East and North Hertfordshire NHS Trust

Quality Account

2013/14

DRAFT 3

For stakeholder review and comment

To continuously improve the quality of our services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services

Contents

…staff should be congratulated on the service they offer to the public, amazing ,thank you

(Lister Emergency Dept, February 2014 Source: NHS Choices)

If members of the public would like to provide feedback on this Quality Account or suggest items for inclusion in next years report please email qualityaccount.enh-tr@nhs.net or contact the Board Secretary on 01438 314333.

Part 1

1a Statement on quality from the Chief Executive

In November I was delighted to attend the Celebration of Excellence Awards. This represented what we are trying to achieve at the East and North Hertfordshire NHS Trust – recognising the achievements of our staff whilst constantly striving to deliver excellent care.

This report contains many examples of those achievements and together we are making a difference by aiming to 'be amongst the best'.

2013/14 has continued to be a year of development, whether that's working with partners such as MacMillan to enhance cancer services; supporting staff through our staff development programme known as ARC; or continuing with the centralisation programme which is nearing its completion.

There are many things to be proud of. The Lister Treatment Centre is now under Trust management and the number of operations has increased significantly. Our mortality rate continues to fall and in many areas is significantly better than the England average. The rate of infection continues to remain low and the number of in-hospital falls and pressure ulcers continue to reduce.

Although there are many successes there is much more to do. We need to focus on getting the basics right. Our patients tell us that while we deliver care and treatment to a very high standard we need to improve on communication and administrative processes. These have been identified as priorities for improvement this year.

We have comprehensive strategies and operating plans to steer what we do in future. All of these have quality at their heart and are monitored by robust established mechanisms and by strong management teams.

The Trust is registered without conditions by the Care Quality Commission (CQC) who published two inspection reports this year. We were delighted to receive a declaration of full Compliance with all standards assessed.

We have an open culture where we learn from mistakes and are honest with staff, patients and the public.

I would like to take this opportunity to thank our staff and volunteers for their dedication and hard work, particularly as our Trust goes through significant change. My thanks also go to our members, including our young members, and stakeholders for their continuing assistance in guiding the Trusts development.

This Quality Account provides just a snapshot of all that has been achieved by our staff, for our patients. To the best of my knowledge the information in this document is accurate.

Nick Carver
Chief Executive

1b Statement by the Board of Directors

Mandatory statement to be added once document agreed by Board in June

I would like to praise the staff in the Fracture Clinic and the Ultrasound department for their kindness, patience and professionalism - the staff worked so well as a cohesive team and had a kind word for all the patients who were waiting. It's clear that they take great pride in their work. Well done and thank you to them all.
(Source: NHS Choices, October 2013)

1c Trust statement on quality

The Trust aspires 'to be amongst the best' performing NHS Trusts in the country**.** This vision is underpinned by:

- the objective *to continuously improve the quality of our services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services,* and
- a set of five values which are integral to the way our staff undertake their work.

A strategy for Quality

The Quality Strategy (2012) outlines how quality is incorporated into the everyday business of the organisation. This strategy is supported by the *Patient Safety Strategy*, the *Patients and Carers Experience Strategy* and the *Improving Patient Outcomes* plans which aim to:

- Improve timeliness and reduce variability of care
- Reduce harm and avoidable deaths
- Promote a culture where safety is an integral part of what we do
- Design services, pathways and systems which protect patients from harm
- Introduce evidence based innovations
- Improve the physical and emotional experiences of patients and their families or carers.

Measuring for quality improvement

To understand how well, or not, we are achieving our strategic plans we measure and monitor a number of factors, known as 'indicators'. Each indicator must have a desired goal known as an 'aim'. The result of what has been achieved is known as an 'outcome'.

For example:

Indicator:	Number of patients to be treated by the end of the day
Aim:	More than 38
Outcome:	40

By measuring outcomes regularly we can see if we are meeting our aims or not. If our outcomes measured over time show that we are improving then we carry on with what we are doing. If not, then we review what we are doing to see how we can improve. In the example above the aim was achieved; but if we had aimed to achieve 45 then we would not have succeeded and would need to look at why and what we would need to do to achieve the aim in the future.

Examples of these indicators, aims and outcomes are given throughout the Quality Account.

Some indicators are set by our Trust to monitor particular aspects of the service; and others are set nationally so that all Trusts can be measured on the same thing. National indicators allows us to compare how well we are doing against others (known as benchmarking) so we can either share our good practices with other Trusts or learn from other organisations that are doing better. The aim of measuring is to plan and deliver improvements which make quality of care even better.

Listening to what you tell us

We take the views of our patients, their families/ carers and the public seriously to help us better understand what you think about our hospitals, staff and services. Examples of how we seek and listen to your views are:

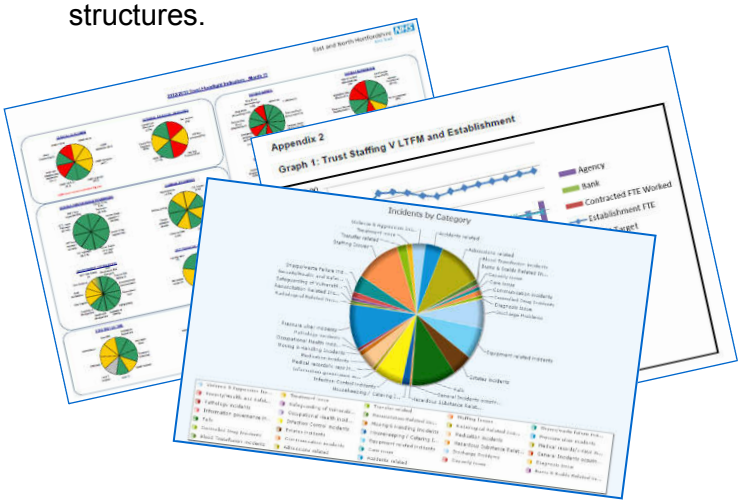
- Surveys—national and local
- Letters of thanks
- Complaints and Patient Advice and Liaison Service (PALS) enquiries
- NHS Choices
- Consultation work on service planning
- Engagement activities
- 'Patient Stories' shared with the Trust Board

Monitoring for quality improvement

It is important to measure how we are performing as it demonstrates how efficient the Trust is in using its resources and how effective it is in achieving the best outcomes. The performance information is used in the following ways:

- By departments who review the outcomes and plan changes where necessary
- By the executive team and the non-executive directors who scrutinise the information, offering praise or challenge as necessary
- By committees who monitor progress
- By the commissioners (East and North Hertfordshire Clinical Commissioning Group) who purchase the Trusts services on behalf of the local community and scrutinise the outcomes to check that a high quality service is being delivered

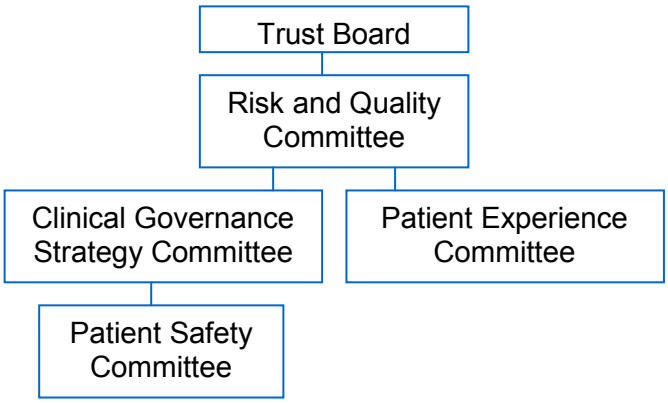
The Trust has a well established accountability framework to support review and monitoring within its committee and management structures.



Committee structure

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

The main sub-committees for monitoring quality are the Clinical Governance Strategy Committee (chaired by the Medical Director), the Patient Experience Committee (chaired by the Director of Nursing) and the Patient Safety Committee (chaired by the Associate Medical Director for Patient Safety). These each receive scheduled reports from departments, committees or individuals tasked with quality improvement, for monitoring and assurance purposes. A process of escalation enables any concerns or significant achievements to be shared with the parent committee.



Management structure

Each Clinical Division and Specialty is led by a dedicated medical, nursing and management team. Together they are responsible for quality within their own areas and are held accountable for this through the organisational hierarchy structure.

Performance reviews

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

Rolling half days

Each month (except August) all elective (non emergency) activity is suspended for half a day to allow a significant proportion of team members to meet and review their practices. This dedicated time offers an opportunity to review outcomes, and where necessary to make plans for improvement.

Reconfiguration

It is impossible to pass the Lister or QEII Hospitals without noticing the building work that is taking place around the hospital sites. Section 3c of the Quality Account provides detailed information about the changes occurring. Essentially acute services are being centralised at the Lister Hospital and the QEII Hospital will become a local hospital offering a range of diagnostic, out-patient and local A&E services.

Detailed planning involving clinical staff ensures that clinical quality is not compromised during the reconfiguration process. Indeed reconfiguration has been an opportunity to redesign our services to improve outcomes.

Engagement

The Trust continues to make strong progress on delivering its Engagement Strategy through working with external stakeholders. Community engagement is now well developed, as demonstrated by the attendance of over 300 public / members, partners and staff at the Annual General Meeting in October 2013.

We systematically capture feedback from stakeholders through a range of methods, including surveys, focus groups and utilizing methods and channels that our patients and the wider public find convenient, including Twitter and Facebook. For example, a workshop held in December sought the views of service users to help us redesign the complaints process.

Engagement work includes:

- Working with community partners including GPs
- Linkage with councils, in particular the Health & Wellbeing Boards
- Market research and campaigns
- Recruitment and involvement of around 10,500 public members
- Managing the Annual General Meeting

Patient Leadership Programme

Eight of our public members are participating in Hertfordshire's first *Patient Leadership Programme*.

The Trust has been working in partnership with other Hertfordshire health providers and commissioners to design and deliver the programme. The aim is to provide committed public and patient representatives with insight, knowledge and confidence to lead involvement work.

Involving young people

The Trust has been developing ideas to involve young people with their local NHS.

The idea is to inspire young people to want to get involved by presenting their local hospital as a fantastic opportunity for applied learning and personal development.

We have worked with a number of schools to recruit over 500 new young members, getting them involved in exciting projects such as rebranding the hospital to make it more attractive to young people. We are about to buddy some of our young members with older members at risk of social isolation through ICT learning.

David Brewer
Head of Engagement

1e A year in the life….

122,704
Emergency Department attendances

5326
babies born

Extending renal dialysis services to Bedford (and also to Harlow)

315,456
radiological tests

34,518
emergency admissions

The new Theatre Block gets underway

217,976
first out-patient appointments

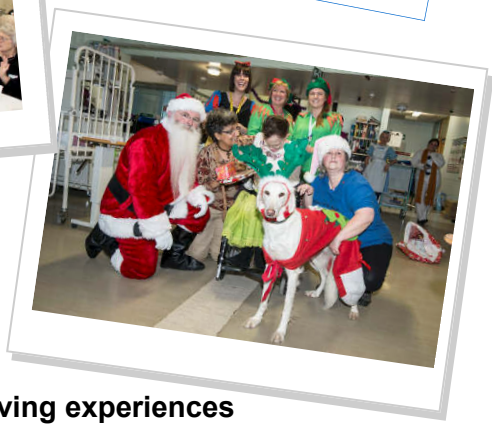
2013 Celebration of Excell

Continuous Improvement Award winners

Lister Treatment Centre opens

14,490
operations
(exc plastics minor operations)

180 years at Hertford



Improving experiences for patients

Recognising our volunteers

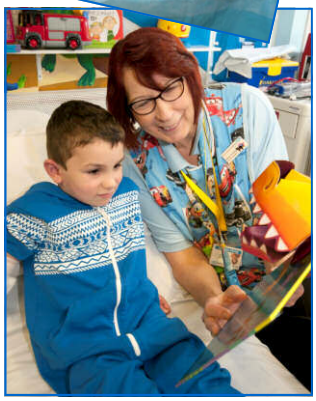
Taking good care of you...

Our experience at A&E was also excellent and the calming influence of a lovely nurse was most welcome. I was treated quickly and efficiently and with compassion. The humour of the staff also helped to stop our worrying and we were informed exactly what was happening and how long we would have to wait.

(Emergency Dept, March 2014
Source: NHS Choices)

What fantastic service !! Excellent doctor sorted out my problem on the spot , a loose stitch in the eye left behind from a previous op at [different] hospital, very pleased that I chose to go to lister thankyou.

(Emergency Eye Clinic, November 2013
Source: NHS Choices)



I waited precisely 15 mins to be seen in casualty and was admitted pretty much immediately. I cannot praise highly enough the nursing and aux staff on Ward 9A...this also includes the cleaning and catering staff. I was in isolation with a potentially highly embarrassing condition but without exception was always treated with care (not just medically) and dignity throughout my entire stay.
(Source: NHS Choices, Dec ember2013)

… but not always getting it right

You wait too long to be seen, the staff attitude is poor putting their social lives infront of the needs of patients.
(Source NHS Choices, December 2013)

I left with the main concern of an adverse reaction to the medication still unaddressed (Complaint, Jan / Feb 2014)

Throughout our dealings with the QEII on this occasion communication has been very poor. Nurses did not seem able to advise us during evening visiting what her treatment and condition was.
(Complaint, Jan / Feb 2014)

2013 Celebration of Excellence

Volunteers award winners

Part 2

2a Priorities for improvement

Priorities for 2014/15

In order to seek views about priorities for 2014/15 the following actions were undertaken:

- Existing priorities and indicators were reviewed to consider their relevance in light of new information. This formed part of the debate during the consultation stages
- Feedback from service users was reviewed eg. national and local surveys, complaints and PALS data, views from NHS Choices
- Relevant committees were asked for their comments and ideas:
    - Patient Safety Committee for safety priorities
    - Patient Experience Committee for patient experience priorities
    - Clinical Governance Strategy Committee for priorities about clinical outcomes
- External stakeholders who are members of the Involvement Committee were asked their views
- Regional and national documentation was consulted to identify key initiatives
- The final decision on priorities was determined by the Executive Committee after deliberation of the new findings and consideration of existing priorities and their outcomes

In addition, to ensure that quality account priorities are aligned with main service developments the following actions were taken:

- Review of the Quality Schedule and consideration of topics through liaison with the Clinical Commissioning Group throughout the year
- Alignment with the Trusts Operating Plan and quality improvement schemes

The priorities and indicators were presented to the Risk and Quality Committee for final approval.

Priority	2013/14	2014/15
1	Improving safety	Improve safety: safety thermometer
2		Improve safety: medications
3	Improving clinical outcomes	Improve outcomes: mortality
4		Improving clinical outcomes: stroke
5	Improving patient experiences	Improve experiences: communication
6		Improve experiences: reduce delays
	Staff development / engagement	This priority has been retired as its elements are captured by the mandatory indicator and within the staff section of the report

Support Service Award Winner

Jill Payne, Medical Secretary, Respiratory Service

"She has a wonderful attitude and helpful nature, and is a privilege to work with. She has proved that - at every position in the Trust - you can make changes to put patients first."
(Dr Gore & Dr Szulakowski,
Consultant Chest Physicians)

Priorities 1 & 2 – Improving safety

No	Indicator	Why this is important	How this will be monitored	Where this will be monitored and Lead Director	Links with other quality initiatives
1	Improve safety thermometer scores	The Trust has seen significant reductions in harms over the past few years and wishes to move towards a zero tolerance for harms relating to falls and pressure ulcers.	• Safety thermometer score for falls, pressure ulcers, UTI and VTE • Number of falls • Number of falls resulting in serious harm • Number of pressure ulcers (hospital acquired)	Bi-monthly report to the Risk and Quality Committee Monthly 'Floodlight' report to the Board <u>Lead</u>: Director of Nursing and Patient Experience	Nursing ambitions Quality contract Trust objective 1.3
2	Improve medication management	Ensuring that patients receive the correct medicines on time and are empowered to take ownership of their treatment	• Survey results (medication purpose & side effects) • Incident reporting re medication • Medication omission audit • Implement Medicines Optimisation Strategy objectives for year • Results of medication thermometer (if decision made to implement)	Bi-monthly report to the Risk and Quality Committee Monthly 'Floodlight' report to the Board <u>Leads</u>: Medical Director & Director of Nursing and Patient Experience	Trust objective 2.1 Medicines Optimisation Strategy 2014-17 Quality contract

Team leader award winner

Tania Taylor, senior sister, ward 8A

"Tania has kept her staff inspired and motivated, and through times of change her leadership has been truly inspirational." (Karen Cameron, Nursing Services Manager)

Priorities 3 & 4 – Improving outcomes

No	Indicator	Why this is important	How this will be monitored	Where this will be monitored and Lead Director	Links with other quality initiatives
3	Continue to improve mortality	The Trust has made significant progress in reducing mortality and wishes to see further improvements. HSMR and SHMI to stay within the 'as expected' range or better	Analysis of: • Hospital Standardised Mortality Rate (HSMR) • Summary Hospital Mortality Indicator (SHMI) • SHMI data adjusted for palliative care Review of outcomes relating to the deteriorating patient: • Unexpected admissions to ICU audit • Cardiac arrest calls • Observation Compliance • Monitor access to PPCI (heart attack treatment)	Monthly 'Floodlight' report and exception report where necessary) to the Board Bi-monthly report to the Risk and Quality Committee (via Medical Director report) Quarterly monitoring reviews with the Clinical Commissioning Group <u>Lead</u>: Medical Director	Trust objective 1.1
4	Continue to improve stroke standards	Whilst progress has been made regarding scanning and treatment of TIAs there are still challenges around the treatment and care of patients with a stroke. Consolidation and further work with community partners is expected to improve this position.	Analysis of: • 3 hr thrombolysis • 4 hrs to stroke unit • 90% time on stroke unit	Monthly 'Floodlight' report (and exception reporting where necessary) to the Board <u>Leads:</u> Director of Operations, Medical Director	Trust objective 4.2

Priorities 5 & 6 – Improving experiences

No	Indicator	Why this is important	How this will be monitored	Where this will be monitored and Lead Director	Links with other quality initiatives
5	Improve communica-tion	Communication is one of the most common subjects in complaints and PALS concerns. Increasing customer care training; the near completion of service consolidation and its consequent care pathways should support staff and offer a period of stability to drive improved communication.	• Improvement in postal & national surveys (involved in decisions, consistent info, providing understandable answers, name of contact) • Further increase customer care training • Monitoring ward staffing levels • Reduction in complaints & PALS concerns (rate) • GP Survey	Patient Experience Committee Risk & Quality Committee <u>Leads:</u> Director of Nursing & Patient Experience; Director of Operations; Director of Human Resources	Trust objectives 2.1, 2.2, 2.3, 4.1, 6.1
6	Reduce delays	Delays feature as common subjects in complaints and PALS concerns; and are also raised as a concern by stakeholders particularly in outpatients.	• Conclude design of pathways for services from New QEII, inc rapid assessment • Reduction in complaints & PALS concerns (rate) • Improvements in postal & national surveys (waiting list, waiting for bed, OPD waiting time)	Bi-monthly report to the Risk and Quality Committee Patient Experience Committee Monthly floodlight to the Trust Board <u>Leads:</u> Medical Director; Director of Operations; Director of Nursing & Patient Experience	Trust objectives 1.4, 2.1, 4.1 Transforming In-Patient Management Programme

On page 10 a number of examples are given where we fall short of delivering the excellent service to which we aspire. It is for these reasons that Priorities 5 & 6 are so important to us.

