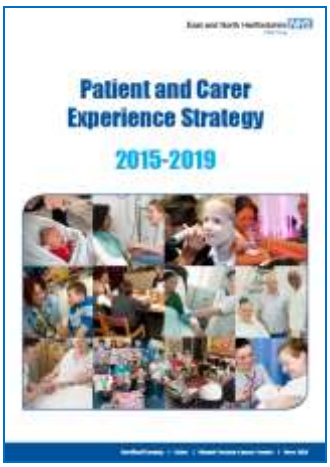
*Sustainability and Transformation Plan – an arrangement between NHS organisations and local authorities to develop shared plans for the effective management of health and care of the local population.

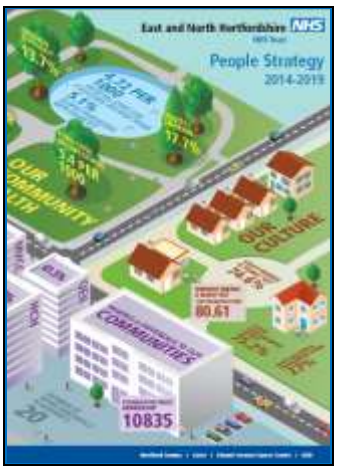
Aim Three	Objectives
3. Develop the Mount Vernon Cancer Centre	…by securing a positive future for the Mount Vernon Cancer Centre

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

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

The strategic aims are underpinned by a range of supporting strategies, such as those shown below. All are accessible via the website http://www.enherts-tr.nhs.uk/about-the-trust/our-publications/.





1c 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.

East and North Hertfordshire NHS Trust has a turnover of approximately £424m and employs 5,155 whole time equivalent members of staff.

During 2017/18:

		
155,000 attendances to the Emergency Department	115,000 admissions	805,000 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.

The **Lister Hospital** is a 642-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 services. 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.

Requires improvement	Care Quality Commission rating is 'requires improvement' (October 2015)

"We are extremely fortunate to have had, and to continue having this amazing service in this country. We will always be grateful for what the NHS has done for us. Our little healthy family will never ever forget this. Thank you xxxx" (Tim Oliver, Maternity, Feb 2018)

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

Good	Care Quality Commission rating is 'good' (October 2015)

"Just back from an X-ray and blood test at Hertford County Hospital and was very impressed with the efficient service and lovely staff. I was expecting to be there for most of the morning but was back home within an hour and a half. Cannot speak highly enough of the service." (Anon, Hertford County Radiology, Feb 2018)

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 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
- 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 offering hospice services for those at the end of their lives, and their families. MSH has an inpatient unit and a day centre.

Requires improvement	Care Quality Commission rating is 'requires improvement' (October 2015)

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

Opened in June 2015, on the site of the original QEII Hospital, the new 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.

Requires improvement	Care Quality Commission rating is 'requires improvement' (October 2015)

"The care and dedication from booking in and via triage, the nurse who attended me and the x-ray dept, was nothing less than superb all the way, although busy all the staff were caring, and made time to ensure I was given the best attention and treatment they had at their disposal" (John Bland, QEII Urgent Care, Feb 2018)

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. Services include provision, by the continuing care team, of respite care in the home for children with complex health needs; specialist school nursing for children with learning disabilities and other medical impairments; and diagnosis and management of a range of conditions through the teamwork of doctors, nurses, therapists and special health visitors.

How we're accountable for quality

There is a vast amount of data available from which to measure how well we are delivering care and treatment:

- Comparative outcome data produced by national organisations using information our Trust supplies to them eg. national audits
- Feedback from patients and members of the public eg. surveys, NHS Choices, complaints
- Local assessments eg. inspections, audits
- Routine data collections which form part of everyday monitoring
- Specialist reviews eg. visits from medical Royal Colleges

Using the data available the Trust's clinical and management teams measure how well we're performing and present this information in a way that we can see how we are doing right now and what progress has been made over time. Progress is monitored locally by committees and departments with oversight by commissioners and agencies such as NHS Improvement and the Care Quality Commission.

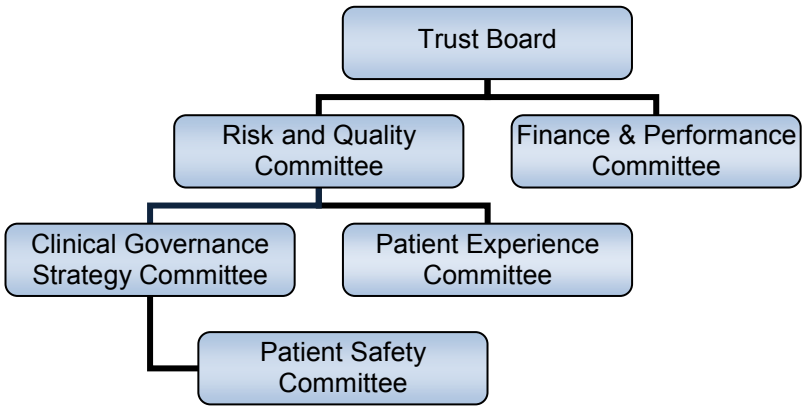
Divisional structure

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 supported by senior nurses and managers. Roles and structures within each division support the monitoring of quality.

The clinical divisions are supported by staff from departments such as education, patient safety and organisation development. Such departments provide advice and information to support evaluation and learning.

Committee structure

The Trust Board has overall responsibility for the delivery of quality with the support of sub-committees who evaluate progress and monitor assurance.



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 to 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.

Part 2

2a	Review of quality performance in 2017/18
2b	Priorities for improvement for 2018/19
2c	Statements of assurance from the Board
2d	Performance against national core indicators

2a Review of quality performance in 2017/18

In the 2016/17 quality account a list of priorities for delivery during 2017/18 was given. Progress with meeting these priorities is given in the sections below.

Improving safety

Priority 1: Medication management

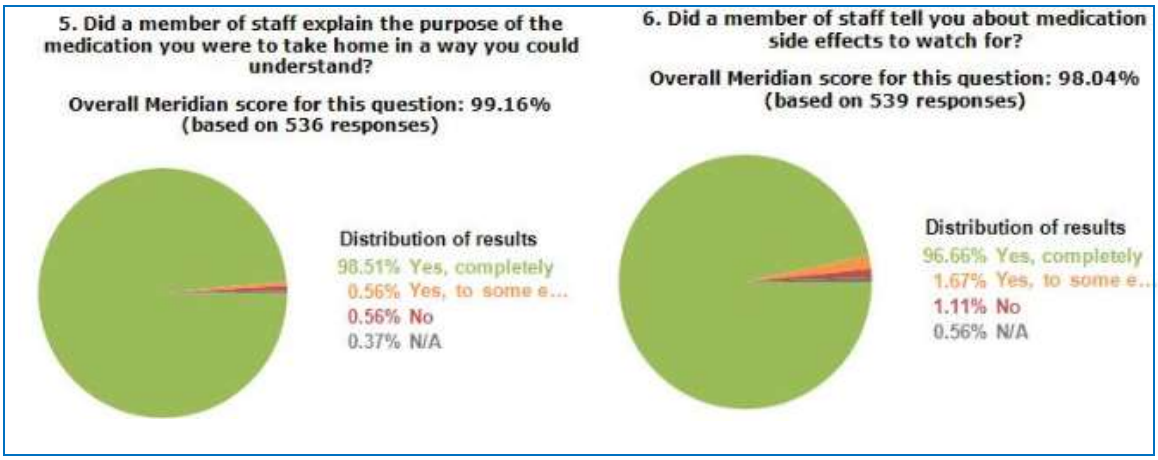
		15/16	16/17	17/18	Aim for 17/18	Met
1.1	Inpatient survey: - medication purpose	8.2	7.9	**72%***	>8.4	✗
1.2	Inpatient survey: - side effects	4.8	3.7	**35%***	>4.8	✗
1.3	Introduce set of leaflets (subject to funding) for medication group eg painkillers, antibiotics	N/A	N/A	**0**	>=1	✗
1.4	% critical medication doses omitted	5.31%	8.38%	**<6.15%**	<7%	✓
1.5	Medicines Optimisation Strategy milestones	125	Not measured	**Improve**	**Improve**	✓
1.6	Demonstrate benefits on 3 wards of the hospital pharmacy transformation programme	N/A	N/A	**Improve**	**Improve**	✓

*Results from the Picker Survey

- Results of the national in-patient survey 2017 are not yet published (due May). However the Trust, together with 80 other providers, employs a company called Picker to undertake the survey on our behalf. The results show that 72% of patients were fully told the purpose of the medications compared with a Picker average of 75%; and 35% of patients were fully told of the side effects compared with a Picker average of 39%.

  There is a stark contrast between these survey results and those asked as part of the ongoing pharmacy electronic surveys (1st April 2017 – 5th March 2018) which show:

  - 99.16% of 536 patients stated the purpose of their medications were explained in a way they could understand
  - 96.66% of 539 patients stated staff told them about side effects to watch out for when going home



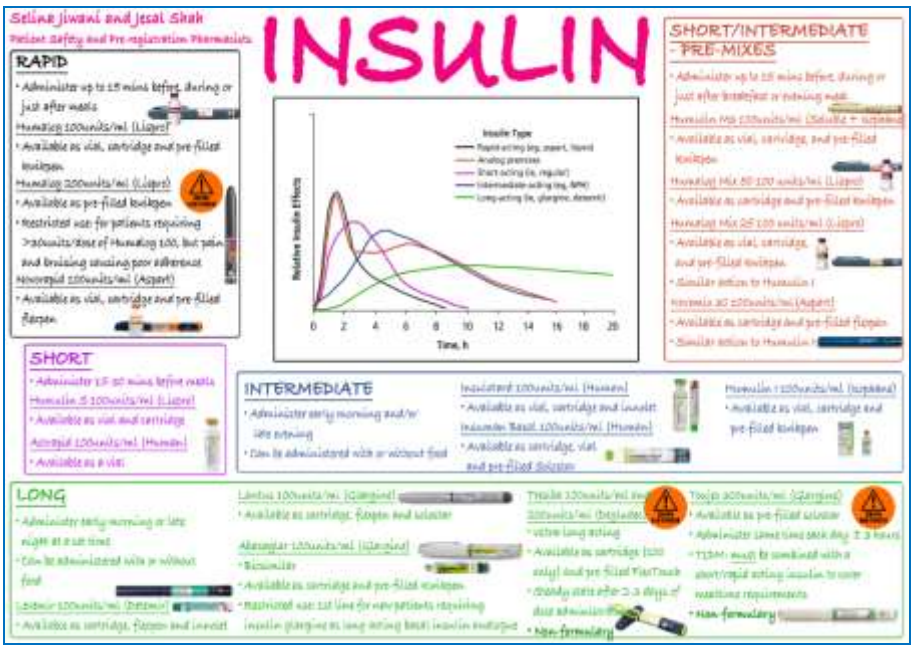
- Due to financial constraints it has not been possible to produce sets of information leaflets.