Retirement of indicators

Some of the indicators used to monitor the 2012/13 priorities will be retired either because they are part of ordinary business or because they are more appropriately reported within Part 3 of the report. Assurance about future reporting arrangements is given below.

Indicator	Plan for 2014/15
Nutrition audits	For inclusion in the patient experience section of Part 3
Access to TIA services / CT scan	This is routinely monitored by Board
Mortality for specific conditions	These are routinely monitored by Board
Emergency admissions / Enhanced recovery	This is routinely monitored by the Transforming In-Patient Management Board
Job satisfaction / team working	For inclusion in the staff section of Part 3
Staff recommending the Trust	This is now a mandatory indicator
Learning disability	For inclusion in the patient experience section of Part 3
Carers survey	
Dementia	
Maternity	For inclusion within the mandatory indicator on friends and family (patients)
Diabetes survey	This is an ongoing survey monitored by the Patient Experience Committee
Insulin pump access	This forms everyday practice within the diabetes team

A review of 2013/14 priorities

Details relating to each of these indicators are given within their relevant priorities sections and month by month outcome data for 2013/14 is presented separately.

Progress against the years priorities, as identified in the 2012/13 quality account, are given on the following pages. The indicators, aims and outcomes are shown in table format. Symbols (see key below) show whether or not they were achieved.

A short description about each of the indicators provides background information and summary of the years achievements.

Key:

The key is based upon the thresholds set by the Board, at the beginning of each year, which are used to monitor performance throughout the year. The majority of indicators have been set by the Trust, rather than being national targets.

✓ Achieved

~ Under achieved (defined mid-range as given on the Trust floodlight scorecard)

✘ Not achieved

Priority 1 – Improving safety

Priority 1 SUMMARY

		11/12	12/13	13/14	Aim for 13/14	Achieved
1.1	Reduce number of in-patient falls resulting in serious harm	N/A	14	16	<=24	✓
1.2.1	Reduce number of avoidable hospital acquired pressure ulcers	323	113	40	<=96	✓
1.2.2	Pressure ulcers – safety thermometer scores	N/A	N/A	0.48%	Variable	✓
1.3	Introduce regular nutrition audits	N/A	N/A	Yes	Comply	✓

1.1: Falls

The number of falls resulting in serious harm has achieved its aim of being less than 24 in the year. The incidence is shown in the graph below.

However the Trust recognises that each fall has serious implications to the patient and their family and therefore continues in its endeavour to minimise the number of falls.

Analysis during the year has shown that these falls primarily occurred at night. There are a number of recognised factors which may increase the chance of falling at night eg lowered lighting, less staff, time and place disorientation. This information has been shared with staff who have been tasked with developing prevention plans.

Actions to prevent falls continue. These include:

- Assessment of falls risk for each patient
- Development of tailored action plans
- Intentional rounding whereby patients are checked hourly to ensure they are wearing correct footware; have call-bells to hand, etc

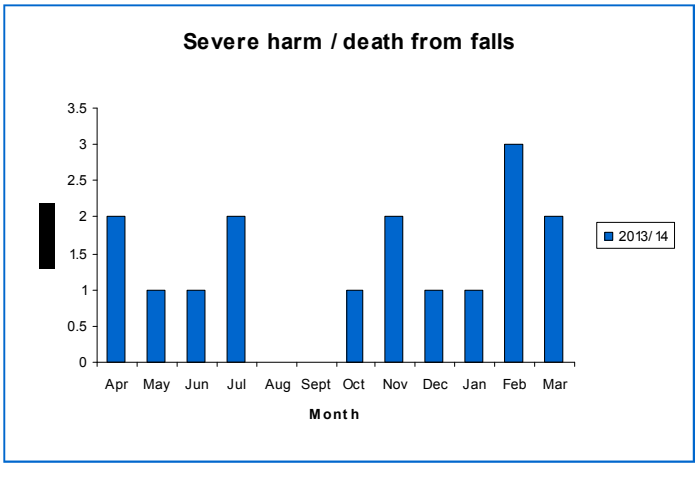
Each incident, where a fall has led to serious harm, triggers a full root cause analysis investigation. This looks at all risk factors including medication, staffing levels, mental capacity etc to understand why the incident happened and what action could have been taken to prevent it.

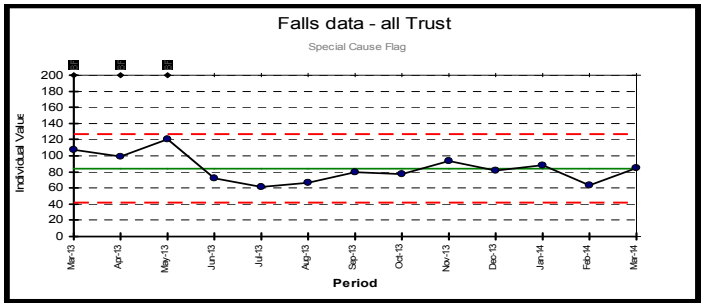
The Falls Prevention Practitioner conducts monthly falls prevention audits of the areas where most falls occur. Feedback is given directly to the staff on duty, ward Sister and Matron to involve them further in falls prevention work.

Reducing the number of falls overall

There have been 988 falls in 2013/14. This is a 19.3% reduction compared with 2012/13 (1224) and is just short of the 20% target reduction. The graph below shows performance against the monthly aim (green line)

Individual wards are now being set falls reduction challenge which will aim to reduce falls by a further 10% in 2014/15. We will also be introducing a new falls risk identification tool, replacing the Morse score system.



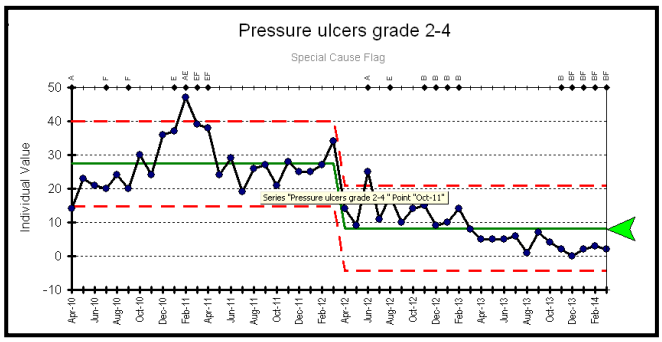


1.2: Pressure ulcers

Reducing the number of pressure ulcers

All admitted patients are assessed for their risk of developing a pressure ulcer whilst in hospital. Such an assessment takes account of the patients general health, their skin and mobility etc. Preventative methods such as special mattresses are used for anyone at risk of developing an ulcer. Occasionally pressure ulcers do occur, despite best efforts to prevent them. In these cases investigations using root cause analysis helps to identify if anything different could have been done to prevent the ulcer from forming. If a patient develops an ulcer but it is found that nothing more could have been done to prevent it then this is classed as 'unavoidable'. Any ulcer which could have been prevented is known as 'avoidable'.

In 2013/14 there were 40 grade 2-4 (see definition in yellow box) avoidable hospital acquired pressure ulcers. This demonstrates a 62% reduction compared with 2012/13 continued reduction in the number of ulcers over the last few years as shown in the graph below.



Achieving zero hospital acquired pressure ulcers

The Trust as a whole, for the first time, had no hospital acquired pressure ulcers in December 2013.

This considerable result sees us on the 'wall of achievement' of the NHS Stop the Pressure Campaign.

Pressure ulcers

Commonly known as bed sores, people develop these ulcers as a result of continued pressure on the skin – mainly on their bottom or heels. There are four grades of ulcer:

1 – skin is red but unbroken
2 – shallow skin break (like a graze)
3 – deep skin break involving all layers of skin
4 – very deep skin break with damage affecting muscle and/or bone

People with fragile skin or who have restricted movement are most at risk of developing them if the pressure is not relieved through turning, movement or protection.

The last Grade 4 hospital acquired pressure ulcer was in October 2011

Safety thermometer

The Safety Thermometer is an initiative to improve safety. Part of this initiative focuses upon pressure ulcers. The aim is for pressure ulcer reduction of 20% in the median percentage of new hospital acquired pressure ulcers in the first six months of 13/14 and then maintenance of the reduction in the latter six months of the year.

This aim has been met.

Measuring ward performance

Staff are proud of the number of pressure ulcer free days on their wards.

At the end of March a number of wards had achieved these milestones of pressure ulcer free days:

Time	No. of wards
Never	1
> 3 years	2
2-3 years	1
1-2 years	15

1.3: Nutrition audits

Introducing audits

Using the electronic surveying and auditing tool 'Meridian' regular nutrition audits have been introduced.

These are ward based audits and in 2013/14 6125 questionnaires were submitted.

These showed:

- 92.93% of patients were weighed on admission
- 87.77% of relevant patients were weighed at least every 7 days
- 94.87% of malnutrition risk assessments were completed fully on admission
- 91.08% of malnutrition risk assessments were completed every 7 days
- 86.65% of food charts were completed thoroughly
- 85.42% of documents showed that the red tray system had been implemented for those who needed it
- 80.93% of patients requiring a nutrition care plan had one documented
- 79.77% of patients at high risk of malnutrition were referred to the dietician

A Nutrition Steering Group was established in the year which reports directly to the Patient Safety Committee.

National nutrition initiatives to improve nutrition and hydration have been introduced within our Trust, and include Nutritional screening; Protected mealtimes; and the use of the Red tray and Jug to highlight patients who may need assistance with eating and drinking or longer time finishing their meal.

When I was taken for a scan I was taken with someone else's notes. (Source: Postal survey)

It was clear that the doctors and nurses worked collectively as a team which meant that the support and information I received was very good. (Source: Postal survey)

In addition to the introduction of national initiatives we have:

- Continued to support our ward volunteers who help and encourage patients at meal times, especially older, frail patients who may require assistance to eat and drink
- Re- launched our multidisciplinary Nutrition Steering Committee introducing "task and finish" groups to work on specific nutrition initiatives for the Trust
- Continued to deliver a rolling programme of nurse nutrition education delivered by senior Dieticians in collaboration with our colleagues at the University of Hertfordshire, and supported by our non medical education committee
- Built on the success of our nurse nutrition study days and have introduced nutrition education for our clinical support workers, and are currently reviewing the provision of nutrition education for ward housekeepers
- Participated in the development of staff *Patient Care & Safety Days* (see page 51) introduced in March 2014 to be delivered 2014/15 including nutrition & hydration
- With the introduction of the Ward Audit Tool, ensured that ward managers provide a nutrition action plan when results fall short of that expected, ensuring that any issues identified are addressed
- Supported the Nutrition & Hydration Week in March 2014, celebrating "afternoon tea" on our wards

Gail Franklin
Lead Clinical Specialist Nutrition & Dietetics (Renal)

Priority 2 – Improving clinical outcomes

What do we mean by improving clinical outcomes?

This can be considered as the result of a patients visit to hospital. For example, good outcomes are when the operation was successful; there were no complications; the length of stay was as expected and the patient did not need to come back for any reason. Clinical outcomes very closely linked with how efficient we are.

We aim to see you quickly so that any tests can completed for early diagnosis and treatment. We aim to use the latest techniques, following national best practices, and for our staff to be highly skilled so they can give you the best care. We aim to protect you from harm so that your recovery goes well and your time spent in hospital is minimised.

How successful we are at achieving this can be assessed by measuring clinical outcomes. A small selection of the many possible indicators are given in the table below

Priority 2 SUMMARY

		11/12	12/13	13/14	Aim for 13/14	Achieved
2.1.1	Increase access to TIA (transient ischaemic attack) services within 24 hours	39.2%	53.3%	69.8%	>63%	✓
2.1.2	Admission to stroke unit within 4 hours of arrival		47.4%	66.3%	>=90%	×
2.1.3	CT Scan within 60 minutes of arrival	39.2%	41.9%	87.8%	>=50%	✓
2.1.4	90% time in dedicated stroke unit	83.8%	79.4%	72.7%	>=80%	=
2.2	For all mortality indicators please see pages 37-40					
2.3.1	Emergency admissions - Monitoring CQUIN milestones	N/A	N/A	Being verfied	Comply	
2.3.2	Emergency admissions - AMBER rollout	N/A	N/A	Ended	Comply	=
2.3.3	Emergency admissions - consultant staff cover at weekends	N/A	N/A	↑	↑	✓
2.4	Enhanced recovery - implementation of plan	N/A	N/A	Partial	Comply	=

The excellent bedside manor of the consultants carefully explained all the options for my treatment in a language that I could understand in order to help me to make informed decisions.
Urology Dept
(Source: NHS Choices, Dec 2013)

Fundraising award winners

Camilla Hamilton runs the 'families group' made up of parents of early babies.
Kerry Duggan, Forster suite—rides her bike to raise money for the department treating people

2.1: Stroke

Access to TIA Services

The Trust continues to make improvements in delivering in this area and performance has surpassed the aim for 2013/14 due to closer working with GPs and an increased number of stroke consultants.

As this performance has been sustained it will be retired as an indicator in 2014/15 although will continue to be monitored as part of the Trusts regular monitoring of all stroke standards.

Admission to stoke unit within 4 hours

This aim continues to be challenging. Although improvements have been made since 2012/13 the aim that 90% of stroke patients are admitted to the stroke unit within 4 hours of arrival has not yet been achieved.

The key reason for these breaches was delay in decision making in the Emergency Department (ED). The medical records of patients where a late decision to admit has been made are re-viewed by a senior doctor to establish if there were opportunities for an earlier diagnosis. A member of the stroke team now visits the ED routinely to identify new stroke patients and as-sist their speedy transfer to the stroke unit.

The Trust continues to have between 8-10% of the stroke beds occupied by patients that could be cared for in a non-acute setting. The Trust continues to work with community partners and commissioners to support earlier discharge and to consider how to create additional stroke beds in the hospital.

CT scan within 60 minutes

Continued and sustained improvements in this area can be seen with the aim for 2013/14 being surpassed.

It is recognised that patients attending the ED with unusual presentations of stroke are at risk of having a delay in diagnosis and therefore scan, which would ultimately affect this performance. On-going education is in place to support recognition.

As this performance has been sustained it will be retired as an indicator in 2014/15 although will continue to be monitored as part of the Trusts regular monitoring of all stroke standards.

90% of time on stroke unit

Improvements in this aim have not been seen during the last few years. The aim that overall in 2013/14 80% of stroke patients will spend 90% or more of their time on a dedicated stroke ward has not been achieved throughout the year.

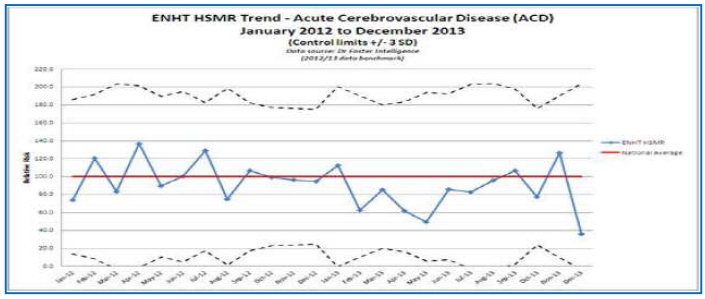
The Trust has set internal targets increasing the percentage month by month and by January 2014 this target was surpassed at 88.5%.

The key reason for breaches is the delayed transfer of care to more appropriate community placements.

Stroke Mortality

Mortality (death) rates following a stroke are overall lower at our Trust compared to the national average. Most recent data shows a HSMR (see page 21) of 82.1 for 13/14 compared with 98.6 in 2012/13.

The graph below shows data from January 2012. The national average of 100 is shown by the red line with the Trust mortality rates largely being below this line, hence a better survival rate.



(Hospital Standardised Mortality Ratio)

During the year two new stroke consultants were recruited and the number of available medical staff out of hours was increased from August.

I visited the TIA Clinic on the 6th Floor. Firstly the Receptionist was friendly and helpful. I only waited a few minutes before seeing the Doctor, who again was extremely helpful, professional and informative...all the staff concerned could not have been more friendly, efficient or helpful..
(Source: NHS Choices, July 2013)

2.2: Mortality

For details of mortality please refer to pages 37-40.

2.3: Emergency admissions

Monitoring of CQUIN milestones

Reducing emergency admissions

A number of projects are underway to reduce emergency admissions across the health economy by 10%. Actions underway to reduce such admissions involve the following:

- Strengthening ambulatory care where a patient is seen just for the day for treatment and is not admitted. Ambulatory care is used by approximately 800 patients per month. Usage has not seen a significant increase over the year.
- Investigating rapid access clinics so people can undergo diagnostic procedures without requiring admission beforehand
- Extending length of time that consultants can see patients in assessment units (consultants are less likely to admit patients than junior doctors)
- Working with the commissioning and community and partners to look at developing new pathways to prevent admission
- Working with community partners to assess patients at home rather than in hospital where the assessment is more realistic and more effective care packages can be put in place

Amber roll-out

The care bundle known as

Assessment
Management
Best practice
Engagement
Recovery uncertain

has been used to care for patients where their recovery is uncertain and who are at risk of dying in the next one to two months.

It's use was rolled-out to three wards but the project ended in October when funding came to an end. The palliative care team are now working on a revised end of life care pathway which will be in use by July 2014.

Consultant staff cover at weekends

The number of consultant staff has been increased both during the week and at the weekend.

2.4: Enhanced recovery

The enhanced recovery (ER) programme is about improving patient outcomes and speeding up a patient's recovery after surgery. This means they go home sooner with less complications.

There are four elements to the enhanced recovery programme:

- Preoperative assessment and preparation
- Reducing the stress of the operation
- Optimim care and treatment post-operatively including pain relief
- Early mobilisation

Enhanced recovery is used in the Treatment Centre, primarily for patients undergoing orthopaedic procedures. Patients are asked to attend 'joint school' where they find out about their surgery and their treatment goals. The principles of ER are also applied within colo-rectal surgery and urology.

The Enhanced Recovery In-patient Care pathway has been updated and is in use at Treatment Centre & in Urology.

There is currently no dedicated lead for the enhanced recovery programme so obtaining statistics for evaluation work is limited at present.

My husband was rushed to a&e on deaths door he was admitted in hdu the care he received was amazing they took wonderful care of him ...he is back to full health thanks to the lister nurses and doctors
(Source: NHS Choices, May 2013)

Priority 3 – Staff development / engagement

Priority 3 SUMMARY

		11/12	12/13	13/14	Aim for 13/14	Achieved
3.1	Improve staff survey score for job satisfaction	3.49	3.62	3.59	>=3.64	✘
3.2	Improve staff survey score for team working	3.63	3.78	3.70	>=3.78	✘
3.3	Improve staff survey score for recommending the Trust as a place to work / receive treatment	3.49	3.62	3.73	>=3.73	✓

Note:
Please refer to section 3b 'our staff' for a general overview of actions underway within the Trust to support staff and improve their working lives.