- Critical drugs are those where a delay or omission could have a serious detrimental effect to the patient eg. medicines used for managing Parkinson's disease, diabetes or sepsis. Historically an annual audit was undertaken looking at medication delays and omissions of critical drugs. To improve monitoring and learning a monthly pharmacy audit commenced in December 2017 on 27 wards. The results of ward performance are reported back to staff for action

Dec 2017	Jan 2018	Feb 2018	March 2018
6.15%	5.41%	2.93%	3.65%

To help reduce medication omissions:

- a link on the home page of the intranet allows staff to easily see which departments hold stock so that in emergencies the medication can be obtained quickly
- a focus on insulin management has resulted in the release of an awareness guide which is supported by Diabetes UK



- The Trust's Medicines Optimisation Strategy was published in July 2014. Since then the Hospital Pharmacy Transformation Programme has subsumed the original strategy

intentions and the score is no longer measured. However, sSome achievements in the last 12 months include:

- Medication Safety Bulletins are published every quarter and focus on common themes and medication related errors within the Trust
- Reduction in the consumption of antimicrobial medication
- Improved management of high cost drugs through close working between finance , pharmacy and IT teams so that costings are appropriately charged
- Discharge medication to community pharmacists has been better established

- The Pharmacy Transformation Programme places pharmacists on dedicated wards to work as part of the team. The programme is being piloted on three wards and the benefits are clear:

  - Discharge medication prescription completion at ward level has increased from 26% to 82% - this greatly improves turnaround times enabling people to go home more quickly
  - Counselling on the purpose and side effects of medications has increased from 40% (Trust average) to 90% on the transformation wards
  - Pharmacists are present on 'board rounds' (meetings of the multi-disciplinary team to discuss patient's needs and plans) to support staff eg in optimising prescriptions
  - Pharmacist time with patients has increased from 53% to 90%

In addition:

- Monthly spot-checks relating to medicines management are undertaken on four to five wards per month. Checks around medication security and correct drug chart completion are undertaken. We have found that not all drug charts are completed fully and not all medication is stored as securely as we would like. The findings are immediately reported back to staff and are shared across the organisation for learning
- A quality improvement project on Ward 10B aimed to improve management of insulin administration. This project was owned by the staff who agreed to complete e-learning, refresh practices on glucose reading meters and ensure stocks of insulin are available 48 hours ahead of when required
- Following the launch of a new electronic patient administration system in September 2017 there were challenges with getting the 'to take out' medications prescribed correctly. This was due to the requirement to record medications on admission which proved to be unfeasible within the emergency department. An alternative method is now in place to support timely and accurate prescription management
- A new stock control system has been successfully implemented which is the foundation towards electronic prescribing

Priority 2: Progress 'deteriorating patient' work

		15/16	16/17	17/18	Aim for 17/18	Met
2.1	Rollout of Nerve Centre as per plan	N/A	N/A	**Completed**	As plan	✓
2.2	Undertake human factors review in maternity	N/A	N/A	**Completed**	Complete	✓
2.3	Audit of Unexpected Critical Care admissions (improvement compared with 2015/16 audit)	N/A	N/A	**Due April**		
2.4	Reduce no. of cardiac arrest calls	208	150	**Improved**[1]	<150	✓
2.5	Compliance with observations	93.61%	96%	**100%**	>=98%	✓

2.6	Reduce frequency of serious incidents involving poor escalation (recorded on Datix)			**N/A**[2]		

[1]The methodology of measuring this indicator this year has changed (see below)

[2] Please see below for explanation

- We have rolled out the use of Nerve Centre which is an electronic system for recording observations eg blood pressure. The system was trialled in paediatrics in March 2017 followed by staff training before the launch in September 2017. Handheld devices are assigned to staff each shift and are used for recording the observations. The data is held centrally and is accessible from remote computers allowing doctors to view information to support early decision making.

  Automatic alerts of patients showing signs of deterioration are sent to the Critical Care Outreach Team to provide early support to ward staff, thus preventing further deterioration.

  Due to the use of Nerve Centre 100% of observations are completed as the system alerts staff when these are due.

- 'Human factors' is an approach used to understand how humans function within their environment. It looks at how teams work together, the tasks they do and the space where they work. Understanding human factors allows staff to recognise circumstances or situations that could potentially lead to error and to address it, thereby minimising harm.

  Maternity staff have completed 'train the trainer' sessions and are rolling out human factors to all staff within the department.

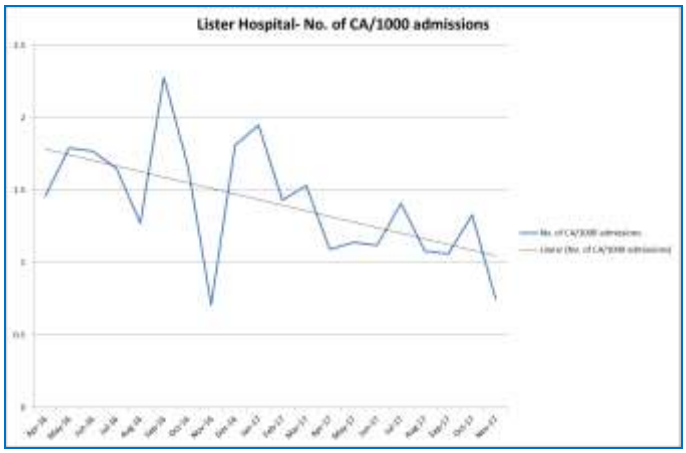
- The Audit of Unexpected Critical Care Admissions

  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. The audit is currently underway with results due in late April.

- If deterioration is not acted upon quickly the patient's survival may be compromised, potentially leading to a cardiac arrest. We previously measured the number of cardiac arrest telephone calls to switchboard requesting assistance from the resuscitation team but this figure does not account for changes in the number of patients being treated so a better measure is the number of cardiac arrests per 1000 admissions. This new way of measuring was introduced during the year.

  In 2016/17 the Trust's cardiac arrest rate was 2.25 per 1000 admissions. This was higher than the national average of 1.87. The most recent data for 2017/18 (April-June) shows a rate of 1.18 per 1000 (Source: National Cardiac Arrest Audit).

  A review this year has identified that the Trust has been supplying data to the national audit of arrests that occurred within the emergency department but excluding arrests of children. Other Trusts do not include emergency department arrests and include child arrests which mean our rate will always appear higher than it should when compared with others. Removing the emergency department arrests and including the arrests in children from the overall data reveals a lower rate per 1000 admissions as previously reported, and a reducing rate over the last 18 months.



Since January 2018 a review of the care given during the 48 hours prior to any cardiac arrest is undertaken to see if there were missed opportunities to act upon signs of deterioration. Any learning is reported back to the clinical team and where necessary informs the incident investigation process.

- [2] Timely escalation of concerns to senior staff helps to ensure that remedial action can be undertaken quickly to prevent further deterioration or to reverse the problem. “Serious incidents” are nationally reportable incidents meeting certain threshold criteria. On our internal systems they are categorised according to the type of incident but information to identify elements relating to poor escalation has not been captured in a way that is measurable. So whilst we have information about deterioration we do not have numbers.

  A review of serious incidents where poor escalation has been a specific factor has indicated a number of shortfalls. Whilst these incidents are usually factorial the main learning and improvements are centred around:

  - Improving identification of sepsis which is known to cause rapid deterioration
  - Supporting the delivery of sepsis treatment within an hour of recognition
  - Introducing Nerve Centre for more accurate recording of early warning scores and automatic escalation of concerns to the critical care outreach team
  - Establishing protocols for better stabilisation of patients before transfer to another department
  - Clarifying processes for timely referral to, and acceptance by, different clinical teams
  - Development of training particularly around human factors and simulation
  - Spreading learning from incidents in a more timely way.

There’s more to do –

Of course, there is always more to do and efforts will continue relentlessly in 2018/19 to design systems to support staff to do the right thing.

- We will introduce the automatic escalations function of Nerve Centre to send alerts directly to doctors where there are signs of serious deterioration
- We need to evaluate the changes being made following the human factors training in maternity
- We are reviewing the processes around ‘do not resuscitate’ decisions and will evaluate the impact this has on cardiac arrests

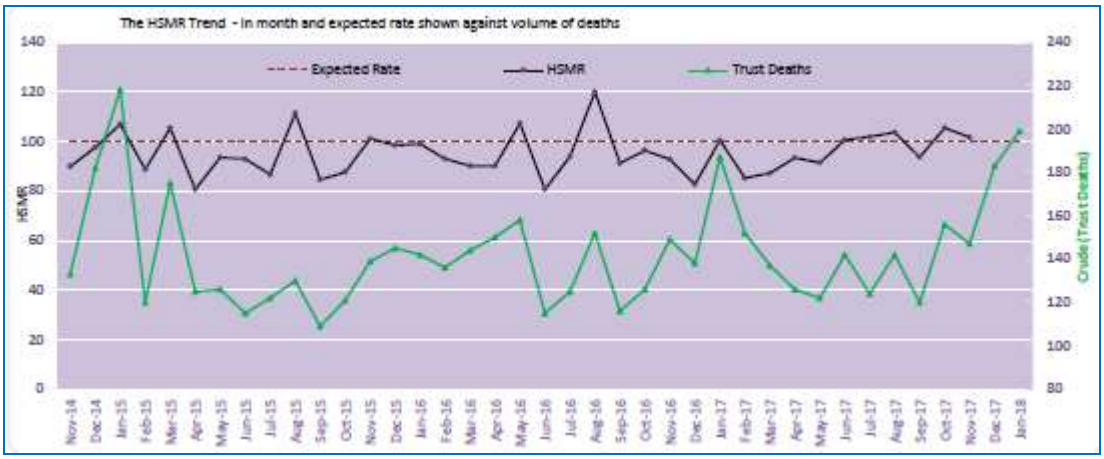
Improving clinical outcomes

Priority 3: Further reduce mortality

		15/16	16/17	17/18	Aim for 17/18	Met
3.1	HSMR (3 month arrears)	93.31	95.18	**99.41**	<94*	=
3.2	SHMI (7-9 month arrears)	109.7	105.61	**102.9**	<100*	=
3.3	SHMI (adjusted for palliative care)	98.69	95.5	**94.5**	<95*	✓
3.4	Mortality review – areas of concern discussed at each meeting of the Clinical Governance Strategy Committee	N/A	Undertaken	Undertaken	Undertake	✓
3.5	Demonstrate learning from mortality review process	N/A	N/A	Undertaken	Undertake	✓