3.1: Job satisfaction

The National Staff Survey 2013 results indicate that the Trust has not met its aim of achieving a score of 3.64 or above for staff satisfaction.

The score of 3.59 is in line with the national average and has stayed static compared with 2012 results.

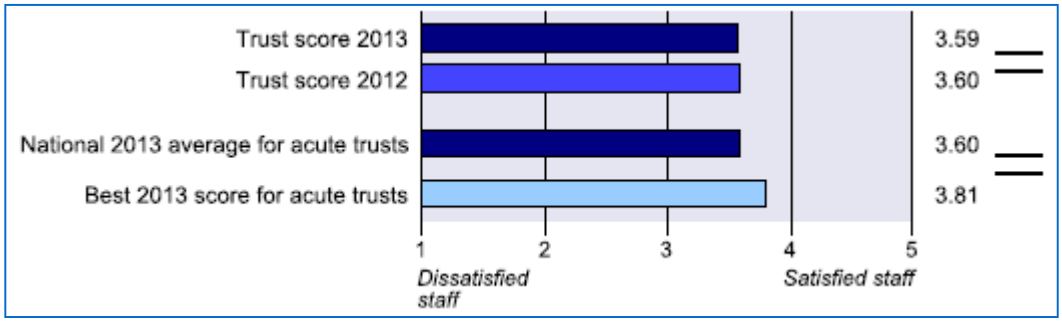
The group of staff who responded to this survey also identified work pressure and longer hours as being a matter of concern. It is likely that these factors are linked.

The Trust is using the staff development Sessions, known as ARC< in the spring 2014 to consider the survey results in detail and to establish an action plan.

The Hospital staff are the real key to making your treatment at Lister Hospital a pleasant experience. Throughout my treatment there, my dealings with the staff, from consultants to nursing staff has been exemplary.
January 2014
(Source: NHS Choices)

The Trusts own quarterly 'Finger on the Pulse' survey showed the following results:

- April to June: 3.31
- July to September: 3.68
- October to December: 3.68



Importantly the same group of staff have reported that they feel satisfied with the quality of care they are able to deliver.

In fact the Trust is one of the **best 20% of Trusts** on this matter.

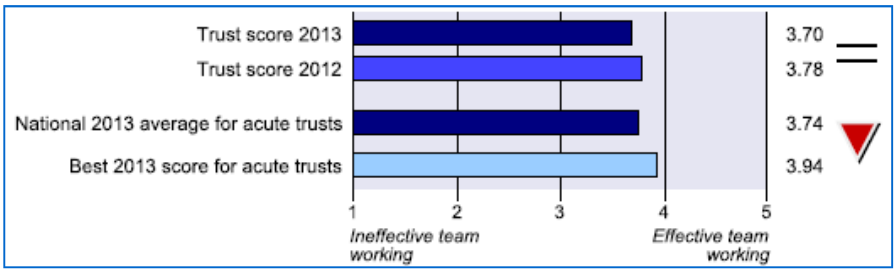
3.2: Team working

The National Staff Survey 2013 results indicate that the Trust has not met its aim of achieving a score of 3.78 or above for team working.

The score of 3.70 is **worse than average** and has stayed the same statistically compared with last year.

The Trusts own quarterly 'Finger on the Pulse' survey showed the following results, with quarters 2 and 3 results exceeding the aim:

- April to June: 3.73
- Jul y to September: 3.82
- October to December: 3.82



The Trust is using the staff development sessions in the spring 2014 to consider the survey results in detail and to establish an action plan.

3.3: Recommending the Trust

This section is reported on page 43 as one of the new mandatory indicators.

The Trust score was **better than average** for this indicator.

Staff engagement

With a Trust score of 3.76 the staff engagement indicator is both an improvement upon last years score and is also slightly better than the national average score.

This score is made up of a composite of three scores:

- Staff members' perceived ability to contribute to improvements at work
- Staff willingness to recommend the Trust as a place to work or receive treatment
- The extent to which staff feel motivated and engaged with their work

Team award winner

Renal satellite project team

"By working as a team,
they won the bid to build and run two new state-of the-art dialysis units in Bedford and Harlow."

(Bridget Saunders, General Manager)

Priority 4 – Further improve experiences

Priority 4 SUMMARY

		12/13	13/14	Aim for 13/14	Achieved
4.1.1	Number of referrals to the Learning Disability Team		**218**	Not defined	N/A
4.1.2	Carers Survey - discharge		**77%**	Not defined	N/A
4.1.3	Staff training on dementia		**396**	Increase	✓
4.2	Friends & Family Test - maternity* - please see page 47				
4.3.1	Diabetes survey	N/A	**50%**	70%	✗
4.3.2	Number of patients with insulin pump access	80	**101**	Increase	✓

*In the 2012/13 Quality Account this was planned for paediatrics. However no national agreement has been made so the indicator has been revised to maternity which was introduced in the year.

4.1

4.1.1 Referrals to the Learning Disability Team

The Learning Disability (LD) Liaison Nurses have Worked with **218** patients during 2013/14 (176 at Lister Hospital; 42 at QEII Hospital).

The Health Liaison Team have delivered Learning Disability Awareness training to 256 staff and shared the work achieved within the Trust with the Learning Disability Partnership Board and Hertfordshire Partnership Foundation Trust colleagues.

Queens Wing are currently working towards being the first clinical area to be awarded the Councils "eQuality for people with learning disabilities" quality standard as part of the Purple Strategy in Hertfordshire.

eQUALITY
for people with learning disabilities

The Trust has a Learning Disability Group which oversees the implementation of the LD action plan.

One of the significant tasks completed this year relates to early identification of people with LD. Using shared local authority records the Trusts patient register has been updated with details of all known LD residents in Hertfordshire. This will help to recognise the needs of these patients when attending hospital in future.

The Learning Disability sub group has also overseen the following:

- Developed an Easy Read Discharge Booklet to improve the handover of information; and an Easy Read version of the Trust Patient Survey so that people with LD can contribute
- Commenced Walking the Wards Audits to assess current practice within the clinical areas and support learning through ward based actions
- Reviewed the LD Admission Policy including Care Pathways and contributed to the development of the Trust Carer Policy to give guidance to staff about the need to support a carer along with the patient
- Increased the number of LD Champions within clinical areas
- Introduced a quarterly report summarising patient feedback gathered through our Service User Evaluations

Louise Jenkins
Health Liaison Team Lead Nurse and Clinical Supervisor

The Trust has also secured £300K funding for Research for Patient Benefit working with Cambridge University, Addenbrookes Hospital and Hertfordshire Health Liaison team to look at "Characterising the experiences of men and women with learning disabilities following inpatient admission to general hospital." This research will start in 2014/15.

4.1.2 Carers Survey

The carers survey is sent to a random selection of patients identified on the patient register as having a carer. Copies are also available from the 'This is Me' booklet and in carers packs.

111 surveys were completed between July 2012 and January 2014 with an overall satisfaction rate reported at 82.76. More specifically:

- 77% of carers had discharge arrangements discussed with them
- 94% of carers are treated with respect and dignity
- 97% were able to visit as frequently as Necessary and when convenient

The main areas of concern were that carers felt they were not visited by the dementia or learning disability champions. Further investigation has shown that visits had occurred but the champions had not been recognised as such.

Due to the small number of responses the survey has been revised with the assistance of the Carer Friendly Hospital Group, Carers in Herts and the Trusts Carers Lead. It is now shorter and focuses on the support aspects.

The Trust has a Carer's Focus Group which meets intermittently to discuss a range of relevant matters. In December 2013 the group received a manual handling training session specifically for carers and discussed the role of the Discharge Team.

The Trusts Carers Lead has been instrumental in improving services and support available to carers. For example:

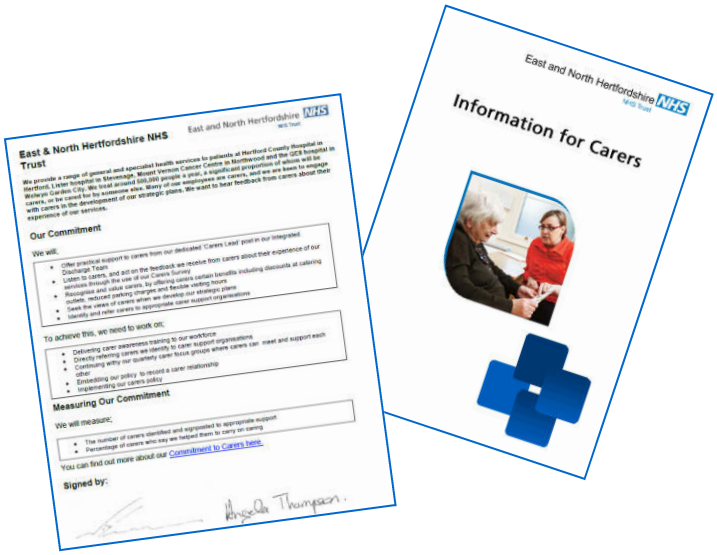
- Carers can now complete, together with clinical staff, a Carers' Agreement which sets out tasks and boundaries for the carer whilst their cared for is in hospital
- A new Carers Policy outlines certain privileges for carers including discounts on parking, catering and the health shuttle
- A carers' leaflet has been produced, and guidance for carers is now available on the Trust website
- There are dedicated carer information boards
- Regular carers' coffee mornings are held

Formal carer awareness training has been attended by 56 members of staff with a further 65 receiving an informal talk on carer awareness. This has improved staff awareness of the needs of carers and the local organisations available to help them.

Where carers have been identified and supported we have seen earlier discharge, reduced length of stay and reduced readmission.

The Trust has made a Commitment to Carers (below) which is available on the Trusts website:

http://www.enherts-tr.nhs.uk/patients-visitors/our-services/carers-support/



4.1.3 Staff training on dementia

396 staff members are clinically trained in dementia awareness through both the University of Hertfordshire and in-house training supported by the RAID (Rapid, Assessment, Interface, Discharge) team.

Implementation of the Trusts Dementia Strategy is overseen by the Dementia Working Group supported by our older persons psychiatry team and adult safeguarding lead.

The team has developed care pathways, worked closely with dementia champions throughout the Trust and is currently working to develop personalized care plans.

During 2013/14:

- 83% of patients over the age of 75 were assessed for possible dementia within 72 hours of admission
- 100% of appropriately identified patients were referred for specialist diagnosis

The RAID team can review patients referred to them 7 days a week and patients with a suspected diagnosis of dementia are able to have many of their investigations carried out during their stay in hospital.

A patients and carers communication lead has been appointed to ensure patients and carers feel fully involved and supported.

We continue to improve the understanding and skills in caring for people with dementia by educating and training 'Dementia Champions'.

"This is Me" booklets, produced by the Alzheimer's Society are now in use. These give detailed information about patients needs, likes, preferences, dislikes and interests which helps when planning individualized care. Posters advertising these booklets are now displayed around the Trust and the newly appointed Dementia Nurse works closely with Dementia Champions on the wards to promote the use of this booklet.

Volunteers have continued to be busy making activity blankets for patients who have dementia or are confused.

CQC assessment of dementia

The Care Quality Commission visited the QEII Hospital in February 2014 as part of an unannounced themed inspection looking at the quality of care provided to support people living with dementia.

The assessment team looked at the personal care or treatment records of service users, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. They talked with staff and with people who use the service, including carers and family.

The visit was extremely positive with good feedback on our current standards of care. The Trust passed all three quality standards that were assessed.

4.2: Friends & Family Test —maternity

Please refer to page 47 for details of this.

4.3: Diabetes care

4.3.1 Diabetes survey

Quarterly diabetes surveys have been introduced. Between July and December 50% of patients (based on 100 responses) reported that that they did not find themselves in a difficult situation regarding their diabetes management, for example having high or low blood glucose levels or having a change in mealtimes.

The diabetes team are working with nursing staff, catering staff and pharmacy staff to improve these results. Also:

- Diabetes support by specialist nurses is now available 7 days per week
- Next working day paediatric diabetic review commenced in Sept
- Insulin safety e-learning has been rolled out
- 2 new diabetes consultants commenced in October
- The number of clinic appointments has increased to match demand

4.3.2 Insulin pumps

43 children are using these pumps

101 adults are using insulin pumps

Insulin pumps are about the size of a mobile telephone and have a reservoir which holds around three days supply of insulin. It is battery operated and delivers insulin throughout the day and night through a small tube connected to a needle (known as a cannula) placed just under the skin. The insulin dose is pre-determined and is individual to the person. During mealtimes the pump can be primed to deliver a boost of insulin.

The benefits of insulin pumps are:

- Keeping blood sugar levels more constant
- Reducing the need for multiple injections of insulin
- Not being restricted at mealtimes, therefore a better lifestyle
- Fewer episodes of low blood sugar levels

Pumps are not suitable for everyone so careful user selection, education and support is required.

Indicator monitoring by month

The chart below and on page 28 shows the breakdown of data by month, quarter or year.

No	Indicator	Plan for 2013/14	Freq of reporting	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Clinical Outcomes															
2.1.1	Stroke: TIA access & high risk treatment within 24 hours	>=62.5%	M	61.90%	81.00%	78.90%	72.20%	47.60%	87.90%	71.40%	66.67%	64.00%	63.64%	64.00%	
2.1.2	Stroke: admission within 4 hours of arrival	>=90%	M	51.30%	76.30%	75.00%	57.60%	70.50%	73.50%	68.60%	55.56%	71.88%	75.00%	58.10%	
2.1.3	Stroke: scanned within 60 minutes of arrival	>=50%	M	83.30%	94.70%	100.00%	93.30%	95.70%	77.80%	73.90%	83.33%	81.25%	100.00%	88.89%	
2.1.4	90% of stay on stroke unit	>=80%	M	73.20%	73.80%	81.80%	64.90%	71.40%	67.60%	75.00%	73.17%	69.44%	88.46%	64.52%	
2.2.1	HSMR (3 month arrears)	96	M	87.65	89.73	86.98	82.5	76.87	98.95	94.39	87.46	90.52	92.2		
2.2.2	SHMI	<=105	Q	111.39			113.88			111.94			111.76		
2.2.3	SHMI (without pall. care)	<=100	Q	102.04			103.55			100.55			100.43		
2.2.4	HSMR (Septicaemia)	<=100	M	85.5	45.4	33.1	62.4	34.6	125.7	87.4	0	62.3			
2.2.5	HSMR (Acute Renal Failure)	<=100	M	136	78.9	100.7	28.4	124.4	47	51.2	98.6	105.8			
2.2.6	HSMR (UTI)	<=100	M	111.9	136.6	179.5	60.7	60.8	107.1	52.2	73.3	47.8			
2.2.7	HSMR (AMI)	N/A	M	50.1	153.1	134.2	155	121.4	112.8	0	143.5	67.5			
2.2.8	HSMR (CCF)	N/A	M	169.1	46.2	23.8	52.6	23.9	141.3	124.5	134.9	113.8			
2.2.8	HSMR (Pneumonia)	N/A	M	86	96.9	79	97.4	61	93.2	86.5	75.5	99.6			
2.2.9	HSMR (Fractured hip)	<=100	M	85.2	74.7	81.3	90.5	47.9	55.6	69.8	39	28.3			
2.3.1	Emergency admissions - Monitoring CQUIN milestones	N/A	Q	Joint plan established with Herts Community Trust									CQUIN data being validated		
2.3.2	Emergency admissions - AMBER rollout	N/A	Q				Rolled out to 3 wards at QEII			Project ended on 1st October					
2.3.3	Emergency admissions - consultant staff cover at weekends	Increase	Year end												
2.4	Enhanced recovery - implementation of plan	N/A	Q	In place for Trauma & Orthopaedics. Principles being followed in Colorectal & Urology											

No	Indicator	Plan for 2013/14	Freq of reporting	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Safety															
1.1	Reduce number of in-patient falls resulting in serious harm	<14	M	2	1	1	2	0	0	1	2	1	1	2	2
1.2	Reduce number of preventable hospital acquired pressure ulcers	1.07%	M	0.30%	0.95%	0.63%	0.85%	0.85%	0.16%	0.16%	0.81%	0.16%	0.94%	0.82%	0.48%
1.3	Introduce regular nutrition audits on the ward														
Staff Engagement															
3.1	Improve staff survey score for job satisfaction	>=3.64	Q	3.31			3.68			3.68			3.59		
3.2	Improve staff survey score for team working	>=3.78	Q	3.73			3.82			3.82			3.7		
3.3	Improve staff survey score for recommending Trust as a place to work / receive treatment	>=3.73	Q	3.54			3.77			3.77			3.73		
Patient Experience															
4.1.1	Number of referrals to the Learning Disability Team		M	218											
4.1.2	Q16 Carers survey (Discharge plans)	Not defined	M	77% (July 2012 - January 2014)										New survey designed & launched	
4.1.3	Staff with dementia training	Increase	Year end	396											
4.2	Maternity - introduce October. 15% response rate	15%	M							20.12%	18.91%	17.19%	20.10%	10.32%	31.82%
4.3.1	Diabetes survey*	70%	Q				50%			50%			Being validated		
4.3.2	Diabetes - number of patients with insulin pump access	Increase	Year end	101 adults, 43 children											

2b Statement of assurances from the Board

In this section "East and North Hertfordshire NHS Trust" will be presented as 'ENHT'. Please note that we are required to use specific words and sentences to describe services and results.

Review of services

During 2013/14, the East and North Hertfordshire NHS Trust (ENHT) provided and/or sub-contracted 30 NHS services. The ENHT has reviewed all the data available to them on the quality of care in 30 of these NHS services. The income generated by the NHS services reviewed in 2013/14 represents 100% of the total income generated from the provision of NHS services by the ENHT for 2013/14.

Jane Knight, Gary Slater and Patti Ortenzi from the Trust's resuscitation team won a prize from the National Cardiac Arrest Audit for timely data entry.

Up against around 165 hospitals the Trust was pleased to receive this award.

The aim of the audit is to improve resuscitation care and patient outcomes for the UK and Ireland.

Participation in clinical audits

The Trust has an extensive clinical audit programme. Each year all clinical teams produce a 'forward plan' of audits to be undertaken throughout that year. An overview of the audit plan for the year, summarising the 687 audits, is given in the table below.

During 2013/14, 40 national clinical audits and 4 national confidential enquiries covered NHS services that the ENHT provides. During that period, the ENHT participated in 38 (95%) national clinical audits and 4 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Division	National & regional priority	Trust priority	Departmental priority	Total
Cancer	14	11	59	84
Clinical Support	3	6	49	58
Medicine	56	61	82	199
Surgery	30	60	133	223
Women's & Children's	47	24	47	118
Trust	2	0	3	5
TOTAL	152	162	373	687

The tables on pages 30-32 show:

- The national clinical audits and national confidential enquiries that ENHT was eligible to participate in during 2013/14
- The national clinical audits and national confidential enquiries that ENHT participated in during 2013/14
- The national clinical audits and national confidential enquires that ENHT participated in, and for which data collection was completed during 2013/14, 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.