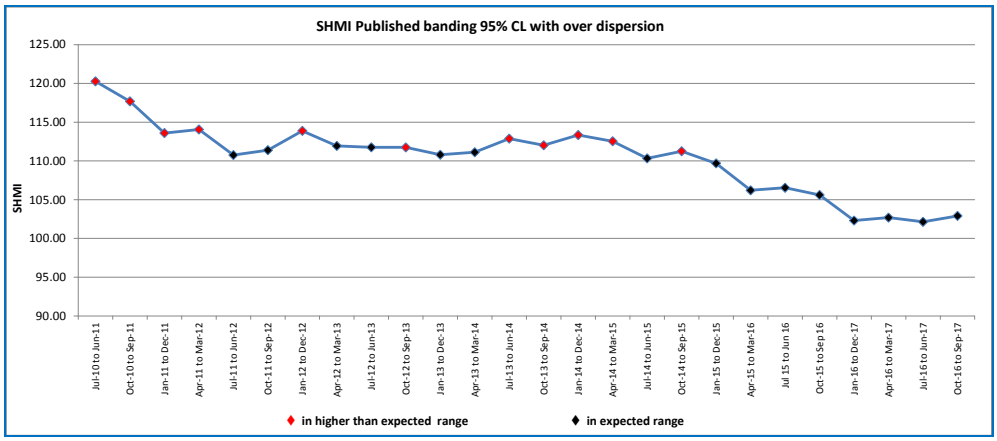
* The 2016/17 Quality Account target stated <95.3 for HSMR, <110 for SHMI and <98.5 for adjusted SHMI. A more stretching target was agreed and monitored by the Trust Board during the year.

- The Hospital Standardised Mortality Ratio (HSMR) measures the actual number of patients who die in hospital with the number that would be expected to die given certain characteristics eg demographics. The England average is always 100 (red line in the graph below) and a lower number indicates better than average. The Trust's HSMR position for the twelve months to December 2017 is slightly higher than plan at **99.41**. It is rated statistically "as expected" and is slightly better than the national average. The Trust's position relative to its East of England peers is 7th of 16.



- 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 not adjusted for palliative care. Like the HSMR the average remains at 100. The SHMI for the twelve months to September 2017 is **102.9**, slightly higher than planned, but remains within the 'as expected' range

  The improved SHMI mortality represents an 17.3 point reduction since our first SHMI was reported for the period July 2010 to June 2011 as shown in the graph below.



Of most concern is the death rate associated with pneumonia, heart failure, lung disease and septicaemia. These are observed closely and improvements plans in place:

- An integrated community respiratory service has been fully established since May 2017. Working with the Acute Chest Team to prevent admission and support early discharge there has been a reduction in Chronic Obstructive Pulmonary Disease admissions by 14.9% this year
- Mortality relating to septicaemia (12 months ending December 2017) is HSMR 133.8. A health records review is underway to establish whether the increase in HSMR is linked with a change in sepsis coding introduced in April 2017. A sepsis action plan is in place and this remains a key focus to carry forward to 2018/19
- Mortality relating to heart attack (12 months ending August 2017) is HSMR 143.9. Work is underway to ensure cardiology related deaths are coded correctly as this had been a concern in the earlier part of the year. The Trust invited a service review from the Royal College of Physicians who reported there to be no concerns regarding mortality rates

- The difference between the HSMR and the SHMI is partly accounted for by having 7-day provision of palliative care services and in addition the Trust remains in a small minority that include a hospice. Once these palliative care influences have been removed the adjusted SHMI for the twelve months to June 2017 is **94.5**

- Mortality reviews are well established (see section on Learning from Deaths). The first part of the Clinical Governance Strategy Committee is dedicated to mortality reviews and cases have been discussed at each meeting

- Learning from mortality is described in the section on Learning from Deaths

There's more to do –

- Following the introduction of Lorenzo the depth of coding has changed. This is a recognised phenomenon following the introduction of new systems and means that mortality data may be affected by data entry rather than actual mortality changes.

Mortality will not feature as a priority in the 2018/19 quality account but progress will continue to be monitored by the Risk and Quality Committee and the Trust Board on a monthly basis.

Priority 4: Further improve stroke standards

		15/16	16/17	17/18 (YTD)	Aim for 17/18	Met
4.1	3 hour thrombolysis	7.47%	6.1%	**7.41%**	≥12%*	✗
4.2	4 hours to stroke unit	62.33%	78.6%	**74.4%**	≥90%	✗
4.3	90% time on stroke unit	82.12%	87.3%	**86.3%**	≥80%*	✓
4.4	60 minute to scan	89.2%	92.7%	**84.9%**	≥90%	✗

* The 2016/17 Quality Account target stated ≥15% for 3 hour thrombolysis and ≥90% for time on the stroke unit. A revised target was agreed and monitored by the Trust Board during the year.

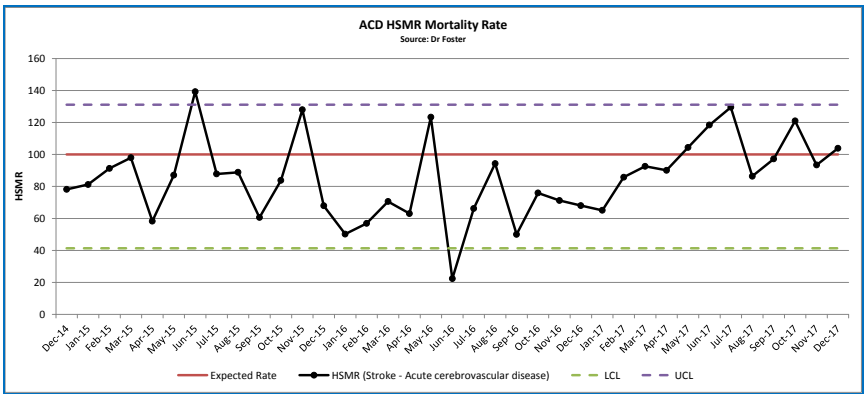
A stroke is caused by a lack of oxygen to the brain. This may be due to a bleed (haemorrhagic stroke) or a clot (ischaemic stroke). Only those who have had an ischaemic stroke can be treated by thrombolysis (an anti-coagulant delivered via a drip). Giving an anticoagulant to someone who has had a haemorrhagic 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.

- 3 hour to thrombolysis has improved in 2017/18 compared to the previous year, but we're not where we want to be. A review of why there were delays has indicated that a significant number of people arrived at the Emergency Department too late to receive thrombolysis ie. due to delays in requesting an ambulance. The Trust is working on developing a pre-hospital thrombolysis pathway with community partners. In addition the Trust has recently agreed to send relevant patients to Addenbrooke's Hospital for the highly specialised thrombectomy (clot removal) procedure.

- We were not able to transfer all the stroke patients to the stroke ward within four hours because of demand for services within the Emergency Department and lack of stroke beds. Whilst we have almost achieved the 60 minute to scan aim we have not been able to complete the tests and assessments in time.

- There are two stroke wards – one for acute treatment, the other for rehabilitation. The bed management processes aim to ensure all patients are on the correct ward for their condition. Our patients were able to spend the majority of time in the appropriate location.

- Mortality (HSMR) remains very good at 97.3 (as expected) for the 12 month period to December 2017.



- The service retained it's 'A' rating in the quarterly Sentinel Stroke National Audit Programme report produced by the Royal College of Physicians (October 2017).

Stroke standards will not feature as a priority in the 2018/19 quality account but progress will continue to be monitored by the Trust Board on a monthly basis.

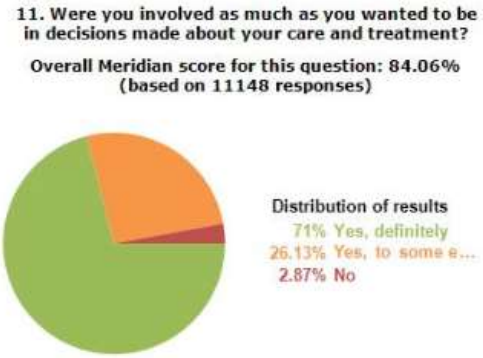
Improving patient experiences

Priority 5: Improve communication

		15/16	16/17	17/18 YTD	Aim for 17/18	Met
5.1	Involvement in decisions (Meridian)	6.8#	83%	**84.06%**	>83%	✓
5.2	In-patient survey results of consistent information	7.8#	7.8	**65.5%~**	>7.8	✓
5.3	Doctors providing understandable answers (Meridian)	8.1#	88%	**87.53%**	>88%	✗
5.4	Nurses providing understandable answers (Meridian)	8.0#	90%	**91.45%**	>90%	✓
5.5	In-patient survey results of having a point of contact	7.8#	7.8	**75%~**	>7.8	✗
5.6	Reduction in rate of communication related complaints per 100 bed days*	0.32%	0.21%	**1.07**	0.21%	N/A
5.7	Reduction in rate of communication PALS concerns per 100 bed days	0.57%	0.26%	**0.76**	0.26%	N/A

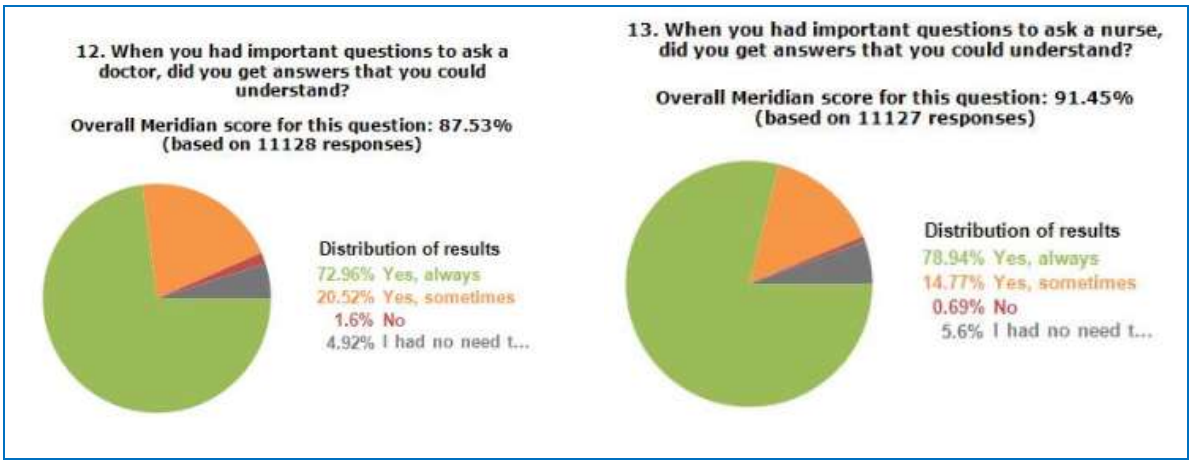
#These scores are from the National In-Patient Survey. The methodology is replicated within the Meridian system although scores are shown on the national survey from 1-10
~Results from the Picker Survey
*Bed days - number of beds occupied at a particular point in the day.

- A national in-patient survey is undertaken each year. To enable more frequent monitoring some of the questions are included within our monthly surveys using electronic devices (Meridian). The majority of people who gave feedback during 2014/18 report feeling involved fully in decisions and had their questions answered in a way they could understand.



Given a similar number of overall responses fewer 'no' answers are given in 2017/18 compared with 2016/17:

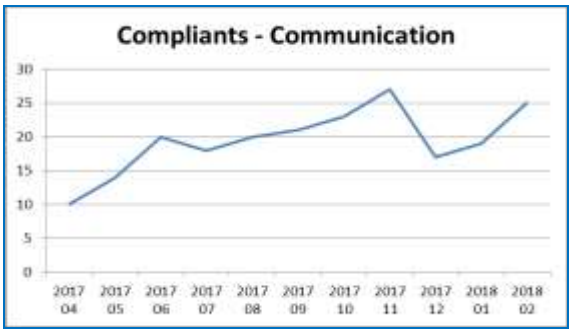
Q11. 3.36%
Q12. 1.87%
Q13. 0.76%



- The provision of consistent information is assessed within the national inpatient survey (not yet published). However the results from the Picker survey show that 65.5% of patients said information was consistent compared with 64% in the previous year and against a Picker average of 69.6%.

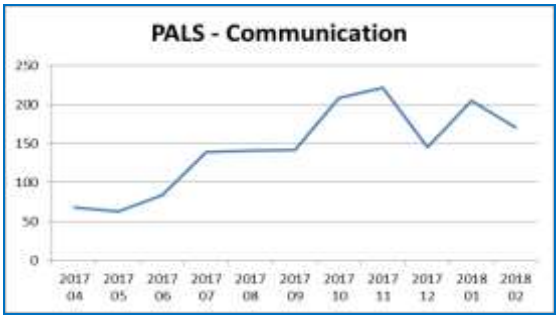
- Having a point of contact is assessed within the national inpatient survey (not yet published). However the results from the Picker survey show that 75% of patients said they had a point of contact compared with 81% in the previous year.

- The number of complaints where communication is the primary subject is shown in the graph below.



1.07 complaints per 100 bed days were reported (YTD – year to date). Whilst this is higher than in the previous year direct comparisons cannot be made because of changes in the way that complaints have been recorded since April 2017.

- The number of Patient Advice and Liaison Service (PALS) concerns where communication is the primary subject is shown in the graph below. 0.76 concerns per 100 bed days were reported (YTD) in 2017/18.



We have seen an increase in concerns about communication and delays following the introduction of the Lorenzo system. The main concerns about communication relate to the difficulty in phoning the ophthalmology services at the Treatment Centre. Patients have found it difficult to cancel, rearrange or gather information about their appointments. The PALS team provide daily details of people who have raised concerns so the ophthalmology team can contact them.

Communication will not feature as a priority in the 2018/19 quality account but progress will continue to be monitored by the Patient Experience Committee and the Risk and Quality Committee on a scheduled basis.

Priority 6: Improve nutrition and hydration

		15/16	16/17	17/18 YTD	Aim for 17/18	Met
6.1	In-patient survey results of quality of food	5.2	5.2	**56%˜**	>5.2	✓
6.2	In-patient survey results of choice of food	8	8.4	**78%˜**	>8.4	✓
6.3	In-patient survey results of help with eating	7.5	6.3	**54%˜**	>7.5	✗
6.4	Delivery of nutrition and hydration strategy milestones		Delivered	Delivered	Deliver	✓
6.5	Compliance with nutritional aspect of ward observational tool	95.25%	96.52%	**97.57**	≥95%	✓

˜ Results from the Picker Survey

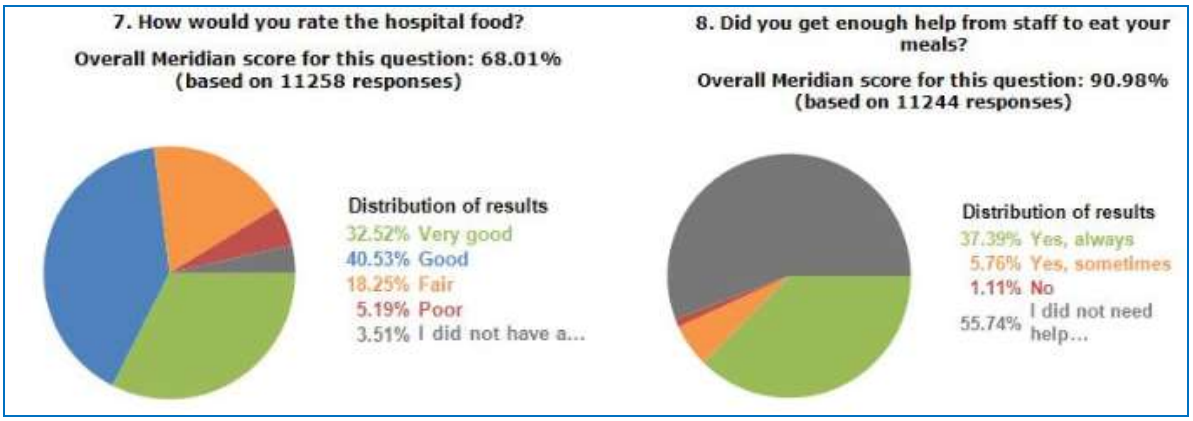
- The national in-patient survey results for 2017 are awaited. The Picker survey shows that:

  - 56% of patients reported the food as good, an improvement from 54%
  - 78% of patients were offered a choice of food, an improvement from 75%
  - 54% of relevant patients received assistance to eat, a reduction compared to 57% in the previous year

  Two of the questions are replicated in the monthly electronic surveys.

  - An overall score of 68% for the quality of food is a slight improvement on last year (65.7%).

  - An overall score of 91% has been given for patients reporting they were helped to eat their meals. This is the same as the previous year.



- The Food and Drink Strategy promotes good nutritional care for our patients. Recent audits show that mealtimes are not always 'protected' ie. patients being allowed time to eat their meals without being interrupted eg for tests.

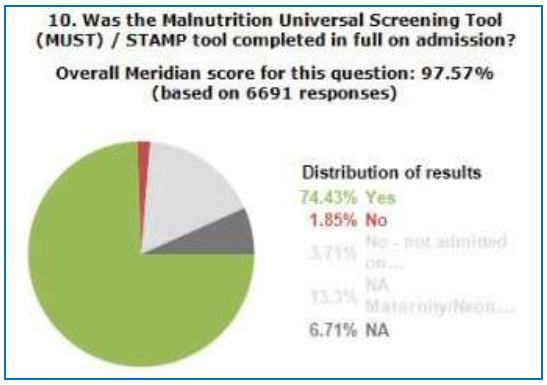
  The catering team have trialled a 'real time' audit by attending wards to gather feedback about meals. The results can be acted upon swiftly.

  A children's and young people's menu has been launched allowing children to mix and match menus to appeal to their preferences

  A 'family service' is planned for the future which allows food to be served 'buffet style' so there is no requirement to pre-order and patients can choose their meal just prior to eating and have a portion size to suit their needs.

  The Trust Patient Led Assessments of the Care Environment assessment (2017) scored above average for food (Trust 93%, Average 90%) and catering (Trust 92%, Average 88%).

- 97.57% of relevant patients were assessed using the Malnutrition Universal Screening Tool. This allows patients with particular dietary requirements to be identified and the necessary help requested.



Nutrition and hydration will not feature as a priority in the 2018/19 quality account but progress will continue to be monitored by the Patient Experience Committee and the Nutrition Group on a scheduled basis.

Priority 7: Improve patient flow

		16/17	17/18 YTD	Aim for 17/18	Met
7.1	Reduce on the day cancellation of operations	467	**759**	<504*	✘
7.2	Reduce readmissions (within 30 days)	8.3	**7.05**	<7.75%	✓
7.3	Reduce delayed discharges from critical care	818	**825**	<818	✘
7.4	Discharge summaries to GP within 24 hours	TBC	**TBC**		
7.5	Reduce complaints relating to delays per 100 bed days	0.08	**1.8**	<0.08%	N/A

*This number was increased from 467 on the Board report

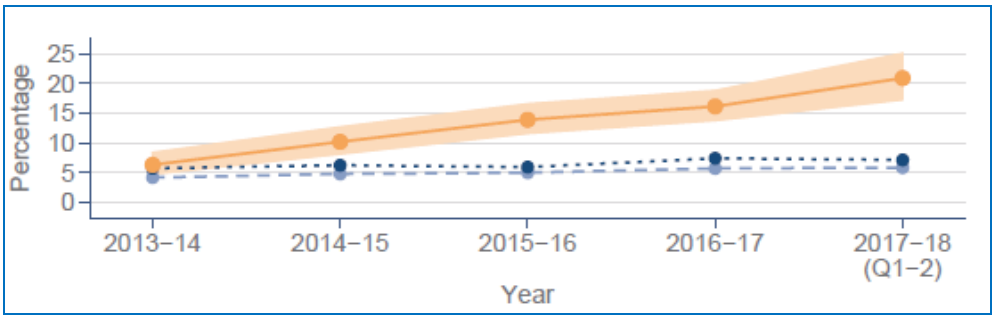
- We have not been able to reduce the number of on the day cancellations for surgery. This has been particularly the case in the winter months when demand has been much greater

than capacity (nationally too) and the trust has been on high alert status. During the year 759 operations were cancelled compared with 467 last year.

- Readmission rate has reduced to 7.05%. This is an improving position compared with the previous year. 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 Trust continues with admission avoidance initiatives.

- We have struggled to transfer people quickly from critical care back to their wards when they are well enough to go. This is because of competing high demand for ward beds from people arriving in the Emergency Department. There have been 825 delays from critical care this year compared with 818 in 2016/17.

    - We know that our patients are almost three times more likely to go straight home from our critical care unit than other similar units. This is not what we want for our patients who may miss out on rehabilitation offered on the wards.



- Discharge summaries should be completed within 24 hours of discharge. This allows GPs to manage care effectively following a stay in hospital. In March 2018 there are (to be confirmed) discharge summaries that are missing or incomplete. This is being addressed but remains as a concern and therefore will be monitored in the quality account next year.

- The rate of complaints per 100 bed days due to delays is 1.8 per 100 bed days. It is not possible to compare with the previous year because of changes in categories. Most of these relate to ophthalmology, orthopaedics and general surgery due to delays for treatment or review.