Relevant national confidential enquiries

	Trust Participation	% Cases submitted
NCEPOD Lower Limb Amputation	✓	100%
NCEPOD Tracheostomy Care Study	✓	100%
MBRRACE – UK 2013 - 2014	✓	100%
CHR-UK (RCPCH) Child Mortality 2013-14	✓	100%

Relevant national audits

Key: IP—In Progress

Acute Coronary Syndrome or Acute Myocardial Infarction	Trust Participation	% Cases submitted
Adult Community Acquired Pneumonia	✓	100%
Adult Critical Care (Case Mix Programme)	x[1]	N/A
Bowel Cancer	✓	100%
Cardiac Arrhythmia	✓	100%
Chronic Obstructive Pulmonary Disease	✓	IP
Coronary Angioplasty	✓	IP[2]
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	✓	100%
Diabetes (Paediatric)	✓	100%
Elective Surgery (National PROMs Programme)	✓	100%
Emergency Use of Oxygen	✓	100%
Epilepsy 12 Audit (Childhood Epilepsy)	✓	IP
Falls and Fragility Fractures Audit Programme, (National Hip Fracture Database)	✓	100%
Head and Neck Oncology	✓	100%
Heart Failure	✓	100%
Inflammatory Bowel Disease	✓	100%
Lung Cancer	✓	100%
Moderate or Severe Asthma in Children (Care provided in Emergency Departments)	✓	100%
National Audit of Dementia	Withdrawn nationally	N/A
National Audit of Seizure Management (NASH)	✓	100%
National Cardiac Arrest Audit	✓	Awaiting
NHSBT (NHS Blood and Transplant) Audit of Patient Information and Consent	x[3]	N/A
NHSBT Anti-d	✓	100%
National Emergency Laparotomy Audit	✓	IP

Relevant national audits (cont.)

	Trust Participation	% Cases submitted
National Joint Registry	✓	Continuous
National Vascular Registry, including CIA (Carotid Interventions Audit) and elements of NVD (National Vascular Registry)	✓	100%
National Neonatal Audit Programme (NNAP)	✓	100%
Non-invasive Ventilation - Adults	✓	Awaiting
Oesophago-gastric Cancer	✓	100%
Ophthalmology Audit	Nationally not started	IP[4]
Paediatric Asthma	✓	Awaiting
Paracetamol Overdose (Care provided in Emergency Departments)	✓	100%[5]
Prostate Cancer	✓	IP[6]
Renal Replacement Therapy (Renal Registry)	✓	IP
Rheumatoid and Early Inflammatory Arthritis	✓	IP (2017)
Sentinel Stroke National Audit Programme (SSNAP), includes SINAP (Stroke Improvement National Audit Programme)	✓	IP[7]
Severe Sepsis & Septic Shock CEM	✓	100%
Severe Trauma (Trauma Audit & Research Network)	✓	100%
National Diabetes in Pregnancy (NPID)	✓	100%
Heavy Menstrual Bleed	✓	IP[8]

[1] In common with most other Trusts, the Respiratory specialty agreed not to audit all the BTS topics this year and also, with the approval of the Associate Medical Director (Clinical Governance), to set up their own 3-year audit programme on these BTS topics from 2012/13 onwards.

[2] There was a delay in the uploading of patient data to the database owing to IBM licensing issues. These have now been resolved and the backlog will be cleared soon.

[3] The Haematology Department has been heavily involved in both the implementation of a new blood tracking system (a major safety initiative which will reduce errors occurring in blood transfusion) and the reconfiguration of pathology services across the region, (Transforming Pathology Partnerships). In view of this the Department reluctantly decided that it did not have the resources to undertake this audit as well, and so asked if they could be exempted from participation. In the circumstances, this was agreed.

[4] A contract for this audit was not awarded to any sponsoring body, and it therefore did not start.

[5] Lister Hospital results have been amalgamated with the QEII results as there was a difficulty with getting the required number for the QEII.

[6] Only an organisational questionnaire was required for this audit, and this has been completed and submitted

[7] There were major technical problems with uploading from Network records to the SSNAP website between October and November 2013, but these have now been resolved. Data for the first 2 months have been uploaded and work is continuing on uploading the rest.

[8] Only an organisational questionnaire was required for this audit, and this has been completed and submitted.

National audits not relevant to the Trust

National audits relevant only to Mental Health Trusts:

- National Audit of Schizophrenia

National audits where services are not provided by the Trust:

- Prescribing Observatory for Mental Health (POMH-UK)
- Adult Cardiac Surgery Audit
- Chronic Kidney Disease in Primary Care
- Congenital Heart Disease (Paediatric Cardiac Surgery)
- Paediatric Intensive Care
- Pulmonary Hypertension
- Specialist Rehabilitation for Patients with Complex Needs

Diabetes specialist nurses promoting World Diabetes day in November to increase general awareness about the condition

National audits: - the findings

The reports of the following national clinical audits were reviewed by the provider in 2013/14 and the ENHT intends to take / has taken the following actions to improve the quality of healthcare provided.

National Heart Failure Audit Report 2013

The Gap Analysis found the Trust's service to be partially compliant, with some improvement compared to previous year, for example in receiving echo test, referral to a specialist cardiology ward, and referral to cardiology follow-up. The Trust has an action plan to ensure more patients are managed on cardiac wards and by cardiologists: - this is being addressed in the Reconfiguration work, including a new ward block that will increase the bed complement. Future action for the Trust's Cardiology service is to develop an in-patient heart failure service, requiring an increased number of inpatient heart failure nurses, and to build a multidisciplinary heart failure team.

Quality Standard QS19 (CG102 Clinical guideline): Bacterial meningitis and meningococcal septicaemia

The Children's Services acute team has audited and fully implemented the recommendations from CG102 to meet the Quality Standard. Actions taken have included rolling training sessions for clinical and nursing staff, and a new Trust guideline has been written.

Quality Standard QS35: Hypertension in Pregnancy

At publication current practice and key maternity guidelines demonstrated compliance with most of the quality standards. An action plan was created and all actions completed by January 2014. These have included updating the guideline, communication to all staff of changes, and Laminated posters on the postnatal ward.

National Paediatric Diabetes Audit Report 2013, and local Paediatric Diabetes audit

The Trust has participated in the National Paediatric Diabetes Audit (NPDA) since it started in 2010. Due to inherent problems in data collection the Paediatrics Diabetes leads have therefore introduced a three monthly audit cycle in line with the NICE Key care processes in the NPDA dataset. Overall results for the first local audit are indicative of good clinical performance, eg measurement of Hba1c, at 99% for the Trust, is in the upper quartile of Trust performance, and in the highest performers in the Herts and Beds Network. The local audit of BMI and Blood Pressure checks showed 95% compliance.

Quality Standard QS32 Caesarean Section

Review of the service showed that the Trust was fully compliant in 7 of the 9 quality statements. The 2 quality statements in which we were partially compliant were fully implemented by January 2014, including amendment of patient information leaflet, and a Trust guideline to include discussion with women and documentation on birth options for future pregnancies.

BCIS National Audit Percutaneous Coronary Interventional Procedures Annual Public Report 2012

The Gap Analysis of the PCI 2011-12 audit results showed the Cardiology service to be compliant in facilities and equipment, cardiac surgical service support, Institutional PCI volume, and staffing requirements. A second fixed Catheter Laboratory was commissioned in 2011, and the service is being developed to provide a 24/7 PPCI service, due to be implemented in April 2014.

Quality Standard QS49 Surgical Site Infection

The Gap Analysis showed the Trust was fully compliant with 4 of the 7 quality statements, and an action plan covering improvement in key areas to achieve compliance has been ongoing. These include a focus on patients with hypothermia preoperatively, for which an action poster has been displayed and an audit undertaken; scrubbing and gowning techniques have been improved by reassessment and implementation of best practice in gloving and gowning technique, new scrubs have been introduced for operating staff only, and also a single patient information leaflet on discharge has been introduced.

Quality Standard QS39 Attention deficit hyperactivity disorder

The Children's Services community team are compliant in having an ADHD pathway implemented in the Trust, and also maintain close relationships with community mental health teams. Actions have been ongoing to improve integration across the healthcare services pathway, including an action for improved access to community psychological group treatment programmes. The team are working with the CCG to obtain funding to increase ADHD clinics, requiring recruitment of additional specialist ADHD nurses, which will improve monitoring and follow-up, and improve patient outcomes for quality of life.

Departmental audits: - the findings

The reports of all completed local clinical audits were reviewed by the provider in 2013/14 and the ENHT intends to take the following actions to improve the quality of healthcare provided. (Details taken from the Outcomes Forms/Action Plans that Audit Leads are required to complete once an audit has been undertaken and presented.)

Oesophagoscopy Audit

The appointments system has been reviewed and there is now closer scrutiny when patients appointments are postponed. The department is in the process of purchasing equipment for trans-nasal oesophagoscopy.

Gentamicin Use and Therapeutic Monitoring

The Gentamicin Guideline is being revised and a nomogram for accurate re-dosing is being Introduced. A gentamicin sticker is being produced and instructions for its use publicised.

Effective Utilisation of Trauma Theatre Time

Urgent transfer of notes from QEII Fracture Clinic to Lister Trauma to be labelled as 'next day admission' on a customised form for collection by the Orthopaedic on call- team. Clerking of patients, investigations and consent is to be completed in A&E or Fracture Clinic before admission. To avoid delays in the theatres regular checks of trauma instruments trays to be carried out.

CG103 Delirium

Introduced use of CAM (Confusion Assessment Method) Score. Implemented Delirium diagnosis on Trust information system (BIMS) as mandatory. Education/training to be provided to junior doctors/medical staff re delirium in the form of e-module assessment and lectures. Posters introduced in A&E/AAU/Geriatric wards re delirium. Written information is to be produced and given to patients who have delirium, and their relatives.

NICE Clinical Guideline CG79: Rheumatoid Arthritis

DAS 28 (Disease Activity Score) to be carried out and documented at each visit. Aiming for 6 weekly visits for early arthritis patients. HAQ (Health Assessment Questionnaire) to be used for every new patient, and yearly thereafter. To use a clear documentation of co-morbidities & a clear assessment of complications.

Vaginal Birth after Caesarean

The importance of an initial discussion to be stressed in discussion with Antenatal / Community Managers and disseminated to staff via Message of the Week. The current flow chart is to be revised to make referral pathways clearer and ensure appropriate services are offered.

Documentation 2013-14 (Renal Medicine)

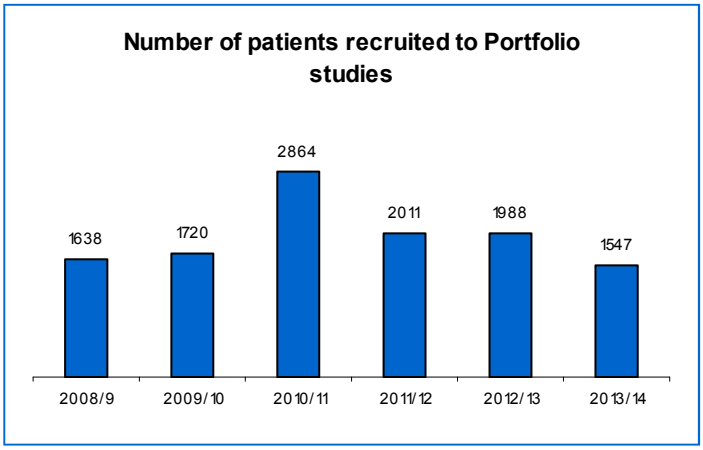
Signature stamps for junior doctors are to be issued by the Renal Department).

Children Presenting with Genital Injury Audit

Continued training of A&E, Gynaecology and Urology staff in Child Protection to make them aware of the need to go through the checklist sticker for Child Protection that is now routinely attached to all CAS cards. Regular training to be instituted for Paediatric staff about non accidental injury and genital anatomy.

Research and development

The number of patients receiving NHS services, provided or sub-contracted by the ENHT in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 1547 according to the latest figures available. In 2013/14 the National Institute for Health Research (NIHR) supported 94 actively recruiting studies through its research networks.



The Trust supports a strong and varied portfolio of research projects. Particular areas of strength include cancer research and renal medicine, with the Trust also providing regional services in these areas which have achieved both national and international recognition. Other areas of strength include cardiology, diabetes and urology. More information about our research activity and the impacts that follow are available in the ENHT Annual Report.

Systems are in place within the Trust to ensure that the principles and requirements of research governance are applied consistently, through a full set of policies and standard operating procedures, which have been ratified by the Trust. In connection with this, during 2013/14 the Trust hosted an MHRA Good Clinical Practice Inspection, which had a satisfactory outcome.

Research staff at ENHT led an initiative to increase the profile of clinical research with patients and the general public at all Trust sites, supporting and implementing the 'OK to ask' campaign – led by the National Institute for Health Research to encourage patients to ask their clinicians about clinical research.

The new Lee Haynes Research Institute was officially opened on 28th February at the Lister site. It includes offices, laboratory facilities and treatment rooms. The facility was funded by £55,000 raised by the family and friends of Lee Haynes, a former renal patient.

A National Institute for Health Research's Annual Best Practice in Research Achievement Awards was given to Professor Diana Gorog (Consultant in Cardiology) for outstanding achievement in recruiting to national industry studies.

Tackling noise at night...

A local committee comprising Trust and university staff together with patient and carer representatives, using funding from the National Institute of Health Research (Research for patient Benefit Programme), has undertaken a trial on sound-masking to reduce noise at night.

"Sound masking adds a non-intrusive background noise to an area that raises the background ambient noise levels. This could mean that when extra noise is added to an area, such as a patient being admitted to the ward, there is less difference between the background ambient and the new noise with less likelihood of waking other patients.

A feasibility exercise was performed, where sound masking was installed on a ward to assess for ease of installation and the effects on patients and staff. The results were all positive, with some patients finding noise levels unacceptable the week prior to the installation, but the week post installation all patients found the levels acceptable.

In mid summer, we will find out if the main committee will approve the application and fund a larger study in our Trust testing ceilings tiles and sound masking."

Julie Fillary, Senior Research Nurse

Goals agreed with commissioners

A proportion of the ENHT's income in 2013/14 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 NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at www.enht-tr.nhs.uk

	CQUIN	Weighting	Full value £	Achieved
1.1	Friends and Family: Phased expansion	1.5%	315,000	Being validated
1.2	Friends and Family: Improved response rate	2%		
1.3	Friends and Family: Staff test	1.5%		
2	NHS Safety thermometer: Improvement	5%	315,000	
3.1	Dementia: Find, assess, investigate and refer	3%	315,000	
3.2	Dementia: Clinical Leadership	0.5%		
3.3	Dementia: Supporting carers of people with dementia	1.5%		
4.1	Venous-thrombo Embolism (VTE): Risk assessment	2.5%	315,000	
4.2	VTE: Root Cause Analysis	2.5%		
5.1	Unscheduled Care: emergency admissions	12.5%	1,230,000	
5.2	Unscheduled Care: weekend discharge	12.5%		
6	Customer Focussed Care	15%	740,000	
7	Diabetes	15%	740,000	
8	Hospital Mortality	15%	740,000	
9	Chronic Obstructive Pulmonary Disease	10%	500,000	
		100%	**5,000,000**	

Statements from the Care Quality Commission

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is *registered with no conditions*. The CQC has not taken enforcement action against the ENHT during 2013/14.

The ENHT has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/14:

- The CQC carried out a routine unannounced inspection of the Lister Hospital on 5th and 6th of September 2013 and the Trust was found to be fully compliant with all five outcomes tested.

- The second inspection took place on 3rd February 2014 at the QEII Hospital and formed part of a national programme of themed inspections looking at the quality of dementia care. The Trust was found to be fully compliant with the three outcomes tested.

Lister Hospital

Coreys Mill Lane, Stevenage, SG1 4AB — Tel: 01438314333

Date of Inspections: 06 September 2013, 05 September 2013 — Date of Publication: September 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Queen Elizabeth II Hospital

Queen Elizabeth II Hospital, Howlands, Welwyn Garden City, AL7 4HQ — Tel: 01438314333

Date of Inspection: 03 February 2014 — Date of Publication: April 2014

We inspected the following standards as part of this inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Data quality

The ENHT submitted records during 2013/14 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 valid General medical Practice Code was:

	Included valid NHS Number	Included valid General Medical Practice Code
Admitted patient care	99.6%	99.5%
Out patient care	99.8%	99.8%
Accident & Emergency care	98.6%	98.1%

Information Governance

Information governance is about ensuring that information such as personal records is properly managed. Such information, whether paper or electronic needs to be cared for properly which means stored safely and accessed only by the right people.

The ENHT's Information Governance Assessment Report overall score for 2013/14 was **86%** and is graded '**satisfactory**'.

Clinical coding error rate

The ENHT was not subject to the *Payment by Results* clinical coding audit during the reporting period by the Audit Commission.

The Audit Commission Data Assurance Programme for 2013-14 was targeted at specific Trusts and specific areas of concern. Our data did not fall within the levels of concern so we were not selected for audit.

The results of the Information Governance coding audit which took place in March 2014 are in the table below. The department achieved Information Governance Level 3 for clinical coding accuracy. The figures for 2012/13 are shown in brackets.

ENHT has taken the following actions to improve data quality:

- Continued to work closely with clinicians to promote the clear documentation of primary and secondary diagnoses within the medical records
- Data review following mortality reviews where it is seen that in the most appropriate codes were not assigned in the first instance

Essentially Trust staff are continuing the work which was reported in last years quality account and are constantly looking for ways to make further improvements.

	Audit Commission	Information Governance Clinical Coding Audit
Primary diagnoses incorrect	N/A	4% (9.5%)
Secondary diagnoses incorrect	N/A	8.1% (6.7%)
Primary procedures incorrect	N/A	4.5% (5.6%)
Secondary procedures incorrect	N/A	4.7% (13.4%)

2c Performance against national core indicators

In section 2c, the outcomes of 9 mandatory indicators are shown and comparisons made with other organisations nationally.

For each of these indicators the ENHT considers that this data is as described for the following reasons—that this benchmarked data is the latest published data available via the Health and Social Care Information Centre (HSCIC) website. Where possible latest Trust data is also shown.

1. Summary Hospital Mortality Indicator (SHMI)

SHMI—what is this?

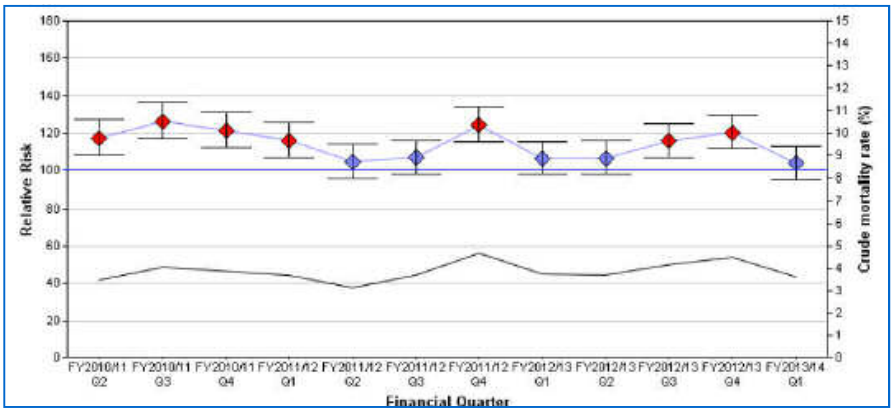
SHMI measures deaths that happen at hospital and within 30 days of discharge. It is the ratio between the actual number of patients who die following a treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the local population. It does not make an adjustment for palliative care ie those expected to die. SHMI data is 7-9 months in arrears.