2b Priorities for improvement for 2018/19

In order to identify priorities for 2018/19 the following actions were undertaken:

- Existing priorities and indicators from 2017/18 were reviewed to consider their ongoing relevance and progress made
- Current performance was considered to identify emerging concerns eg. complaints and survey results
- Cross-referencing with the Trusts operating plan
- Consideration of the Trusts highest risks

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

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

The final decision on priorities was determined by the Executive Committee.

Priority One: Reduction in avoidable harm to our patients:

- Focus on reducing medication errors and timely delivery of critical medications and management of antibiotics
    - Omissions of critical medications <5% (currently <6.15%)
- Increase compliance with sepsis pathway – particular focus on Mount Vernon Cancer Centre
    - Screening for sepsis in ED > 90%
    - Neutropenic sepsis door to needle time >80%
    - Antibiotics in ED within an hour >90%
    - Antibiotics on the ward within an hour >90%
    - Introduce sepsis module on Nerve Centre
- WHO safety checklist across all our services
    - Redesign WHO checklist compliance audit
    - Compliance >95%
- Reduce the number of avoidable arrests through improving the way we manage the deteriorating patient
    - Rate of cardiac arrests <2/1000 patients
    - Introduce revised DNACPR form with launch
    - Root cause analysis completed for all cardiac arrests with learning captured and shared

Progress to achieve this priority will be monitored by the Patient Safety Committee. It will be provided with outcome data by its sub-committees tasked with co-ordinating and overseeing day to day improvements. The sub-committees are the Medication Forum, Sepsis Group, Antimicrobial Forum, Resuscitation Committee and the Clinical Audit team.

Responsible Directors
Director of Nursing & Medical Director

Priority Two: Use of digital technology

- Further embed the way we use technology to improve the care we provide to our patients through e-observations and live bed state
    - Complete roll-out of Nerve Centre across all areas
    - Launch escalation module
    - Audit of compliance with timely observations
    - Audit of compliance of response to escalations
- E-prescribing
    - Progress with plan towards implementation of electronic system
- Electronic discharge summaries
    - Reduce number of discharge summaries not sent to GP within 24 hours of discharge

Progress to achieve this priority will be monitored by the Patient Safety Committee and the Information Management and Technology Board.

Responsible Directors
Director of Finance & Director of Nursing

Priority Three: Respect our patient's time through improving the flow through our in and outpatient services by:

- Reducing delays in the discharge process
    - Delayed transfers of care (<96)
    - Patients discharged by midday (<156)
- Improving experience and access to our outpatients department
    - Friends & Family Test improved scores (>95% across all sites)
    - Access targets (improve cancer waits from 2017/18 position; report referral to treatment data by November 2018)
- Reduce the number of patients who are delayed in the care they receive through the ED
    - 4 hour waiting time (>=95%)
    - Reduce average waiting time (from confirmed 2017/18 position)

Progress to achieve this priority will be monitored by the Patient Experience Committee and Finance and Performance Committee.

Responsible Directors
Director of Operations

Priority Four: To be amongst the best in the experience our patients have through:

- Implementing 'always events'
- Improving our friends and family response rate in our services:
    - Maternity >30% (currently 24%)

- Emergency Department >10% (currently 4.7%)

Progress to achieve this priority will be monitored by the Patient Experience Committee.

Responsible Director
Director of Nursing

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 2017/18, 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 2017/18 represents 100% of the total income generated from the provision of relevant services by the ENHT for 2017/18.

Participation in clinical audits

During 2017/18 55 national clinical audits and 6 national confidential enquiries covered relevant health services that ENHT provides.

During that period ENHT participated in 54 (98%) national clinical audits and 6 (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 2017/18
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2017/18, and for which data collection was completed during 2017/18, 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 Clinical Audits	**Eligible**	**Participated**	**Numbers submitted** (by % or total number)
Myocardial Ischaemia National Audit Project (MINAP) (previously called Acute Coronary Syndrome or Acute Myocardial Infarction)	Yes	Yes	100%
Adult Cardiac Surgery	No	This surgery not undertaken within the Trust	
BAUS Urology Audits: Cystectomy	Yes	Yes	Ongoing - BAUS operate continuous data collection
BAUS Urology Audits: Nephrectomy	Yes	Yes	
BAUS Urology Audits: Percutaneous nephrolithotomy	Yes	Yes	
BAUS Urology Audits: Radical prostatectomy	Yes	Yes	
BAUS Urology Audits: Urethroplasty	Yes	Yes	
BAUS Urology Audits: Female stress urinary incontinence	Yes	Yes	
National Bowel Cancer (NBOCA)	Yes	Yes	Ongoing - NBOCA operate continuous data collection
Cardiac Rhythm Management (CRM)	Yes	Yes	TBC
Case Mix Programme (CMP) Intensive	Yes	Yes	100%

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
care National Audit & Research Centre (ICNARC)			
National Congenital Heart Disease (CHD)	No	These procedures not undertaken within the Trust	
Elective Surgery (National PROMs Programme)	Yes	Yes	Ongoing - PROMs operate continuous collection
Endocrine and Thyroid National Audit	Yes	Yes	Ongoing - BAETS operate continuous collection
Falls and Fragility Fractures Audit programme (FFFAP) – Fracture Liaison Database	No	No Fracture Liaison Service within the Trust	
Falls and Fragility Fractures Audit programme (FFFAP) – Inpatient Falls	Yes	Yes	100%
Falls and Fragility Fractures Audit programme (FFFAP) – Hip Fracture Database	Yes	Yes	Ongoing - FFFAP operate continuous data collection
Fractured Neck of Femur	Yes	TBC	TBC
Inflammatory Bowel Disease (IBD) programme	Yes	Yes	40%
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	100%
Major Trauma Audit	Yes	Yes	62.4%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality and Morbidity confidential enquiries	Yes	Yes	TBC
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries	Yes	Yes	TBC
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	TBC
National Audit of Pulmonary Hypertension	No	Not one of the 8 specialist pulmonary hypertension centres	
National Bariatric Surgery Registry (NBSR)	No	This surgery not undertaken within the Trust	
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease Audit programme (COPD) – Pulmonary Rehabilitation	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease Audit programme (COPD) - Secondary Care	Yes	Yes	Ongoing - Continuous data collection from Feb 2017
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	Not one of the Major Trauma Centres (MTC)	

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
National Comparative Audit of Blood Transfusion programme - red cell and platelet transfusion re-audit	Yes	Yes	100%
National Comparative Audit of Blood Transfusion programme - of Transfusion Associated Circulatory Overload (TACO)	Yes	TBC	TBC
National Diabetes Audit - Adults - Foot Care	Yes	Yes	8 cases
National Diabetes Audit – Adults – Inpatients (NADIA)	Yes	Yes	100%
National Diabetes Audit - Adults - Core	Yes	Yes	100%
National Diabetes Audit – Adults – Pregnancy in Diabetes	Yes	Yes	Ongoing - Continuous data collection
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Ongoing - Continuous data collection
National Heart Failure Audit	Yes	TBC	TBC
National Joint Registry (NJR)	Yes	Yes	727 cases
National Lung Cancer Audit (NLCA)	Yes	TBC	TBC
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	NNAP operates continuous data collection
National Ophthalmology Audit	Yes	.No	Unable to participate due to lack of funds to purchase & install the audit software
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
National Prostate Cancer	Yes	TBC	TBC
National Vascular Registry - AAA Repair	Yes	Yes	46 cases
National Vascular Registry - Carotid Interventions	Yes	Yes	44 cases
National Vascular Registry - Lower Limb Amputation	Yes	Yes	40 cases
National Vascular Registry - Lower Limb Angioplasty	Yes	Yes	In progress
National Vascular Registry - Lower Limb Bypass	Yes	Yes	40 cases
Neurosurgical National Audit Programme	No	This surgery not undertaken within the Trust	
Non-Invasive Ventilation -	Yes	Yes	100%
National Oesophago-gastric Cancer (NAOGA)	Yes	Yes	NOGCA operates continuous data collection
Paediatric Asthma	Yes	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	No	The Trust does not have a Paediatric Intensive Care	
Paediatric Pneumonia	Yes	Yes	100%
Pain in Children	Yes	Yes	100%
Procedural Sedation in Adults (care in	Yes	TBC	TBC

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
emergency departments)			
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	99.6%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	100%
UK Parkinson's Audit	Yes	Yes	100%

National Confidential Enquiries	Eligible	Participated	% Cases submitted
Chronic Neurodisability	Yes	Yes	100%
Young Peoples Mental Health	Yes	Yes	100%
Acute Heart Failure	Yes	Yes	100%
Cancer in Children, Teens and Young Adults	Yes	Yes	100%
Perioperative Diabetes	Yes	Yes	In progress
Pulmonary Embolism	Yes	Yes	In progress

National Audits

The reports of 32 national clinical audits were reviewed by the provider in 2017/18 and ENHT intends to take the following actions to improve the quality of healthcare provided.

National audit	Action
National Audit of Inpatient Falls Audit Report 2017	• Information team and digital transformation teams to amend Lorenzo program to provide a function for calculating bed days. • Proforma developed and education to be delivered to staff. • RCP assessment tool incorporated into a revised Trust policy which was launched February 2018.
National Lung Cancer Audit 2017	• All CNSs should attend MDT. • Implement diagnostic MDT and Job planning. • All Consultants should record FEV1 at clinic letter. • To appoint Clinical Data lead.
Perinatal Mortality Surveillance Deaths for Births June 2017	• Await guidance from NHS England / MBBRACE. • Work in progress through STPs.
National Comparative Audit of Blood Transfusion: 2016 Audit of Red Cell & Platelet Transfusion in Adult Haematology Patient	• Update guidelines to include section on prevention of TACO. • Bar coded wristbands need to be used and the ward modules activated. However some issues over the age of hardware and support for the ward modules. • Ongoing education. • Policy updated and included in training.

Local audits

The reports of 87 local clinical audits were reviewed by the provider in 2017/18 ENHT intends to take the following actions to improve the quality of healthcare provided.

Local clinical audit	Actions to be taken
Child Protection (Laming audit)	• Discharge summaries will improve when Lorenzo goes live, given a patient cannot be discharged without a letter. • Nurses to complete a nurse proforma which identifies Ethnicity & Schools. This will be disseminated through education.

	• Funding has been withdrawn for integration of community records into main records. New procedure - bring all records to Bramble. Return for amalgamation.
Adverse Drug Reactions	• Every member of staff prescribing, administering or dispensing medication should check a patient's drug allergy status on their records and with the patient.
Nasogastric Tube Documentation on Stroke Wards	• Ongoing education of staff. • Re-audit every year if possible
Comparing the Management of Ankle Fractures to BOAST Guidelines	• Ensure A&E and orthopaedics document mechanism of injury specifically is discharge letters. • Ensure FY's and juniors use VTE Prophylaxis flowchart on knowledge centre. • For consultants to discuss and come up with consensus re weight bearing status as tolerated. • Educate A&E before being referred to orthopaedics.

Research and development

The number of patients receiving relevant health services, provided or sub-contracted by the ENHT in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 2772.

Goals agreed with commissioners

A proportion of the ENHT's income in 2017/18 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.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at www.enht-tr.nhs.uk

In 2017/18 £8.5 million of income was dependent upon achieving CQUIN targets set out by NHS England and the Clinical Commissioning Group. The final data is yet to be confirmed but indications suggest that during the year we secured a part payment of the CQUIN target generating £7.5 million of income.

The CQUINs for 2017/18 agreed with the Clinical Commissioning Group are set out in the table below, together with their full value and achievement status.

	CQUIN Indicator	**Target value (£m)**	**Achieved***
CCG CQUIN Indicator			
1	Staff health & wellbeing	0.7	=
2	Reducing the impact of serious infections	0.7	=
3	Improving services for people with mental health needs in the ED	0.7	=
4	Offering Advice and Guidance	0.7	✘
5	NHS e-Referrals (2017-18 only)	0.7	=
6	Supporting Proactive and Safe Discharge	0.7	=

	CQUIN Indicator	Target value (£m)	Achieved*
7	Preventing ill Health by risky behaviours - alcohol and tobacco (2018-19 only)	N/A	N/A
8	Engagement with STPs	1.4	✓
9	CQUIN Risk Reserve	1.4	✓
10	Renal Telemedicine (2017-18 only)	0.3	=
	CCG Total	**7.3**	
NHS England CQUIN Indicators			
11	SACT Dose Banding	0.3	✓
12	Hospital Medicines Optimisation	0.1	✓
13	Enhanced Supportive Care	0.3	=
14	Optimising Palliative Chemotherapy Decision Making	0.2	✓
15	Shared Decision- Making	0.2	✓
	NHS England TOTAL	**1.1**	
NHS England Dental CQUIN Indicators			
16	Dental	0.1	✓
	NHS England Dental Total	**0.1**	
	TOTAL	**£8.5m**	**£7.5m**

*Quarters 3 & 4 subject to validation

Statements from the Care Quality Commission

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is 'requires improvement.

The Commission rated the Trust as '**requires improvement**' overall but judged Hertford County Hospital and Children's Community Services to be '**good**'. The Trust was rated '**good**' for caring.

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

Lister Hospital's registration includes the registrations for renal satellite units in St Albans Hospital and Luton and Dunstable Hospital. The Renal Satellite Units at Harlow and Bedford were inspected but not rated in 2015.

The Care Quality Commission has not taken enforcement action against ENHT during 2017/18.

The ENHT has not participated in any special reviews or investigations by the CQC during 2017/18.

As part of CQC's ongoing monitoring and inspection programme, the CQC confirmed a number of the Trust's core services would be re inspected – this was unannounced and commenced in March 2018. The inspection is to check whether the services that we are providing are safe, caring, effective, responsive to people's needs and well-led. The Trust will also receive a well led review which is scheduled to commence in April 2018. The outcome of the inspection will be published in the summer 2018.

Data quality

The ENHT submitted records during 2017/18 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	TBC	98.8%
Out-patient care	99.9%	99.6%
Accident & Emergency care	98.5%	100%

Information Governance

The ENHT's Information Governance Assessment Report overall score for 2017/18 was 76% and was graded 'satisfactory' (green).

Clinical coding error rate

The ENHT was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission. However the Trust undertook an information governance audit with results at Level 3 (highest level) as follows:

Primary diagnoses incorrect	4.5%
Secondary diagnoses incorrect	1.9%
Primary procedures incorrect	0.02%
Secondary procedures incorrect	0.42%

Over the last 12 months the Director of Finance and Chief Information Officer instigated a data quality improvement initiative to improve activity recording in preparation for the implementation of 'Lorenzo'. This has now been embedded in the organisation and extensive validation continues to address the legacy data quality issues that were migrated from the old system. However, the quality of the activity data being recorded since 'go live' in September 2017 shows a great improvement, particularly recording within Out-patient and Accident and Emergency departments.

There are a number of on-going data quality improvement related programmes underway across ENHT to progress and improve patient experience, service delivery and patient flow which include accuracy of data recording. ENHT will be taking the following actions to improve data quality:

- Ongoing training and recruitment of specialist Data Quality Team members with a strong understanding of the links between Clinical Coding, Finance, Information and Operations
- Reviewing the data quality across all services and working with identified stakeholders to agree improvement plans
- Developing the training programme
- Establishing management meetings and further developing monitoring tools

Learning from deaths

[Item 27.1] During 2017/18 1748 of ENHT patients died.	This comprised the following number of deaths which occurred in each quarter of that reporting period: 392 in the first quarter; 386 in the second quarter; 488 in the third quarter; 482 in the fourth quarter.

<table>
<tr><td colspan="2">By 31 March 2018, 1166 case record reviews and 93 investigations have been carried out in relation to 1748 of the deaths included in item 27.1</td></tr>
<tr><td>In 93 cases a death was subjected to both a case record review and an investigation.</td><td>The number of deaths in each quarter for which a case record review or an investigation was carried out was:

198 in the first quarter;
304 in the second quarter;
341 in the third quarter;
323 in the fourth quarter.</td></tr>
<tr><td>[Item 27.3]
0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.</td><td>In relation to each quarter, this consisted of:
0 representing 0% for the first quarter;
0 representing 0% for the second quarter;
0 representing 0% for the third quarter;
0 representing 0% for the fourth quarter.</td></tr>
<tr><td colspan="2">These numbers have been estimated using the Trust's Mortality Review process. Stage 1 is undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It is a structured, evidence based review format comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections.</td></tr>
<tr><td colspan="2">Potential areas of concern found by reviewers trigger a Stage 2 review by the relevant Specialty with discussion and identification of learning/actions points at their Clinical Governance Forum.</td></tr>
<tr><td colspan="2">Outputs feed into Stage 3 where the case is considered by the Mortality Surveillance Group, a subset of the Trust's Clinical Governance Strategy Committee. Here the adequacy/appropriateness of actions/learning points suggested by Specialties is considered and an avoidability of death score is agreed (using the scoring criteria adopted from the RCP methodology). No 2016-17 deaths were identified within the item 27.3 definition.</td></tr>
<tr><td colspan="2">89 case record reviews and 53 investigations completed after 1 April 2017 which related to deaths which took place before the start of the reporting period.</td></tr>
<tr><td colspan="2">7 representing 0.41% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the mortality review process methods detailed above in 27.3.</td></tr>
<tr><td colspan="2">10 representing 0.59% of the patient deaths during 2016-17 are judged to be more likely than not to have been due to problems in the care provided to the patient.</td></tr>
</table>

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	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
SHMI	Value	1.029	Oct 16 – Sept 17	1.056	0.72	1.24	1
	Banding	As expected	Oct 16 – Sept 17	As expected	-	-	N/A
% deaths with palliative care code	N/A	2.4%	Oct 16 – Sept 17	44.19%	0.7%	3.6%	-
Groin hernia	EQ-5D	0.09	2016/17	0.09	0.14	0.06	0.08
	EQ-VAS	0.94		-0.56	3.27	-6.5	-0.24
Varicose vein surgery	EQ-5D	0.12	2016/17	0.06	0.15	0.01	0.09
	EQ-VAS	3.05		0.63	6.27	-4.9	0.08
	Aberdeen	-11.11		-9.66	2.11	-18.07	-8.24
Hip replacement surgery	EQ-5D	0.41	2016/17	0.44	0.53	0.33	0.44
	EQ-VAS	12.27		8.33	20.18	7.89	13.1
	Oxford	20.75		21.69	25.04	15.96	21.4
Knee replacement surgery	EQ-5D	0.35	2016/17	0.32	0.39	0.24	0.32
	EQ-VAS	5.75		4.17	14.44	0.46	6.9
	Oxford	17.29		Insufficient	19.69	12.23	16.4
28 day emergency readmission rate	Age 0-15	13.65%	2011/12	13.52%	6.4%*	14.94%*	Not given
	Age 16 and over	11.11%	2011/12	10.56%	9.34%*	13.8%*	11.45%
Responsiveness to personal needs	N/A	64.5	2016/17	66.1	60	85.2	68.1
Recommending the Trust	Staff	62%	2017	69%	87	60	76*
	Patients	IP 97% A/E 92% Mat 93% OP 96%	Jan 2018	IP 97% A/E 94% Mat 94% OP 95%	-	-	IP 95% A/E 86% Mat 97% OP 94%
VTE assessments		No data[1]	2017/18 Q2 & Q3	97.34% Q1	100%	76%	95.36%
Clostridium Difficile infection rates	Trust apportioned cases	10.1	2016/17	7	0	82.7	13.2
Patient safety incidents	Number of incidents	3500	Oct 16 – Mar 17	3446	-	-	-
	Rate	32.6		31.8	69	23.1	-
	Number of severe harm / death	23		27	-	-	-
	% of severe harm / death	0.6		0.8	0.01	0.53	0.4

*Large acute trusts
[1] – see explanation below

The information provided in the table above is sourced from NHS Digital and is not necessarily the most recent data available. More up to date information, where relevant, is given below.

Readmissions – please see Part 2a, priority 7

Recommending the Trust (Patients)

March 2018 results show that patients would recommend the Trust:

- Inpatients / day case: 96.6% (1919 responses, 41.51% response rate)
- Accident & emergency: 88.7% (640 responses, 4.73% response rate)
- Maternity: 95.9% (466 responses, 24% response rate)
- Outpatients: 95.1% (1532 responses)

Venous Thromboembolism

A blood clot in the leg (deep vein thrombosis) or lung (pulmonary embolism) may develop for a number of reasons eg. reduced mobility. Patients in hospital tend to be less mobile than at home and should therefore receive an assessment as to their likely risk of having a blood clot and be prescribed anti-coagulant (blood thinning) medication if required. As part of the admission process patients are assessed and this information is recorded on the paper medication charts. Teams of staff undertake daily audits by reviewing the medication charts and validate this information against our electronic systems before uploading the data to the national system. Since the introduction of Lorenzo this validation process has not been possible. Therefore while the risk assessments have been completed, and medication prescribed, it has not been possible to supply data after quarter 1 (April-June 2017). This is one of the Lorenzo functions that will be corrected during 2018/19.

Clostridium Difficile

During 2017/18 the Trust reported 28 cases of clostridium difficile against a planned maximum of 11. Each of the cases is subject to an investigation to identify causes and apply future preventative measures. In thirteen of these cases all appropriate care was given and these were deemed as unavoidable. To reduce the incidence of infection further actions are required relating to handwashing, optimum antibiotic usage and timely diagnosis.