	ENHT Previous Period	ENHT Current Period	National Current Period	National Best Performance	National Worst Performance
	Apr 12 – Mar 13	Jul 12 –Jun 13			
a) Summary hospital-level mortality indicator ("SHMI") value	1.12	**1.12**	1	0.63	1.156
a) SHMI banding	2	**2**	-	3	1
b) Percentage of patient deaths with palliative care coded at diagnosis or specialty level	44%	**44.1%**	-	0	44.1%

The latest data for October 2012 to September 2013, reported in April 2014, gives the SHMI at 1.12. This places the Trust in 130th position nationally out of 141 Trusts and is in the 'higher than expected' band.

The Trust is one of very few in England that delivers hospice care thus patients dying within the hospice are incorporated into the SHMI figures. Making an adjustment which removes the hospice factor results in an adjusted SHMI of 100.43 - just above national average.

The ENHT intends to take the following actions to improve these values, and so the quality of its services by continuing with the initiatives to reduce mortality eg. pathway reviews, mortality notes reviews and improved coding. Pages 39-40 provide summary details of some initiatives.



The chart shows a rolling trend for SHMI on a quarterly basis since 2010/11 against a 100 national average. (Note crude mortality rate on right axis).

It illustrates an increase in SHMI in the final quarter of 2012/13, which coincides with the national trend in higher mortality during the winter months. Improvement was seen in Q1 13/14.

Hospital Standardised Mortality Ratio

The definition of the HSMR is given in the yellow box below.

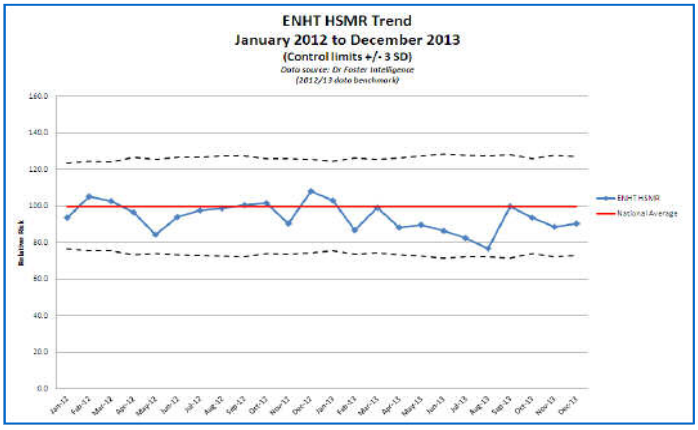
Reducing mortality is a key improvement priority for the Trust.

Trust HSMR has remained at or below 100 (national average) during the year. This means that less patients have died at the Trust than were statistically expected to die, given the characteristics of the population.

The Trust's position for the first nine months of 2013/14 is 4th out of the 17 acute Trusts (excluding the cardiac Papworth Hospital) in the East of England.

The graph (right) shows the changes since January 2012. The rate is calculated against a 2012/13 baseline. Later in the year the data will be rebased for 2013/14 once all national data becomes available.

A Mortality Review Group reviews the medical records notes of every patient who has died within the Trust. This is to determine whether anything could have been done differently to prevent that death. A database has been established to monitor the themes of these reviews and in 2014/15 the themes will be discussed by the Clinical Governance Strategy Committee.



		11/12	12/13	13/14	Aim for 13/14	Achieved
2.2.1	HSMR (mortality)	97.8	97	**88.96**	<=94	✓
2.2.2	SHMI (mortality)	114.1	111.4	**111.76**	<=105	✗
2.2.3	SHMI (adjusted for palliative care)	103.7	102	**100.43**	<=100	✗
	HSMR (Medicine)	105.2	103.9	**93.33**	96	✓
	HSMR (Surgery)	102.3	89.4	**82.58**	90	✓
	HSMR (Cancer)	61.3	62.9	**73.63**	75	✓
	HSMR (Women & Children)	37.4	110.2	**23.42**	85	✓

Note—HSMR figures are different to those reported in the 2012/13 report due to national rebasing against subsequent years data

HSMR – what is this?

The hospital standardised mortality ratio (HSMR) is a way of tracking a hospital's mortality over time. It is a measure of the number of people who **actually** die against the number who are **expected** to die.

Measuring mortality is complex. It is based upon the average mortality for 56 clinical conditions (affecting over 80% of our patients) which is adjusted to take account of the local population, eg age and illness. The figure excludes patients that are expected to die who have been referred for palliative (end of life) care.

An HSMR equal to 100 suggests that there is no difference between a local mortality rate and the average national rate. A HSMR below 100 means that a Trust is performing better than the average; a HSMR above 100 indicates a Trust performing worse than average.

Mortality for selected conditions

Mortality (using both HSMR and SHMI rates) are also monitored monthly for certain conditions. Details of the mortality rates associated with six conditions are given in the box below and are described in more detail on the following pages.

	Condition	HSMR 2011/12	HSMR 2012/13	HSMR Jan 13-Dec 13	HSMR July 12-Jun 13	SHMI Jul 12-Jun 13	Aim for 13/14	Met
2.2.4	Septicaemia	122	109.0	**69.1**	83.9	86.2	<=100	✓
2.2.5	Acute Renal Failure	113	101.3	100.2	85.5	**104.5**	Norm[1]	✓
2.2.6	Urinary Tract Infection	106.1	83.8	**89.2**	85.8	120.8	<=100	✓
2.2.7	Acute Myocardial Infarction	-	128.6	112.1	131.8	129.7	N/A	N/A
2.2.8	Congestive Heart Failure	108.1	103.6	96.4	94.2	**115.1**	Norm[1]	✓
2.2.9	Pneumonia	-	101.2	97.7	87.4	**107.9**	Norm[1]	✓

[1] The 'norm' aim is where the data is within normal limits for the SHMI indicator

Septicaemia

Septicaemia is infection in the blood. It can be fatal if not diagnosed and treated quickly.

Reduction in mortality as a result of septicaemia have been evident since 2011/12.

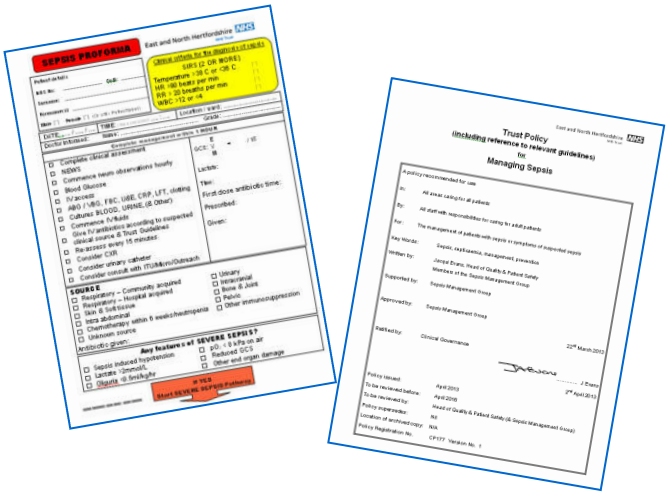
The following actions have been put in place during the year:

- Revision of a proforma to guide diagnosis and record treatment
- Review of guidelines
- Review of drug chart to make antibiotic prescribing clearer
- Launch of sepsis App
- Development of dedicated intranet page with all sepsis guidance in one place
- Enhanced teaching in induction and mandatory updates for doctors
- Launch of national observation chart for easier identification of the deteriorating patient
- Audits in critical care and emergency Department

Acute Renal Failure

Mortality associated with acute renal failure has seen significant improvement and outcomes are now within normal limits.

An Acute Kidney Injury App was launched this year and is in use to guide staff in the management of the condition.



Urinary Tract Infection

Improvements in the HSMR for urinary tract infections (UTI) can be seen since 2011/12 and current mortality is well below national averages.

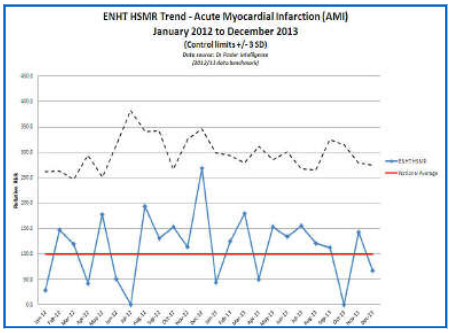
Following an audit in September 2013 the need to follow antibiotic policy and to communicate with Microbiology staff have been reinforced.

It is noteworthy that the SHMI rate is high than national average. This rate captures all deaths up to 30 days after discharge and 41% of the deaths within this group occur in the community. The Clinical Commissioning Group who oversee quality improvement across the local health economy have initiated an audit on patients who die in the community within 30 days of a hospital admission with the primary diagnosis of UTI to understand the reasons.

Acute Myocardial Infarction

Mortality associated with acute myocardial infarction (AMI), otherwise known as a heart attack, during the year has not been statistically elevated but has been above average. The graph below shows a fluctuating HSMR since January 2012.

The medical records of entire group of AMI patients who died between April and September 2013 have been reviewed with some of these deaths associated with incorrect coding. Revised coding will result in changes to the end of year mortality rate with the HSMR expected to be around 100.



The following actions were undertaken during the year:

- 3 new Consultants were appointed in October
- The cardiac catheterisation laboratory has been in use for 24 hours per day for 4 days since January
- Additional medical staff out of hours since August 2013

A clinical pathway audit was completed in September and showed that overall patients were receiving good treatment meeting almost all NICE guidelines. Some areas for improvement were:

- Encouraging clinical teams to use the Acute Coronary Syndrome proforma
- Use of the radial (wrist) approach where possible, rather than the groin when providing treatment
- Improving documentation and coding

A coding review has shown that some cases of cardiac arrest and other higher risk diagnoses were coded as AMI, hence showing an elevated AMI figure. This has now been corrected.

Congestive heart failure

The most recent mortality data shows that patients with this condition are less likely to die at our hospitals compared with the national average.

Patients with heart failure are cared for by a variety of clinical teams on any ward as it's often an additional condition. The Trust is in the process of writing a business case to seek funding to appoint a Heart Failure Nurse. This specialist nurse would be able to visit patients with heart failure wherever they are located and work with all clinical teams to deliver best care.

Pneumonia

Mortality associated with pneumonia has seen continuous improvement over the last few years and are within normal limits. Some initiatives that have contributed to this improvement are:

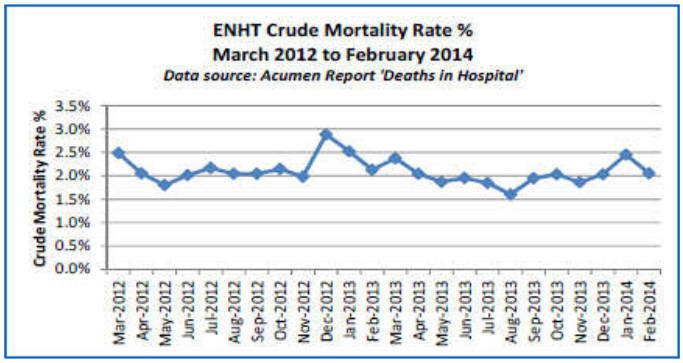
- Centralisation of the Respiratory service to the Lister in August
- Centralisation of non-invasive ventilation to the Lister (this is assistance with breathing that does not require ventilation in the critical care unit)
- Recruitment of an additional respiratory Consultants for the acute chest team
- Additional medical staff out of hours

Crude Mortality

Crude mortality is a simple analysis of the percentage of patients who died against the number of admissions to hospital. It makes no adjustment for complexity and is subject to significant seasonal variation, ie more deaths in the winter.

The Trust's crude mortality rate from April 2013 to February 2014 is 2.0%.

Between March 13 and Feb 2014 177 fewer patients died in the Trust compared to the previous year despite a similar number of inpatients being treated.



2. Patient Reported Outcome Measures (PROMS)

PROMS—what is this?

Patient Reported Outcome Measures (PROMs) were introduced in 2009. Each patient undergoing four types of surgery as listed below are asked to complete questionnaires before and after surgery. The information is compared and improvements noted. There are a number of ways of measuring the improvements, one of these - the EQ-5D index health gain – is given. This is an overall weighted assessment relating to function and feeling. The measure ranges from -0.594 to 1 where 1 is the best possible state of health.

	ENHT Previous Period	ENHT Current Period	National Current Period	National Best Performance	National Worst Performance
	2012/13 (Provisional)	Apr-Sept 2013			
a) Groin hernia surgery	Number too low for analysis		0.086	0.492	0.019
b) Varicose vein surgery	Not undertaken		0.102	0.094	0.058
c) Hip replacement surgery	Number too low for analysis		0.44	0.506	0.378
d) Knee replacement surgery	Number too low for analysis		0.339	0.429	0.264

The ENHT considers that this data is as described for the following reasons:

In last years quality account it was reported that the majority of the elective procedures were then undertaken at the Surgicentre managed by Clinicenta. The more complex procedures were undertaken by the Trust, but these were low in number. It was impossible to calculate exact figures as it had not been possible to separate the Surgicentre and Trust data.

During the April - September 2013 reporting period , the same surgical arrangements were in place but separating the data was possible.

The number of procedures undertaken within the Trust was too low for analysis.

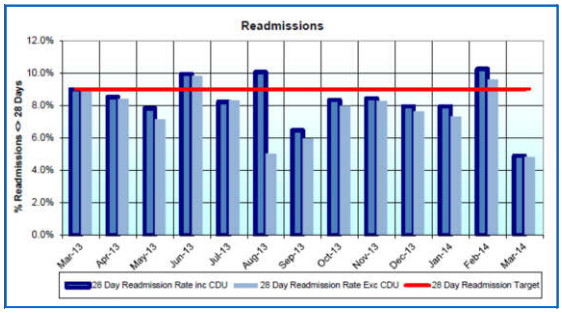
In September 2013 the Surgicentre became the Lister Treatment Centre and all elective procedures were once again undertaken by the Trust. In the future PROMS data will become meaningful but this is not expected until late 2015.

3. Readmission rate

	ENHT Previous Period	ENHT Current Period	National Current Period	National Best Performance (Large acute)	National Worst Performance (large acute)
	2010/11	2011/12			
a) Percentage of patients aged 0 to 14 readmitted within 28 days of discharge	13.52	13.65	10.01	6.4	14.94
b) Percentage of patients aged 15 and over readmitted within 28 days of discharge	10.56	11.11	11.45	9.34	13.80

The ENHT has taken the following actions to improve these percentages, and so the quality of its services by collating and reviewing data available as part of the Transforming In-patient Management Programme.

The current re-admission rate for 2013/14 is 10.52% with March 2014 at 5.93%. The Trust monitors performance using more recent Hospital Episode Statistics (HES) data with information shown on the graph (right).



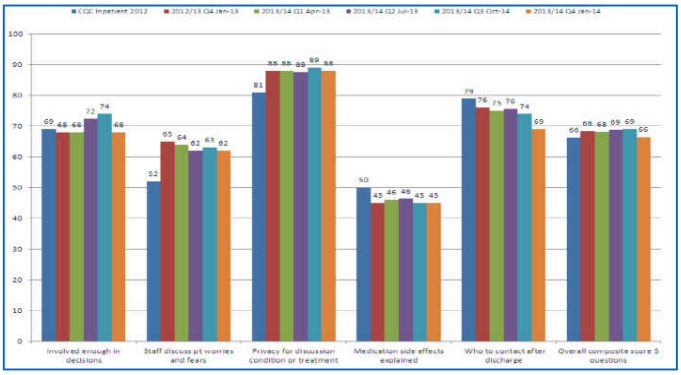
4. Responsiveness to Personal Needs

	ENHT Previous Period	ENHT Current Period	National Current Period	National Best Performance	National Worst Performance
	2011/12	2012/13			
Responsiveness to the personal needs of patients	64.8	66.3	68.1	84.4	57.4

The ENHT has taken the following actions to improve the score, and so the quality of its services by continuing to monitor the scores quarterly via the postal survey, reviewing results at the Patient Experience Committee and tasking clinical divisions to improve their scores through local initiatives as part of their patient experience action plans.

The score is a composite score of five questions relating to being involved, privacy, understanding medications and who to .contact after discharge is there is a problem and if there are any worries.

The individual scores are shown on the graph (right) for the past five quarters and compared with the 2012 in-patient survey result.

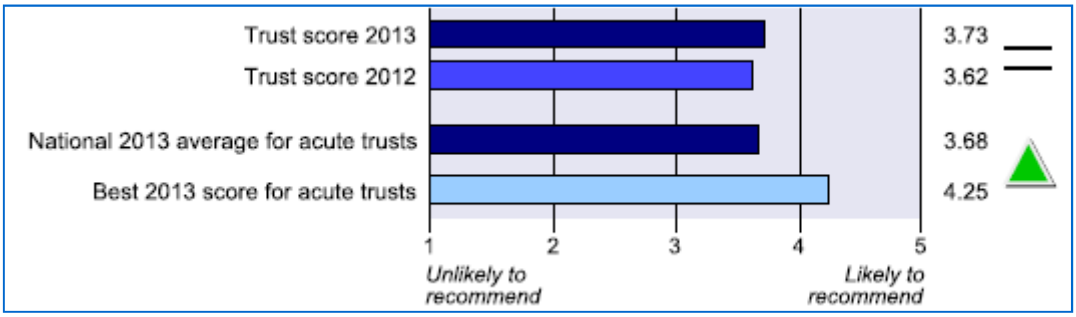


5. Staff recommending the Trust

	ENHT Previous Period	ENHT Current Period	National Current Period	National Best Performance	National Worst Performance
	2012	2013			
Percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends	66%	66%	65%	94%	38%

The ENHT has taken the following actions to improve the score, and so the quality of its services by continuing its staff development opportunities through its range of available courses; by continuing its staff engagement work via the ARC programme and by continuing in its endeavour to be 'amongst the best'.

Details of this indicator can also be found on page 26. The Trust is in the best 20% of organisations for this indicators as shown below in the 2013 staff survey result.



6. Venous thromboembolism (VTE) assessment

	ENHT Previous Period	ENHT Current Period	National Current Period	National Best Performance	National Worst Performance
	Oct-Dec 2013	January 2014			
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism	98.9%	99%	96%	100%	75%

The Trust has consistently performed better than national average for the last two years.