Benchmarking data to February published by Public Health England indicate the Trust has reported 12.91 cases of c. difficile per 100,000 bed days which is better than the East of England (14.74) and England (13.77) rates.

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.

Staff report patient safety incidents via an electronic reporting system. Managers review the incidents and add details of the action/s taken where relevant. This information is uploaded to a national system to support benchmarking and learning.

More recent data (April –Sept 2017) shows improvement as follow:

Number of incidents reported:	3582
Rate of incidents per 1000 bed days:	35.25
Number of severe harm or death:	20
% of severe harm of death:	0.5%

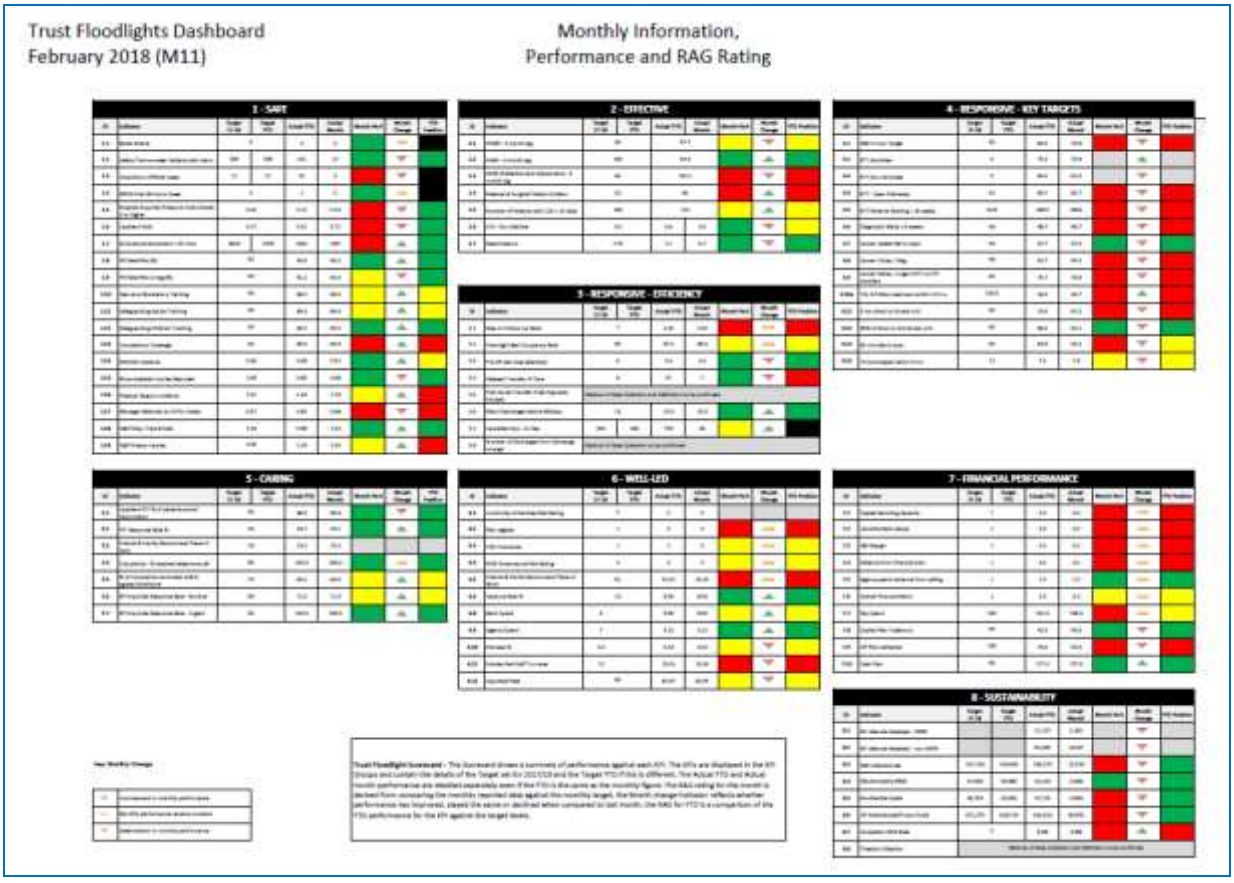
Part 3

3a Review against selected metrics
- Safety
- Clinical effectiveness
- Patient experiences

3b 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 ‘at a glance’ performance in relation to eight areas which includes the components of quality – safety, experiences (caring) and effectiveness.

The metrics include national and local indicators and for each of these targets are set outlining the goal (green), an acceptable level (amber) and under-performance (red).

Patient safety

Indicator	14/15	15/16	16/17	17/18 (March)	Aim for 17/18	Met
Never events	1	4	2	**6**	0	✘
MRSA Bacteraemia (post 48 hours)	5	0	2	**1**	0	✘
Number of inpatient falls	919	861	867	**780**	<845	=
Number of inpatient falls resulting in serious harm	14	13	15	**11**	≤15	✓
Number of preventable hospital acquired pressure ulcers	54	26	27	**27**	≤25	✘
Safeguarding adults training	90.6%	87.6%	90.9%	**89.4%**	90%	=
Safeguarding children training	89.1%	88.5%	91.2%	**90.5%**	90%	✓

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 2017/18 the Trust reported 6 never events:

- A needle was retained after suturing following childbirth. The needle and thread separated during the procedure and whilst it was believed that the needle had been safely disposed of in fact it had been retained
- An operation was undertaken on the wrong finger. The operation site marking was on the back of the hand rather than a circumferential mark (like a ring) around the finger
- A patient was fed fluids via a feeding tube that was placed in the lung rather than in the stomach
- A gallstone retrieval bag was left in place following surgery. The operation had been started laparoscopically (using instruments though three small cuts in the skin) but due to complications the procedure extended to fully opening the abdomen. During this transition the retrieval bag was accidentally left inside the body and was not visible during the open procedure
- A small quantity of the wrong blood was given to a patient
- A guidewire was accidentally left in place after inserting a central line (tube into a large vein to allow fluids and medication to be given). The wire is used to help insert the wire and should be removed after insertion

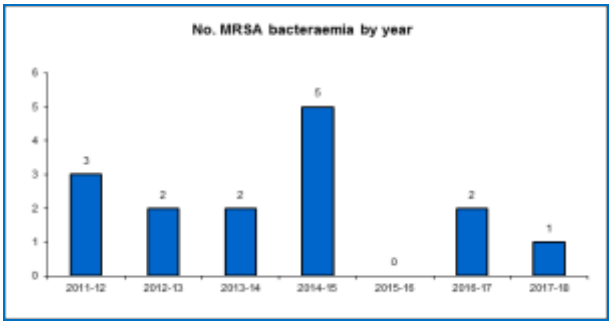
Each of these incidents is investigated fully to understand how they happened and to apply methods to prevent a re-occurrence. As a result of these incidents the following changes have been made / are underway:

- Amendments to the surgery checklist to include additional products in the count of items used
- Review of training and competency assessments for doctors as they progress from junior to middle grade
- Update to training programmes
- Review of products available for central line insertion to prevent lines being left in place

MRSA bacteraemia

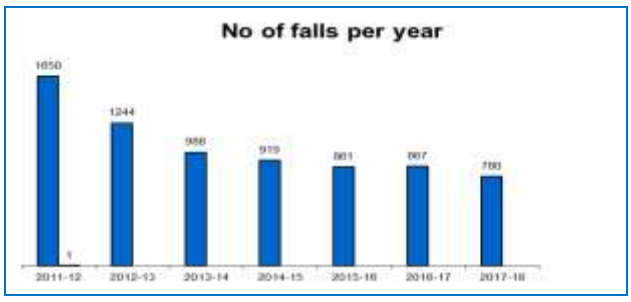
Methicillin Resistant Staphylococcus Aureus (MRSA) is a type of bacteria that is resistant to many widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections resulting in patients staying in hospital for a long length of time.

In 2017/18 the Trust had a target of achieving zero avoidable MRSA Bacteraemias. These are bloodstream infections from the MRSA bacterium. There has been one hospital associated MRSA bacteraemia in the year. This equates to 0.54 cases per 100,000 bed days against the East of England average of 0.97 cases (data to end Feb 2018).



Falls

Between 1st April 2017 – 28th February 2018, a total of 780 inpatient falls were recorded in the Trust which is 11 incidents above the weighted 2.5% reduction trajectory set for 2017/18 but have fallen by 2.25% compared to the same time period 2016/17.



Actions underway to help prevent falls include:

- Application of fallsafe bundles (prescribed range of actions to prevent falls) – compliance of 91% was achieved in the February 2018 audit
- Baywatch system of observing cohorted patients at high risk of falls
- Safety huddles which support staff in identifying and managing key patient risks on a daily basis

11 severe harm falls were recorded by the end of February, compared with 14 in the same time period the previous year.

All severe harm falls are routinely subject to an investigation. Where deficiencies in care are identified as a contributory factor the incident is automatically investigated as a serious incident. The findings from the investigations are routinely shared amongst relevant members of the multi-disciplinary team to ensure that risk mitigation measures are put in place. The incidents are discussed at the Falls, Fragility and Bones Group for consideration to ascertain whether the findings/learning from individual investigations warrant an amendment to the Trusts falls prevention strategy.

Pressure Ulcers

There have been 27 grade 2 and 3 unclassified avoidable hospital acquired pressure ulcers reported during 2017/18. Analysis of these incidents identifies shortfalls in relation to documentation, equipment use, skin inspections and repositioning. Actions underway to help prevent pressure ulcer development include:

- Promotion of heel protection
- Amendment of the Intentional Rounding chart to improve documentation.

It is noteworthy that there has not been a grade 4 avoidable hospital acquired pressure ulcer since October 2011, a total of six years.

Safeguarding Adults

Safeguarding adults training has just fallen short of the planned position. However:

- ✓ A learning disability alert is available on Nerve Centre and daily alerts are sent to staff to notify them of the presence of a patient with a learning disability. This alert is also sent to the sepsis nurses to help improve identification and management of patients with sepsis
- ✓ An Admiral Nurse has been appointed to support patients with dementia and their families. The role offers one to one support, expert guidance and practical solutions to challenges. Working with the community Admiral Nursing team at carers in Hertfordshire patients are supported throughout admission and discharge
- ✓ An assurance visit by the Clinical Commissioning Group in March identified many good practices and have proposed some areas for further improvement such as developing safeguarding champions roles
- ✓ Ambulatory Care at the New QEII has been awarded the Purple Star - an accreditation to recognise the achievement of a service in improving the health outcomes for people with learning disabilities.

Safeguarding Children

Safeguarding children training has achieved its planned position.

Clinical effectiveness

Indicator	14/15	15/16	16/17	17/18 (March)	Aim for 17/18	Met
Length of stay (non-elective)	3.53	3.50	3.9	**3.6**	≤3.5	=
Number with length of stay > 14 days	N/A	N/A	145	**121**	<100	=
Cancelled operations (on the day)	1.41%	1.71%	467	**759**	≤504	✗
Medical and surgical outliers (PCM)	N/A	N/A	115	**85**	<50	✗

Source: Information accessed from local teams

Length of stay

The average length of stay has improved compared to the previous year, although falls slightly short of the plan. The number of patients with a length of stay >14 days has improved compared with the previous year, although again has not reached the desired level.

Cancelled operations

The number of 'on the day' cancellations that have occurred during 2017/18 is 759 against a plan of below 504.

The increasing demand for NHS services has been well reported in the media. Where there is intensive emergency demand, routine planned activity is typically cancelled i.e. the only inpatient planned surgery to continue are cancer and clinically urgent cases. 2017/18 has seen a large increase in the number of cancellations because of this extra demand – a 14% increase in admissions in 2017/18 compared with the previous year.

Outliers

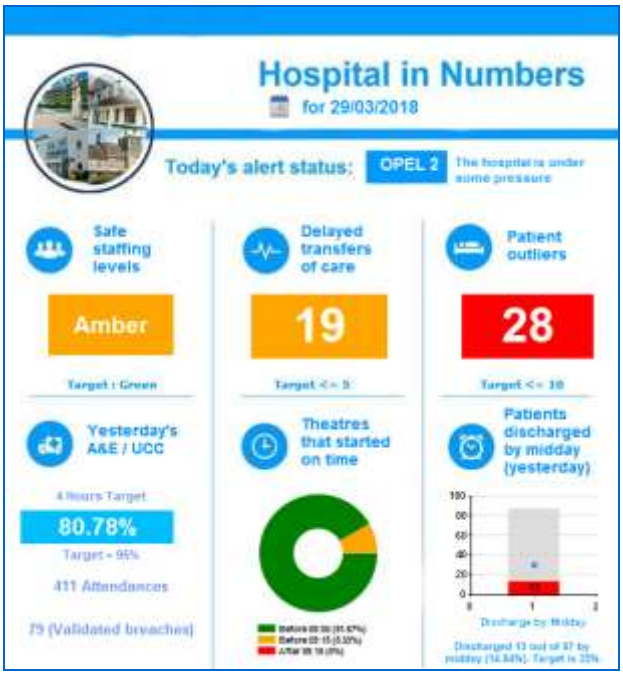
Patients are admitted ideally to a ward where their care and treatment can be provided by specialists with expert knowledge of their condition. Where a patient is placed on a ward within a different specialism this is known as 'outlying'. Although care and treatment is still provided the specialist teams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

When demand for services is very high and the wards are effectively 'full' it is not always possible to place people in the optimum ward. However, all outlying patients are reviewed by a dedicated medical outlier team.

The indicators described in this section are all inter-related whereby improvements in one area can 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 from lack of beds; and reducing the number of outliers. A number of actions are underway to address this whole matter of patient 'flow' as follows:

- 'Red to Green days' where the tests, tasks and reviews are optimised so that plans can be made and decisions or discharges expedited. Reducing delays will therefore improve patient flow and free up beds
- Discharging by mid-day through timely review and writing of prescriptions
- Model Hospital workstreams – a new concept whereby some departments (emergency department, theatres, endoscopy) are redesigning their services to maximise efficiency
- Working with community partners to minimise delays to being discharged whilst awaiting community support
- Reviewing roles of staff to increase competencies eg Advanced Practitioner Nurse roles and nurse prescribers
- Increasing the number of care pathways which outline the steps in care required to optimise outcomes whilst minimising length of stay
- Furthering of 7 day services including timely consultant review
- Use of the SAFER care bundle (Senior review by midday, All patients have an expected discharge date, Flow commences at the earliest opportunity, Early discharge and Review for those with an extended length of stay)
- Professional standards for medical staff agreeing attendance on ward rounds and response times to attending the emergency department
- Extending ambulatory care (preventing the need for admission)
- Optimising start times eg theatre slots

A daily situation report 'Hospital in Numbers' is circulated to operational teams by email to highlight the current position. This helps to raise awareness and trigger local actions.



This exciting work is still evolving and as such has been included as Priority 3 for the 2018/19 quality account.

Patient experiences

Indicator	14/15	15/16	16/17	17/18 (March)	Aim for 17/18	Met
Number of complaints	1181	1095	924	**1106**	<previous year	✖
Number of PALS concerns	2306	3279	3195	**4174**	N/A	-
Complaints per level of activity - per 100 bed days (Before 2015/16 this was per finished consultant episode)	1.32%	0.5% (New methodology)	0.42%	**0.51% (Q1-3)**	<0.5%	=
Complaints – response within agreed timeframe	59%	54%	48%	**65.5%**	≥75%	✖

Source: Datix internal system & Information held by local teams

Complaints and PALS concerns

The number of complaints and PALS concerns is showing an increase compared with the previous year.

Complaints by activity

Data for Jan-March has not formally been validated yet. However for quarters 1-3 (April – December 2017) there were 802 complaints reported. This equates to 0.51% of complaints per 100 bed days, just slightly short of our aim.

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 65% of occasions against a plan of ≥75%. This is an improvement compared with the previous year.

Designated staff from within the clinical divisions have been given responsibility for liaising with the complaints team case handlers to try to improve the timeframes to complete the investigations. This has resulted in some improvements but there remain delays due to:

- Incorrect coding resulting in delays in identifying the correct clinical team with whom to liaise to generate a response
- Operational pressures within the division which reduces the amount of time available to compile responses
- Variation in the quality of responses – failure to address all of the concerns leads to potential delays whilst seeking additional information

The complaints team continue to work with investigators to achieve timely completion of good quality responses.

Learning outcomes

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

You said…	We did…
Patient left alone in the radiotherapy department following treatment whilst awaiting ambulance transfer	All “treat and transfer” patients will be admitted under a ward to ensure their care needs are met.
Patient did not receive any information regarding the change in where his bloods needed to be taken	Explanation that there is no longer a blood facility at Charing Cross and as a result patients are now asked to have their bloods tested at Mount Vernon.
A family raised concerns relating to communication and delays in receiving medication	It had been necessary to withdraw medication and an explanation as to the rationale for this was given.
Family stated that the 'red bag' information was not handed over to staff [red bag supplies information from a care home that describes the patient’s needs and preferences]	Staff were not fully aware of the 'red bag' system but this has been rectified. Documentation has been revised to improve the standard of information recording.
An overseas patient did not receive a six week follow-up appointment following surgery	The patient has not sent payment and as a result the follow up appointment was cancelled. This was explained and further advice given.
A patient was dissatisfied with the attitude of the sonographer	Lead Sonographer contacted the patient directly to apologise
The patient cancelled his appointment online but subsequently received a letter stating that he had failed to attend an appointment	Explained that during the implementation of a new system it was not possible to action online cancellations. A appointment was offered

3b Performance against national requirements

The indicators in this section form part of the NHS Improvement Single Oversight Framework.

	15/16	16/17	17/18 (March)	Plan for 17/18	Met
Max 18 weeks from referral in aggregate – patients on incomplete pathways	92.7%	92.2%	**85.7%**	≥92%	✗
Four hour maximum wait in A&E	85.2%	84.6%	**83.5%**	≥95%	✗
62-day urgent referral to treatment of all cancers	76%	73.6 [a] %	**75.7%**	≥85%	✗
C Difficile - Rate of infection per 100,000 bed days	16	22 [b]	**28**	≤11	✗
Maximum 6 week wait for diagnostic procedures	-	99.7%	**98.7%**	≥99%	✗

Source: Single Oversight Framework (NHS Improvement)
[a] Successful appeals resulted in an increase in the outcome from 72.2% given in last year's report
[b] Following adjustment

3c 7 day services

The Trust continues to work towards 7 day working and fully achieving the Keogh standards set out in the report NHS Services, Seven Days A Week. ENHT was confirmed as being in the tranche of trusts tasked with achieving compliance against the four prioritised standards by the end of March 2018. These four prioritised standards are:

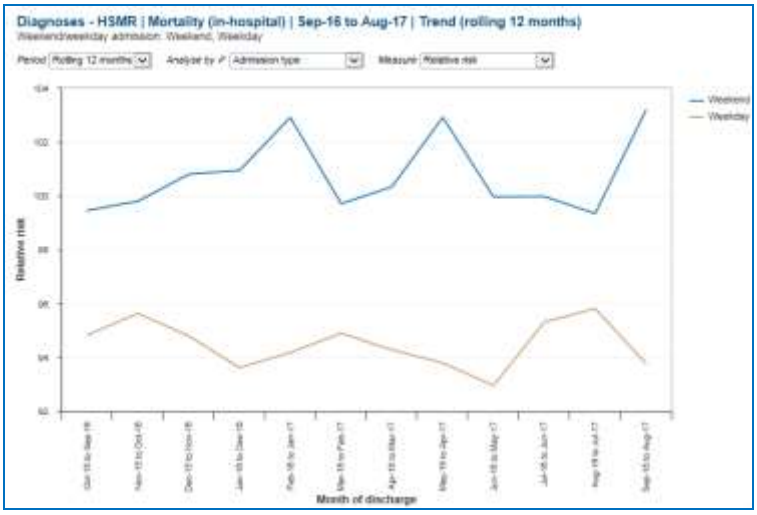
- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review.

Similar to many other organisations the Trust is struggling to make progress towards achievement of the required standards. The most recent audits (March 2017) confirm the following achievements [Note: further audit underway].

Standard	Requirement	Outcome	
2	Patients should be seen by a consultant within 14 hours of admission	The overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission	70%
8	All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate).	The overall proportion of patients who required twice daily consultant reviews and were reviewed twice by a consultant	98%

Standard	Requirement	Outcome	
	All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate).	The overall proportion of patients who required a daily consultant review and were reviewed by a consultant	90%
5	Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: Within 1 hour for critical patients and Within 12 hours for urgent patients	Are these diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales	Yes
6	Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Do inpatients have 24 hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements: Critical Care, Primary Percutaneous Coronary Intervention, Cardiac Pacing, Thrombolysis for Stroke, Emergency General Surgery, Interventional Endoscopy, Interventional Radiology, Renal Replacement, Urgent Radiotherapy)	Yes

There continues to be a divergence between weekday and weekend mortality levels. The reasons are not fully understood but this is being monitored.



Annexes

Annex 1 Statements from stakeholders

Annex 2 Statement from auditors

Annex 3 Statement by the Directors