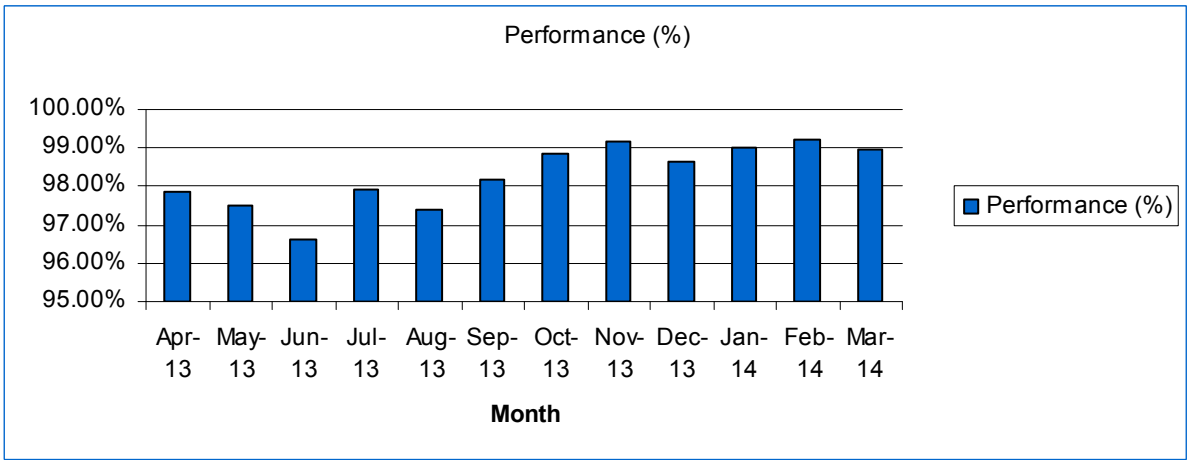
The ENHT has taken the following actions to improve the score, and so the quality of its services by:

- Redesigning the medication chart to incorporate VTE assessment as part of the document thus enabling clot preventative medication or treatment to be prescribed at the same time
- Continuing the education around VTE prevention during induction and mandatory training for doctors
- Challenging any poor performance when identified through audit or safety walkabouts

The Thrombosis Committee oversees the delivery of actions to prevent blood clots. It is currently reviewing its guidelines around the provision of Dalteparin for obese patients and is looking at the Provision and supply of anti-embolic stockings for obese patients.

Where patients have acquired a blood clot either in the leg or lungs their medical notes are reviewed using root cause analysis techniques to identify any common theme or area of poor practice. These reviews are ongoing.

The Trust is proud of its VTE assessment scores as shown below and will continue towards reaching 100% all of the time.



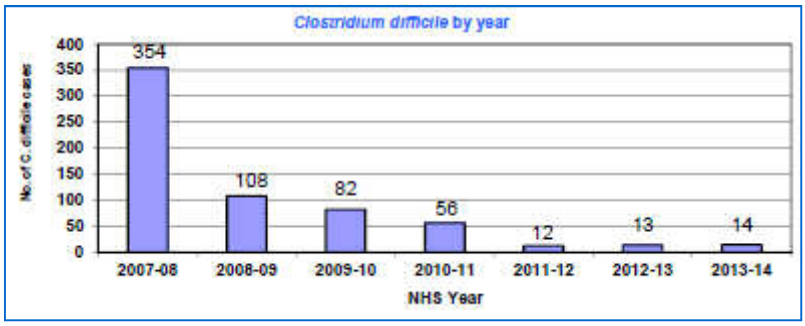
7. Clostridium Difficile rate

Clostridium Difficile	ENHT Previous Period	ENHT Current Period	National Current Period	National Best Performance	National Worst Performance
	2011/12	2012/13			
The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over	4.9	5.7	17.3	0	30.8

The ENHT has taken the following actions to improve this rate, and so the quality of its services by continuing with the C Diff reduction action plan which includes:

- Undertaking root cause analysis investigation within 10 days to identify any learning for future prevention
- Sharing findings of such investigations and incorporating them into local action plans
- Having weekly ward rounds (side room) by Infection Control Doctor and Infection Control Nurse
- Daily follow-up of all patients made known to the Infection Prevention and Control Nursing Team
- Undertaking antimicrobial audits

The reduction in the number of cases of C Diff has been impressive with 14 recorded in 2013/14.



8. Number of patient safety incidents

Number of Patient Safety Incidents	ENHT Previous Period	ENHT Current Period	National Current Period	National Highest Performance	National Lowest Performance
	April-Sept 2012	October 2012—March 13			
The number of patient safety incidents reported within the Trust	4678	4204	-	-	-
The rate of patient safety incidents reported within the Trust	10.84	9.7	Not given	11.9	3
Percentage of severe harm or death [Large acute Trust average]	0.3%	0.3%	0.8%	0	3.5%

The ENHT has taken the following actions to improve these rates and percentages, and so the quality of its services through the ongoing encouragement of incident reporting and supporting staff when things do go wrong. Incident trends including level of harm are routinely monitored by the Risk and Quality Committee. National data received in September 2013 (Sept 12—Mar 13) shows the Trust as the 5th highest reporter out of 39 large acute Trusts.

Further information on incidents is given over the page and in Part 3 on pages 49-51.

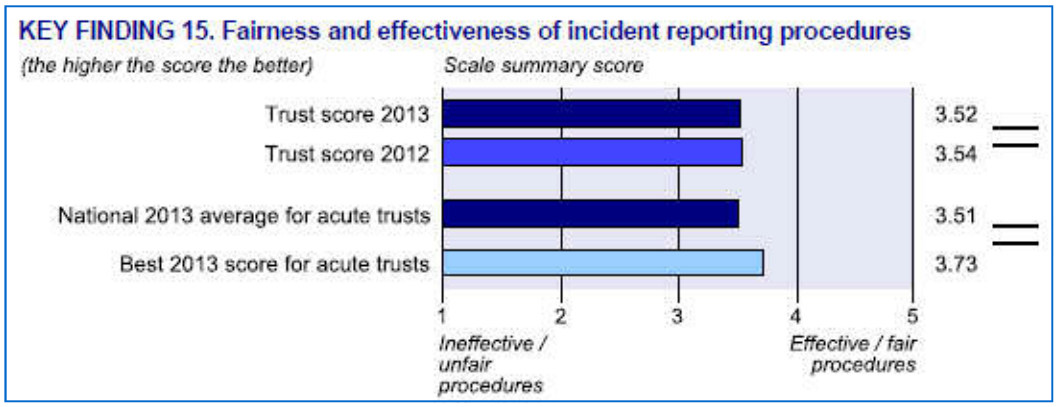
Electronic incident reporting

The Trust has completed the roll-out of Datix-web for electronic capture of incidents, rather than paper forms.

There was an expected initial fall in reporting practice as people moved from an established process to a new way of reporting. At year end the numbers are increasing and have reached the same reporting rate as prior to electronic reporting. The Trust is proud of this reporting rate as it demonstrates a willingness to be open when things go wrong.

Any member of staff can report incidents and almost 500 managers / supervisors have been trained in the more detailed sign-off and report writing functions of the system to aid local analysis and management. form also mandates that when a patient suffers harm there is an acknowledgement of 'being open' .

Results of the 2013 NHS Staff Survey indicate that the Trust is average for the fairness of incident reporting.



Electronic blood tracking

Electronic blood tracking allows units of blood to be bar coded from its point of preparation to the point of transfusion. This safety initiative will help to reduce errors associated with transfusion.

Dr Harvey, Consultant Haematologist explains

- A successful bid was submitted for capital funds to support blood tracking for the Lister Hospital.
- MSOFT were awarded the contract for their product 'Blood Hound'
- A project board, project team, and stakeholders group has been set up, led by Sheila Needham, Transfusion Practitioner
- Working with MSoft and IT, the project team has purchased hardware and is developing the IT infrastructure needed to support the project
- It is anticipated that training of staff will commence in late Spring with the project will be completed by Autumn 2014

Continuous Improvement award winners

2013 Celebration of Excellence

Leanne Welch, carers lead
Tim Walker, consultant anaesthetist

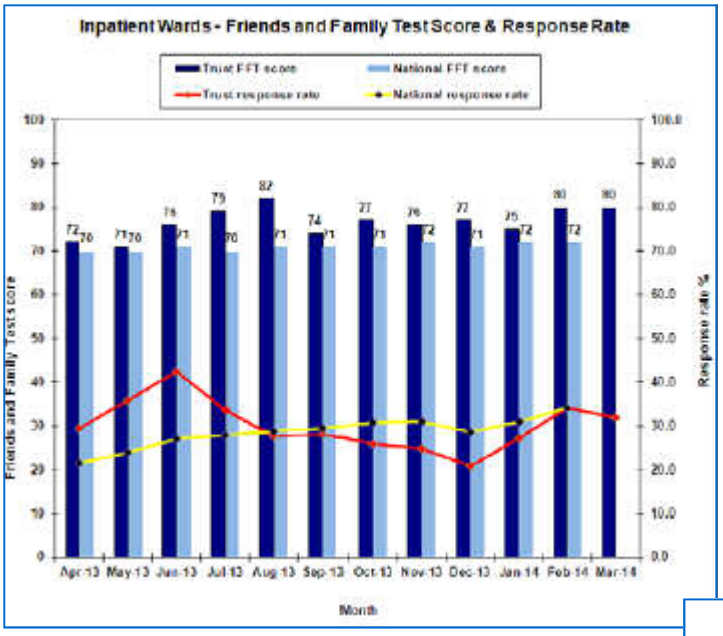
9. Friends and Family Test - patients

	ENHT Previous Period	ENHT Current Period	National Current Period	National Best Performance	National Worst Performance
	Jan 2014	Feb 2014			
Friends & family test—combined score of inpatient and patients discharged from the accident & emergency department	66	**56**	64	94	4%

All adult (aged >16) inpatients, patients discharged from A&E to home and all maternity women must be given the opportunity to answer the FFT question. The national FFT results, including a detailed breakdown of the FFT score and response rate for each Trust, is published by NHS England.

The ENHT has taken the following actions to improve the score, and so the quality of its services by promoting the importance of the test and publishing its results on a weekly basis in the staff newsletter; and by providing means of answering the question.

The following charts detail the FFT score and response rate for both inpatient wards and A&E for ENHT compared to the national average.

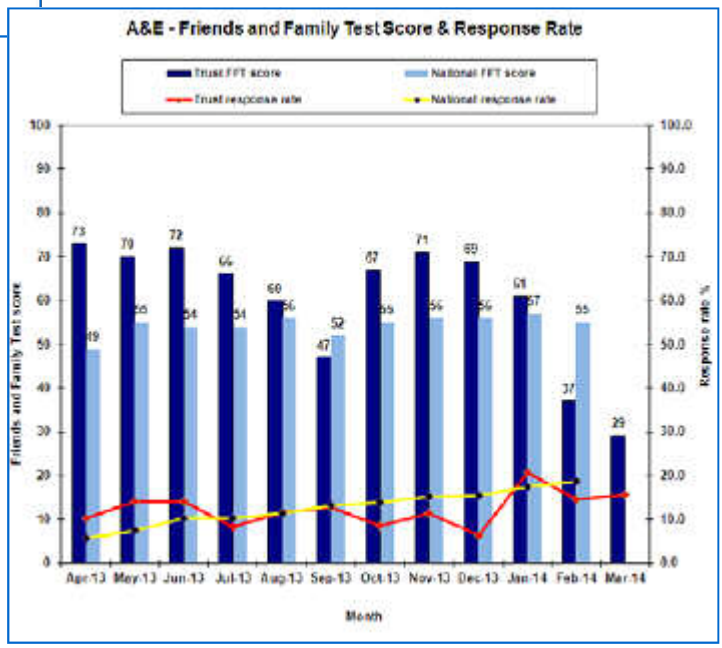


The adult inpatient FFT score has remained above the national average each month between Apr-13 to Feb-14.

The response rate was below the national average for the six months Aug-13–Jan-14. In Feb-14 the response rate improved to meet the national average.

The A&E FFT score exceeded the national average score for most of the year. However the score dropped significantly after the move to collect responses via text message.

Response rate is increasing, most likely as a result of the texting service. It is important to recognise rise in the number of A&E attendances and the fact that the A&E department is undergoing major refurbishment.



Maternity Friends and Family Test (FFT)

		12/13	13/14	Aim for 13/14	Achieved
4.2	FFT - maternity* (submissions)	N/A	31.8%	15%	✓

Priority 4.2, as alluded to on page 26 involved the friends and family test (see yellow box in right for an explanation) within maternity. The aim for 2013/14 was that the survey was introduced and a 15% response rate achieved.

The rate is a combined score from four areas: before birth, during birth, after birth and community.

The survey was introduced in October 2013 and since then all maternity women have been given an opportunity to answer the FFT question. Our response rate was 10.32% in February and 31.82% in March 2014.

Information below shows the Trust and comparative national scores for December 2013.

		FFT Score
Antenatal	ENHT	44
	National	63
Birth	ENHT	72
	National	75
Postnatal	ENHT	58
	National	66
Community	ENHT	89
	National	74

The results are reported back to wards and departments where staff can review the weekly figures and take action where improvements are required.

Friends & Family Test
Patients are asked
"How likely are you to recommend our ward/A&E department/maternity service to friends and family if they needed similar care or treatment?"

This is known as the Friends and Family Test (FFT).

A scale of five options is used from 'extremely likely' to 'extremely unlikely' plus a don't know option . The FFT score is calculated by subtracting the negative scores (not recommending the Trust) from the extremely likely scores.

The 'likely' scores have no value in this scoring methodology. So if 100 people respond and 50 score 'extremely likely' and the other score 'likely' the overall FFT will be 50.

My daughter recently gave birth in Lister's Midwife Led Unit and as a family we had the most fantastic care from start to finish, the service was first class...Thank you so much for the wonderful, memorable experience
(Source: NHS Choices, February 2014)

Patient experience award winners

Midwifery-led Unit

Mr Fred Schreuder,
Consultant Plastic Surgeon

Part 3

3a Review of quality performance in 2013/14

Key:

The key is based upon the thresholds set by the Board at the beginning of each year which are used to monitor performance throughout the year.

✓ Achieved

~ Under achieved (defined mid-range as given on the Trust floodlight scorecard)

✘ Not achieved

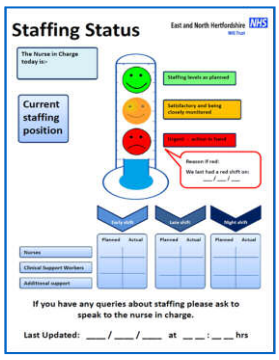
This section of the report provides some general narrative about what we are doing to improve quality within the Trust. It is intended to provide an overview to demonstrate our commitment to quality improvement and to show you how we are delivering that by focusing not only on the three main aspects of quality (safety, effectiveness and experiences) but also by making improvements for our staff and our environment.

On this page matters of national or strategic importance relating to quality are also given.

Francis Inquiry

Last year we reported that we had reviewed all recommendations of the Francis Report. Since then we have:

- Re-launched the Raising Concerns at Work Policy
- Reviewed staffing establishments
- Committed to ensuring every member of staff attends Customer Care training
- Revised the appraisal process in line with Trust values
- Published ward staffing levels each day on each ward



The action plan has been published on the Trusts website.

Care Quality Commission Intelligent Monitoring

The CQC assessment of Trusts against 150 measures places the Trust at Band 5 (scale 1 to 6) with an overall risk score of 5 out of 180. Band 6 Trusts have the lowest risk scores.

This monitoring, alongside feedback from relevant stakeholders helps to determine which Trusts are involved in a full inspection by the CQC. The Trust was not selected for such an inspection during 2013/14.

Keogh Reviews

The Trust was not selected for an in-depth inspection by Sir Bruce Keogh's (England's Chief Medical Officer) team as part of a national review of Trusts with a higher than expected mortality rate.

However in July 2013 the Trust undertook its own mini review and scrutinised our performance in the areas where concerns were raised in the Keogh reviews. The Trust compared favourably in the majority of areas but there were some areas where, although not a significant concern, improvements could be made. These areas had previously been identified and improvement initiatives were already underway.

Quality checking of cost improvements

In these times of austerity looking for ways to save money is essential. Healthcare is becoming more expensive and to be able to deliver effective healthcare in the future means that we have to be as efficient as possible in the way we use resources.

All plans identified by Divisions as potential a cost-saving must be submitted to the Clinical Governance Strategy Committee for assessment. The committee scrutinises these plans in detail and will reject any where there is a negative impact upon quality.

Patient safety

The **Patient Safety Strategy** (2011-14) summarises intentions to:

- Reduce harm and avoidable deaths
- Promote a culture whereby safety is an integral part of what we do

In 2013/14 the strategy was supplemented by a set of objectives. These are summarised in the table below together with an indication as to whether, or not, they were met.

	Priority	Met
1	Revise patient safety walkabout programme so it is risk based and linked with other indicators, reporting findings to Patient Safety Committee bi-monthly	✓
2	Undertake projects outlined within the safety workstream coordinated by the Eastern Academic Health Science Network	✓
3	Review handover / ward round process to take account of GMC/ RCN guidance	In progress
4	Monitor sepsis action plan and progress	✓
5	Progress consent action plan	✓
6	Policies – appoint person and work with IT to populate central intranet page	✓
7	Patient notes—continue review	In progress
8	Launch National Early Warning Score	✓
9	Complete roll-out of Datix-web for online incident reporting	✓

Safety walkabouts

Scheduled walkabouts are undertaken by the quality and compliance teams. These are based largely upon the assessment format of the Care Quality Commission, although are much shorter. There are four elements to the walkabouts including discussions with staff and patients; and a review of documentation and the environment.

The vast majority of patients are highly complimentary about their care and about the staff. Observations demonstrate that dignity and respect is of an excellent standard and that people are involved in their care where possible. The standard of documentation is not always 100% and where there are matters that could be improved these are fed back to staff together with a summary of the entire findings.

Eastern Academic Health Science Network

The Trust is involved in the Patient Safety Clinical Study Group which forms part of the EAHSN. The network aims to bring together expertise from business, academic establishments and healthcare to provide innovative solutions to improve safety.

Consent

The Trust has increased the number of consent forms for specific procedures to 74. These provide more detailed information about a proposed procedure to help decision making.

Policies

A dedicated member of staff has been appointed to centralise the location of policies and guidelines on the intranet to make them more easily available to clinical staff.

Last Wednesday I was under the care of my consultant and their team to have spinal injections. I couldn't fault the treatment I received and the consideration of the staff. Well done and thanks to all.
24 March 2014, Orthopaedics
(Source: NHS Choices)

Safety indicator set

The following indicator set gives an overview of some of our safety indicators with results over the last few years.

Indicator	10/11	11/12	12/13	13/14	Aim for 13/14	Met
Medication errors	1176	1250	1175	893	N/A[1]	N/A
Never events	1	1	2	1	0	✘
MRSA Elective Screening (all elective inpatient admissions)	92%	99.5%	99.9%	99.86%	100%	✘
MRSA Bacteraemia	5	3	2	2	0	✘
Number of falls	2058	1650	1224	988	<=980	=
WHO Surgery Checklist				100%	100%	✓

[1] The Trust wishes to encourage open reporting of incidents so no targets are set for this indicator

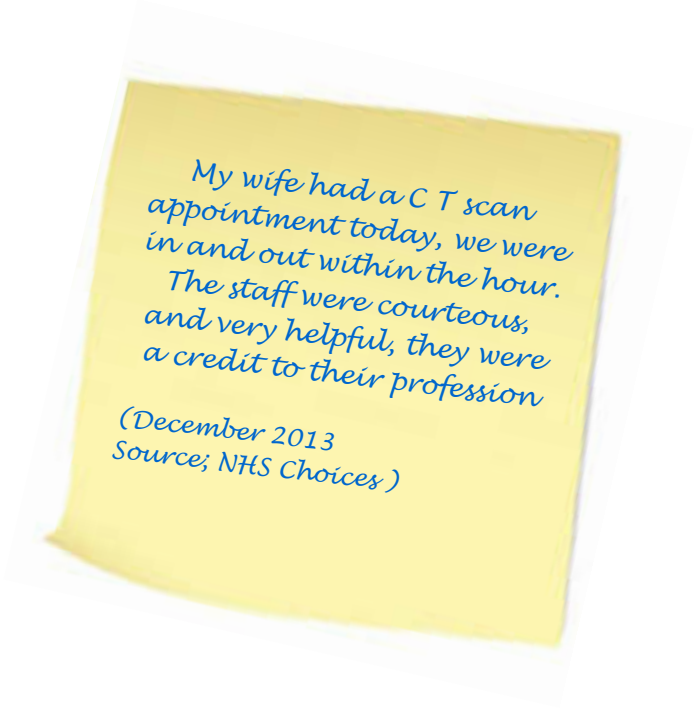
Focusing on medication errors

The Medication Forum meets every two months and it's role is to:

- Review medication incident trends and audit results
- Review all medication incidents that have led to harm
- Consider all national medication safety alerts and oversee any required improvements
- Consider new national or regional initiatives

Where changes or improvements are required the Forum directs and monitors the changes and consequent outcomes. During the year teaching programmes have been updated; critical drugs list updated and circulated to all wards; various medication guidelines updated; change in glucose supply for better management of critically low blood sugar levels in people with diabetes; medication change across the organisation to prevent blood clots; approval of guidelines to facilitate patients taking charge of their own medication.

In April 2013 new drug charts were launched, including one specifically for patients with diabetes. The revised medication charts include a range of improvements including dedicated sections for prescribing of antibiotics and oral anticoagulants; and better assessment and treatment of patients at risk of blood clots. The chart for patients with diabetes allows blood sugar levels to be recorded on the chart so required changes in treatment plans can easily be identified.



Safety alerts

All relevant national safety alerts are circulated to a group of core representatives and responded to accordingly. The patient Safety Committee oversees the implementation of any actions ensuring that the responses are robust and delivered within required timescales.

Never events

These are incidents which should never occur if safety procedures are fully in place and are followed.

For acute Trusts there are 23 categories of never event. These include operating on the wrong site, leaving something behind (retained foreign object) after surgery which requires having another operation to remove it.

Summary details of never events are now reported online. Provisional data for England from April 2013 to December 2013 indicates that there were 229 such incidents, of which 100 were retained foreign objects and 59 wrong site surgery.

One never event was declared by the Trust in 2013/14. This involved wrong site surgery where it was thought that the appendix had been removed when in fact it was different tissue. This was identified when the tissue samples were examined. An operation was required later to remove the patients appendix and the patient subsequently recovered well.

A comprehensive action plan was produced to include better supervision of junior doctors and a review of local escalation practices.

Being Open

The Trust is committed to being open with patients and their families / carers when things have gone wrong.

Being open forms part of incident and complaints training. Copies of serious incident reports are sent to patients / families who are also offered an opportunity to meet clinical staff to discuss the report findings.

Board meetings are held in public and board

Serious Incidents

Serious incidents are reported on a calendar year, rather than a financial year thus for 2013 the following serious incidents were reported:

Indicator	2010	2011	2012	2013
Serious incident (other)	19	22	8	**25**
Healthcare acquired infection	12	9	3	**13**
Hospital acquired pressure ulcers	N/A	26	49	**16**
Serious fall	N/A	N/A	6	**14**
Total	**31**	**57**	**66**	**68**

The ‘other’ incidents are linked with a range of other matters, usually associated with delays in treatment, information breach or a failure to identify and treat a deteriorating patient.

All incidents are investigated fully using a root cause analysis technique. Reports are written and action plans developed with learning identified either for specific teams or across the organisation. Examples of learning have included:

- Additional training for specific staff
- Clearer liaison between trainee medical staff when seeking assistance from their consultant
- More regular checking of water temperatures in patient bathing areas

Patient Care and Safety Day

The nursing team have introduced a ‘Patient Care and Safety Day’ for nursing staff. It’s a workshop style day using case studies and some formal teaching to consider a range of safety matters. Throughout this day communication using the SBAR (situation, background, assessment, recommendation) method is promoted.

Patient story….

From the time I entered NHS Treatment centre I felt I was in save hands, i.e. from the lead nurse thorough to the Surgeon and until the nurse that wheeled me back out for my journey home, the staff are excellent, these are all very professional people, I had an hip replacement the checks on me where boundless, and that can only be good, all personal I came in contact with had a very caring attitude the lady that cleaned and ladies' that served the food which was very good, if there where any bad marks against this department well I could not see them, but then you can only speak as you find

(October 2013. Source: NHS Choices)

Clinical effectiveness

Indicator	11/12	12/13	13/14	Aim for 13/14	Met
Mortality—please see pages 37-40					
Emergency readmissions to hospital within 28 days of discharge*	15.04%	11%	**10.52**	<=9%	=
% of admitted patients risk-assessed for Venous Thromboembolism (VTE)	92.8%	99.16%	**98.41**	>=98%	✓
Delayed transfers of care	2.5%	2.83%	**3.19**	<=3.5	✓
Cancelled operations (% of elective workload)	0.75%	0.58%	**0.81**	<=0.8	=

The **Improving Patient Outcomes** document describes the Trusts intention to enhance the effectiveness of care.

Four aims have been identified for focused action during the year:

- Improving the timeliness of care
- Reducing the variability of care
- Reduction of error through improved communication
- Introduction of evidence based innovations and therapies

Effectiveness indicator set

The indicator set above gives an overview of some of our effectiveness indicators. The results since 2011/12 are shown together with this years achievements and whether or not the aims were met.

Specific details about emergency readmissions can be found on page 41 and VTE on page 43.

Examples of improving effectiveness

Some examples of where the outcomes of care have improved are given below.

Following up on new interventional procedures

If a member of staff wishes to introduce a new interventional procedure that has never been carried out in the Trust they need to apply for approval by the Clinical Governance Strategy Committee. This is to ensure that staff are properly trained; that equipment and facilities are available and that patients are appropriately informed. Successful applicants are required to present a summary of their progress and outcomes to the committee one year after approval.

Within **Urology** the results following robotic procedures are impressive. Of the 211 operations that were carried out between April 2012 and September 2013 the major complication rate was 0.9% (Internationally 5-17%).

The urology team offers the first robotic fellowship programme in the UK recognised by the Royal College of Surgeons (England) & British Association of Urological Surgeons.

Also within Urology, the Urolift procedure to deal with urinary tract symptoms has been under-taken within the Trust with good outcomes. The consultant undertaking the procedure was a specialist advisor to NICE on this procedure which became subject to NICE guidance in January 2014.

Managing the deteriorating patient

When people are sick sometimes their condition deteriorates. If the deterioration is recognised and acted upon quickly then it may be possible to reverse this decline.

To try to prevent deterioration we've implemented a number of initiatives to identify deterioration early and to understand from a review of medical and nursing notes of those

who have deteriorated how this may have been prevented.

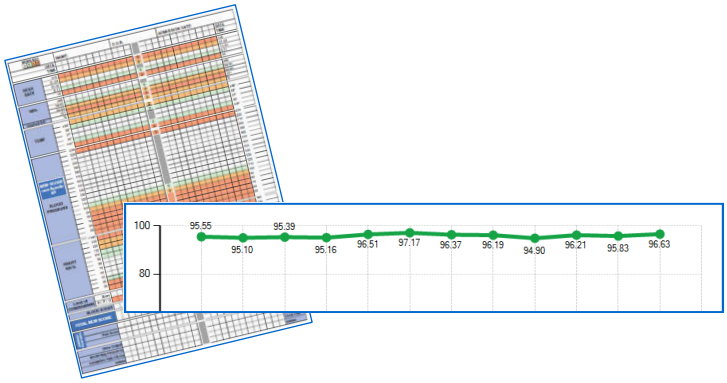
A) Launched the National Early Warning Score (NEWS)

This is an observation system using a national observation chart. Abnormal readings of pulse, blood pressure etc are given a score and the total of the scores indicates what action to take.

A patient whose health is deteriorating will have an increasing score so recognising it early and seeking help from doctors and specialist nursing staff will improve the chances of the patient receiving the best care and treatment quickly.

The measuring of observations is audited to ensure they are completed thoroughly.

The data below shows that each month from April 2013 to March 2014 over 95% of observations were recorded thoroughly.



B) Improving the management of sepsis

Please refer to page 39.

C) Review of unexpected admissions to critical care

Some people are expected to be cared for within the critical care department. Eg. following surgery or because they have been admitted from home in a critical state.

There are however occasions when people deteriorate on the wards and need to go to critical care. To understand this deterioration in detail we undertook an audit to see if there was anything we could have done differently to have prevented those admissions.

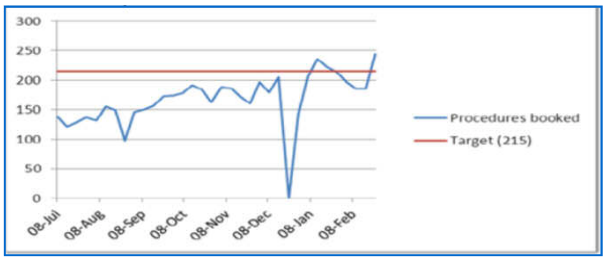
Analysis indicated that there were a number of factors involved from not fully completing observations; failing to recognise deterioration early and failing to seek senior medical assistance quickly.

Even though this audit was undertaken before NEWS was launched in October and before ward managers were required to take action where observations audit results fell below expected standards the results were shared widely and an action plan developed. Actions include clarity around thresholds for escalation, consultant to consultant referral and better management of resuscitation decisions.

A re-audit is scheduled for 2014/15 to see if changes have made a difference.

Treatment Centre Activity

Since taking responsibility for managing the Treatment Centre in September the number of operations carried out per week has increased, reaching the Trusts internal target of 215 per week by January.



(Note: fall in December is due to Christmas closure)

Clinical Outcomes and Patient Safety award winner

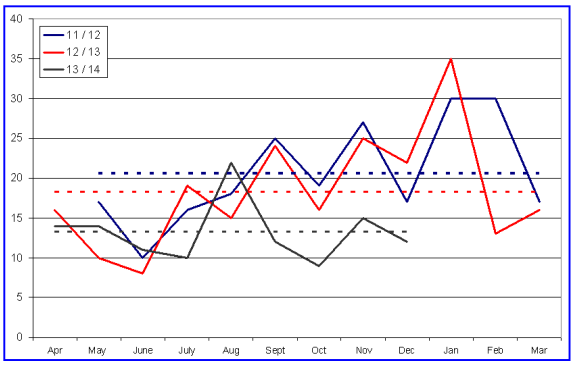
Fractured neck of femur team QEII.

"The whole team have worked together to improve communication between specialist staff, which means that patients get to theatre quicker, start to get better faster and go home sooner."
(Helen Beaton, Deputy Nursing Services Manager)

Cardiac arrests

When patients deteriorate they may have a cardiac arrest. One way of measuring how successful treatment plans are to reduce deterioration is to measure the number of cardiac arrests.

The figure below shows the number of cardiac arrests across Lister and QEII Hospitals per year since 2011/12, with the average showing as the dotted line.



Fractured hips

All of our patients with fractured hips are cared for on the Princes Wing at the QEII Hospital.

Strict plans of care are in place so that surgery and recovery go as well as possible. These plans include nursing care, anaesthetist review, length of operation.

Compliance against these plans is measured routinely and actions taken where results indicate a shortfall.

In February 27 patients were admitted to Princes Wing for emergency hip fracture surgery. 89% of patients had surgery within 36 hours (4 patients had other problems that required correcting first). All patients were seen by the anaesthetist before their operations and all documentation reviewed at the time of the audit demonstrated 100% compliance with nursing care and assessment. Only one operation took longer than the expected 3 hours as the fracture was complicated.

Mortality (HSMR following fractured hip is 69.4 (Jan—Dec 2013) compared with 88 in 2012/13.

Medihome

Medihome is a company which provides acute home healthcare for patients that would have traditionally remained an inpatient within the acute hospital setting. It is particularly valuable for patients who are not yet medically fit for discharge, for example because they are having intravenous antibiotics, but are otherwise well enough not to require a hospital bed. Whilst not fully discharged from hospital and still under Consultant care these patients receive care and treatment by Medihome staff within the patients own home until they are signed off as fit for discharge.

The pilot scheme commended 31December 2013 and by 6 March Medihome has provided home healthcare to 61 patients.

Prior to being transferred to the scheme all patient have an agreed expected date of discharge. Based on this date the scheme has released 471 bed days. These patients would have previously occupied an acute hospital bed for the entire duration of their admission.

Three patients transferred back, two following a fall and one requiring an adjustment to treatment.

The costs of running the service so far have been similar to the cost of keeping a patient in hospital. However increasing the number of referrals will reduce the cost per patient overall and therefore improve financial viability. Efforts are now being put in place to increase referrals to Medihome via better linkage with the bed management and therapy teams. A full assessment of viability, taking account of overall effectiveness and experiences will be undertaken as the pilot progresses.

Public nomination award winners

2013 Celebration of Excellence

Jo Gohill, senior sister, Mount Vernon
Ibrahim al Bakir, gastro registrar, QEII.
Marilyn Goodhew, senior play specialist, Lister.

Patient experiences

The Trust has as its vision 'to be amongst the best performing NHS Trusts in the country', with high quality care and excellent patient experience at the heart of all we do.

We aim "to excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction".

This section provides a snapshot of some of the work our staff are involved with to improve the experiences of patients and their families / carers.

I would like to thank all the staff at Queens for the treatment I received today. The doctor and his operating team are wonderful, caring professionals and the standard of sympathetic care and support from each member of staff was outstanding.

Queens Wing, QEII. February 2014
(Source: NHS Choices)

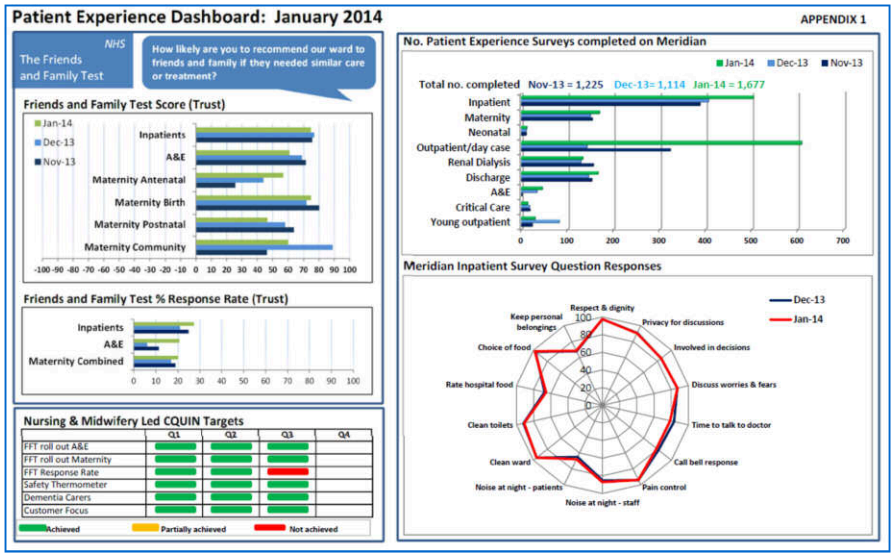
Experiences indicator set

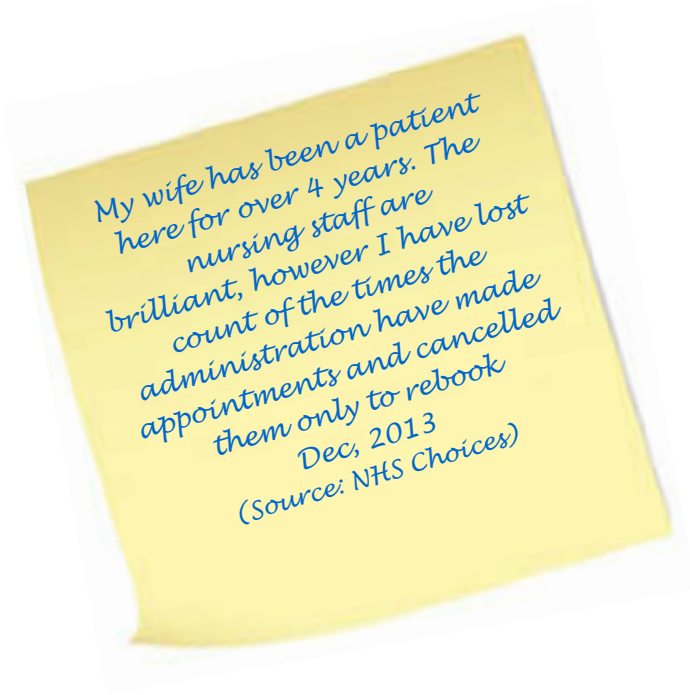
The following indicator set gives an overview of some of our experiences indicators. The results since 2010/11 are shown.

Indicator	10/11	2011/12	2012/13	2013/14
Number of complaints	889	1063	969	**868**
Complaints – care	142	140	113	**186**
Complaints – communication	299	402	385	**149**
Complaints – response within 25 days	37%	57%	58%	**TBC**
Local resolution meetings	36	26	30	**24**
Ombudsman investigation	2	2	7	**17**
Complaint per level of activity	0.7%	1.07%	1.08%	**0.9%**
Number of PALS concerns	1819	1733	1724	**1728**
Mixed sex accommodation breaches	0	0	0	**0**

The **Patient Experience Committee** oversees the implementation of the Patient Experience Strategy. It monitors progress, for example, via an 'at a glance' dashboard (right) and by receiving updates on initiatives or survey results. Some examples are given on the following pages.

There are five members of the public on the Patient Experience Committee.





Divisional Action Plans
Divisions use information from local surveys, the Friends and Family Test responses, complaints, national surveys etc to develop divisional action plans.

Some examples of actions include:

- Improved preparation of notes prior to clinic appointments
- Waiting times audit at Mount Vernon
- Improved changing facilities for patients undergoing radiotherapy
- Extension of nurse facilitated discharge
- Improved signposting
- Future paediatric outpatient appointments set up before a child / parent leaves the hospital
- Dedicated 'child only' orthopaedic clinic supported by childrens services staff
- Change in pharmacy work patterns has increased the dispensing of medicines to outpatients to over 70% within 30 minutes.

National In-patient Survey, 2013

	2012		2013		
Question	**Trust**	**Comparison to other Trusts**	**Trust**	**Comparison to other Trusts**	**Highest national score**
Emergency / A&E department	8.2	Same	**8**	Same	9.5
Waiting lists & planned admissions	8.7	Same	**8.6**	Same	9.6
Waiting to get to a bed	6.9	Same	**6.9**	Same	9.6
Hospital & ward	7.7	Worse	**7.8**	Same	9.1
Doctors	8.2	Same	**8.2**	Same	9.4
Nurses	8.2	Same	**8.1**	Same	9.2
Care & treatment	7.3	Same	**7.2**	Same	8.7
Operations & procedures	8	Same	**7.8**	Worse	9.1
Leaving hospital	7.2	Same	**6.9**	Same	8.4
Overall views & experiences	5.2	Same	**5.1**	Same	7.2

Note: the scores are out of 10

320 patients responded to the survey, with a 38% response rate (49% nationally).

There are no significant improvements since the 2012 report. The most significant decline since 2012 relate to:

- Patients being given enough notice about when they were going to be discharged
- A member of staff telling patients about danger signals to watch out for when they go home

Action planning is underway at the time of writing the report.

Volunteers
A team of activity volunteers visit the elderly care wards on Wednesday afternoons to engage patients in conversation or activities.

Ward assistants help around mealtimes serving food and assisting with feeding.

Welcome cards
On admission, postcard sized cards are given to patients informing them of the nurse in charge, their consultant and the date they are expected to go home.

National Maternity Survey, 2013

169 patients responded to the survey, with a 48% response rate (46% nationally).

In comparison to other participating organisations the Trust compared equally regarding aspects relating to staff and post-natal care but performed better during labour and birth.

A focus group of 34 women has helped to explore the findings in more detail and advise on improvements.

Some of these women have consequently joined the Maternity Services Liaison Committee to advise and be involved with future developments.

	2010	2013	Change since 2010	Highest national score
During labour, could you move around and choose the most comfortable position?	8	**8.7**	↑	9.2
Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	7.7	**7.8**	↑	8.6
During labour and birth, were you spoken to in a way you could understand?	8.9	**9.3**	↑	9.8
During labour and birth, were you involved enough in decisions about your care?	8	**8.8**	↑	9.1
Did you have confidence and trust in the staff caring for you during your labour and birth?	8.3	**8.8**	↑	9.3
Do you feel that the length of your stay in hospital after the birth was appropriate?	6.6	**7.7**	↑	8.6
After the birth of your baby, were you given the information or explanations you needed?	5.6	**7.1**	↑	8.8
After the birth of your baby, were you treated with kindness and understanding?	6.9	**8.3**	↑	9

Even better facilities coming soon

The Diamond Jubilee maternity unit has been awarded funding for an additional two birthing pools and to improve the antenatal clinic environment where additional consulting rooms will be created. This will further increase choice and the experience of women.

It's better for companions too...

Feedback from women in the focus group referred to above indicated that they would like their companions to be able to stay overnight.

In mid March 2014 arrangements were made and within two weeks 60 companions had stayed overnight sleeping in recliner chairs next to mothers and babies.

Local surveys

Electronic surveys are widely undertaken throughout the Trust as listed (right).

During 2013/14:

16,754 surveys were completed:

86.74%
Combined satisfaction score
(max. 100%)

- Carers 2014
- AandE Survey
- Critical Care
- Discharge Survey
- FFT A&E
- FFT Inpatient
- Focus on Communication
- Food
- In-patient Survey
- Maternity (Community Midwifery)
- Maternity (Homebirth)
- Maternity Survey 2014
- Maternity (Antenatal)
- Neonatal Parent experience
- Noise at Night
- Outpatient Department Survey
- Pharmacy
- Renal Dialysis Unit
- Young Outpatient Department

In-patient electronic survey (April 2013-March 2014)

The top three and the bottom three ranking scores are given below for the in-patient survey.

The top three are the same as last year with improvement shown in each case. Of the three bottom scoring questions, the scores of two have improved since last year. Food is the only area where an improvement is not seen.

Did you feel you were treated with respect and dignity while you were in the hospital?	97.71	↑
Were you offered a choice of food?	97.42	↑
In your opinion, how clean was the hospital room or ward that you were in?	94.60	↑
After you used the call button, how long did it usually take before you got help?	75.66	↑
Were you ever bothered by noise at night from other patients?	69.29	↑
How would you rate the hospital food?	66.53	↓

Noise at night

Regarding noise at night staff pursue the appropriate management of confused, noisy patients and are increasing their knowledge and skills to care for patients who may call out at night. Staff are asked to contact the specialists to offer support for dementia patients (see aim 4.13. on page 28) and a Dementia Nurse is in post to provide support and advice for staff. Ear plugs are available on all wards and herbal and decaffeinated drinks are provided.

An innovative approach to reducing noise at night was detailed in the research section on page 38.

Food

A closer analysis of the food survey results (184 responses) shows that whilst the experience of mealtimes is largely very good it is the appearance and taste of the food that is the greatest concern.

The Catering Manager is trialling steam meals on the maternity ward and also a system whereby meals are plated on the wards at Lister rather than in the Kitchen. This would allow for increased flexibility to respond to patient preferences on the day.

Question	Score
Have you been offered condiments with your meals?	97.28
Have you been offered enough food?	96.74
Have you been made comfortable before your meals are served?	96.05
Have you been offered help with eating if you required it?	95.78
Have you been offered hot drinks?	94.94
Have you received what you have ordered?	94.84
Were you offered the chance to wash your hands before your meals?	93.82
Was your bedside table cleared before you ate your meals?	93.61
Is the ward atmosphere pleasant during meal times?	92.58
Have you been able to eat your meals without interruption?	87.43
How would you rate the temperature of the meals?	79.89
How would you rate the appearance of the meals?	76.09
How would you rate the taste of the meals?	71.20
How would you rate the food you have received whilst in hospital?	70.83

Out-patient electronic survey (April 2013-March 2014)

The top three and the bottom three ranking scores are given below for the in-patient survey.

The top three are the same as last year with improvement shown in each case. Of the three bottom scoring questions, all scores have improved since last year with the main concerns relating to waiting.

Overall, did you feel you were treated with respect and dignity in the Department?	98.74	↑
Were you given enough privacy when discussing your condition or treatment?	97.48	↑
Did a member of staff explain the purpose of the medications you were to take home in a way you could understand?	97.14	↑
How long after the stated appointment time did the appointment start?	73.50	↑
Were you given a choice of appointment time?	67.60	↑
On arrival were you told how long you would have to wait?	54.57	↑

The division has identified a number of actions to improve out-patient appointments. These include a review of all appointment slots; auditing start and finish times and checking that patients are kept up to date with any delays.

Discharge Surveys

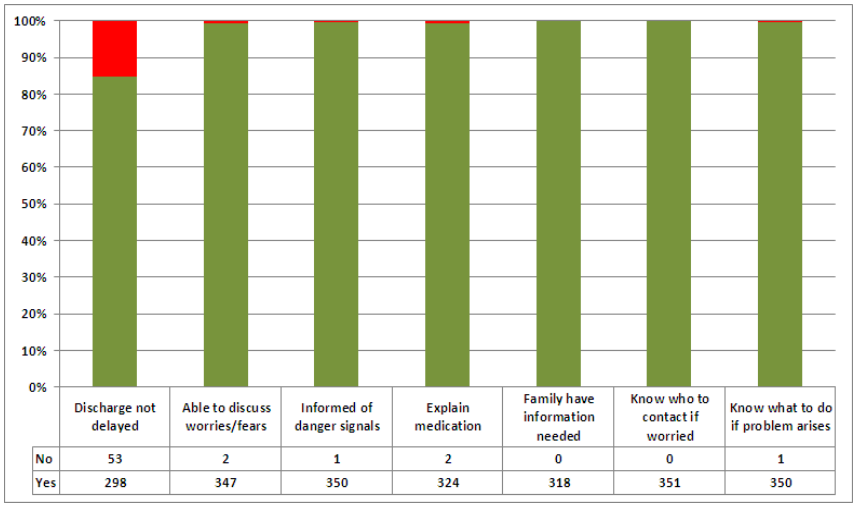
Dedicated patient experience coordinators are carrying out follow up telephone calls to patients who have an unplanned admission. This is to ensure that they are supported after their discharge and to address any remaining questions or problems they may have .

The team liaise closely with ward staff and produce a monthly report of positive or negative issues for staff to consider in future discharges.

The graph (right) shows the responses from the Post-discharge Survey undertaken in January 2014.

Clearly our patients are reporting concerns relating to delays. Further analysis shows this to be linked with medication (62%), the discharge letter (19%) and transport (11%).

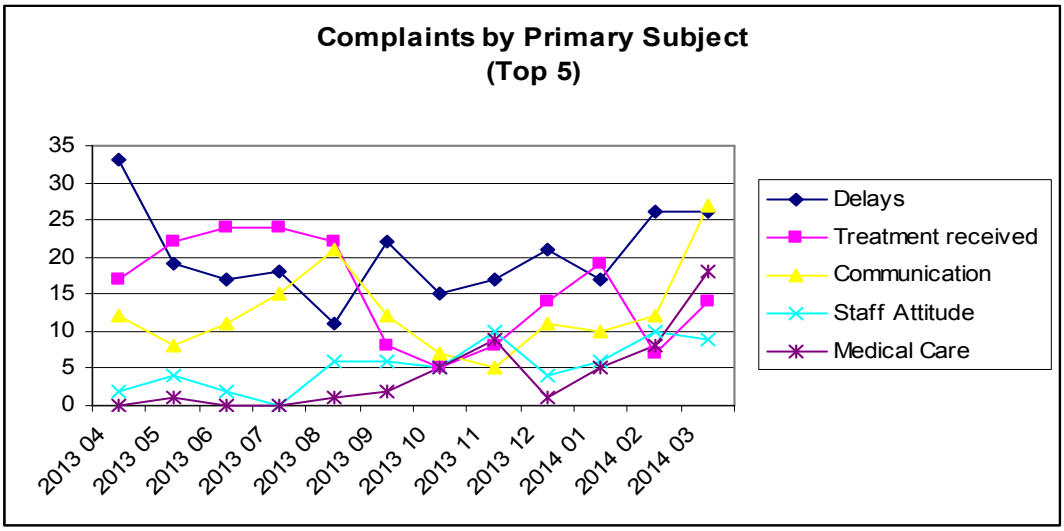
Assistance given at the time of the call includes seeking copy letters and booking transport to accommodate the needs of that patient.



	Discharge not delayed	Able to discuss worries/fears	Informed of danger signals	Explain medication	Family have information needed	Know who to contact if worried	Know what to do if problem arises
No	53	2	1	2	0	0	1
Yes	298	347	350	324	318	351	350

Complaints and PALS concerns

Analysis of complaints over the year indicates five main themes as shown below.



Complaints are increasingly complex and similar themes are seen with concerns raised with the Patient Liaison and Advice Service. The complaints team work with clinical staff to address these where possible and aim to respond within 25 days.

The working practices of the complaints team was reviewed and changed in early 2014 with team members were assigned to specific divisions. In almost all cases complainants are telephoned to discuss their complaint in the first instance.

The vast majority of complaints are graded as very low or low severity, although 9 complaints have been transferred to the risk management team and investigated as incidents.

Communication and delays feature as a main theme in complaints and PALS concerns. It is also a feature of concerns expressed on NHS Choices. A priority for 2014/15 is that of improving communication and reducing delays. This is detailed in part 2a of the report.

NHS Choices

NHS Choices provides patients with information to enable them to make choices about their health. It is also as a means for service users to give feedback about their experiences. Overall, the Lister and QEII Hospitals show a 4 star rating; Hertford County and Mount Vernon Cancer Centre have 4.5 stars.

Throughout this report, on yellow notes, comments from NHS Choices are shown. The Trust reviews all comments left, sometimes asking for additional information so a matter can be followed up in more detail. The Trust also reviews comments left on the Patient Opinion website in the same way.

Quality of service at Lister Hospital	
Friends and Family Test score: Inpatient	77 from 389 responses More detail
Friends and Family Test score: A&E	56 from 581 responses
Friends and Family Test score: Maternity	View maternity scores
Care Quality Commission national standards	All standards met Visit CQC profile
Number of MRSA cases in last 3 months	1 case(s) in the last three months
Patient survey score for cleanliness	As expected with a score of 8.65
C. difficile infections in last 3 months	Better than average (0.00 cases per bed in the last three months)
NHS Choices users rating	235 ratings More information about NHS Choices user ratings
Responding to patient safety alerts	Good - All alerts signed off where deadline has passed

Quality of service at Queen Elizabeth I I Hospital	
Friends and Family Test score: Inpatient	59 from 68 responses More detail
Friends and Family Test score: A&E	71 from 332 responses
Friends and Family Test score: Maternity	View maternity scores
Care Quality Commission national standards	All standards met Visit CQC profile
Number of MRSA cases in last 3 months	0 case(s) in the last three months
Patient survey score for cleanliness	As expected with a score of 8.65
C. difficile infections in last 3 months	Average (0.01 cases per bed in the last three months)
NHS Choices users rating	91 ratings More information about NHS Choices user ratings
Responding to patient safety alerts	Good - All alerts signed off where deadline has passed

The tables (left) are the summary screenshots of views about our two main hospitals from NHS Choices. (Source: NHS Choices, 1st April 2014)

Family story….

I & I'm sure my family would like to praise the doctors & nurses of the ICU department at the QEII. My grandfather was admitted on Boxing Day & being given fantastic care firstly in the A&E department, he was then moved to ICU where we were all treated with empathy & respect by the team, keeping us informed at all times of my grandfathers condition.

The care & attention the nurses gave my grandad went above & beyond & they were very tolerant of our big family being ever present. As my grandad deteriorated they were even more brilliant. Today when my grandad sadly passed away, one of the few consolations was that his final days consisted of his family & his dignity being upheld by a team of people who could not be more caring, professional & also sympathetic to a family.

Our gratitude can't really be described, a thank you doesn't quite seem enough.
(December 2013. Source: NHS Choices)

Kissing it Better

Working with community partners to improve the patients experience our patients have:

- received beauty therapy treatments such as manicures and hand massages
- been entertained by choral societies and singers
- been visited by animal care students accompanied by a variety of animals.

These visits are scheduled. Community volunteers this year have transformed the Strathmore Garden into a very beautiful and peaceful environment where patients and their visitors can relax.

Macmillan Award

Ward 10 at Mount Vernon Cancer Centre has achieved a **very good** rating (Level 4) in its Macmillan Quality Environment Mark®.

A maximum score was achieved for 'service experience'

Patient Stories

Staff visit wards and departments to seek 'patient stories' - that is to listen to what service users say about their experiences in the hospitals.

Themes of these stories are reported back to the relevant area for action and extracts from some of the stories are reviewed at Trust Board meetings.

Toiletry Packs…

...are now available to make a patients stay more comfortable.

Funded by the Stevenage League of Hospital Friends

Outstanding Neonatal Team

The Trust's Neonatal team have won 'Outstanding Neonatal Team of the Year' from Mother and Baby magazine. They were nominated by a mother whose son spent five weeks in the unit.

Empathy Project

Feedback from patients is being used to improve staff training and the quality of care provided to patients within the Medicine Division.

During 'lunch and learn' and 'induction' sessions staff within the Division share patient stories and ask themselves "How does this make you feel?" and "How can we improve?".

This is helping staff to consider the whole patient experience and not just the medical aspects of their experience.

Last Wednesday I was under the care of my consultant and their team to have spinal injections. I couldn't fault the treatment I received and the consideration of the staff. Well done and thanks to all. Orthopaedics, March 2014 (Source: NHS Choices)

3b Our staff

Staff indicator set
The following results are from the national staff surveys.

Key Indicators	11/12	12/13	13/14	Aim	Met
Staff engagement	3.63	3.72	**3.76**	N/A	N/A
% staff who would recommend the provider to friends or family needing care (composite of agree & strongly agree)	57	66	**66**	N/A	N/A
Appraisal completions	88.12%	70.2%	**45.33%**	90%	✘
Sickness rate (annualised)	4.7%	3.6%	**3.41**	3.5	✓

Staff development

The programme of organisational culture change is outlined in the Organisation Development Strategy. The intention is to further develop staff and their skills, increase staff involvement, develop leadership and improve the environment in which staff work.

The ARC programme

ARC is a programme of education and support for all Trust managers aimed at building a culture of excellence.

Accelerate: quality, staff training, communication

Refocus: on our patients, on our staff, on our values, on our partners

Consolidate:services, patient pathways, our hospitals, our teams.

Providing a clear vision and direction, which is then shared amongst teams, ensures that our staff understand their role and the contribution they make towards making the Trust a better place to work and a better place to receive care and treatment.

During 2013/14 there were four ARC sessions. The first looked at the findings of the Francis Report and explored the wealth of evidence available (eg. survey feedback and listening to patient stories) to assess quality and the role of staff in preventing a similar occurrence in our hospitals. The second looked at the physical changes in the hospitals as a result of service consolidation and focused upon how managers can support staff in dealing with these changes. In the third clinical staff presented how they had integrated the Trust values into their work with their patients. The final session introduced the new appraisal system.

Management and leadership

A number of development programmes are available including:

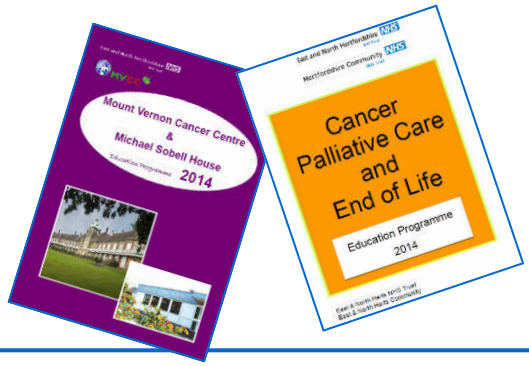
- Excellence in Management Programme
- Excellence in Supervision Programme
- Orientation programme for new managers

Delivering Excellent Customer Care

Every member of staff is required to attend this programme. Delivered by an external company and using role play this programme demonstrates how every individual is important in delivering excellent care.

Other training opportunities

The Trust offers a wide variety of developmental training for staff to enhance clinical and administrative skills.



Statutory and mandatory training

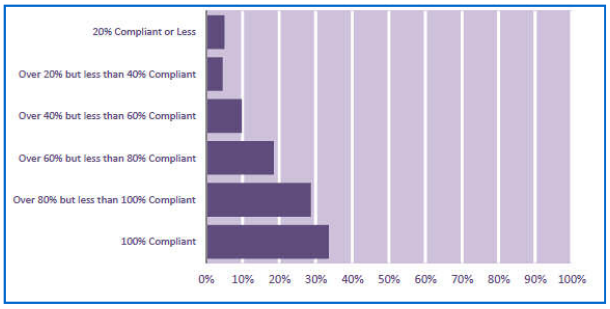
A new Statutory and Mandatory Training Programme, known as Vital, started in April 2013. This followed a complete overhaul of the previous programme to address the rising training requirements nationally whilst minimising the time staff are away from their normal workplace.

The Trust recognises its duty to ensure staff are adequately knowledgeable and skilled in the following nine key areas:

- Infection prevention
- Safeguarding adults
- Safeguarding children
- Moving and handling
- Conflict resolution
- Fire
- Information governance
- Equality & diversity
- General health & safety

The aim is for Trust staff to be up to date with training in all nine areas. A standard of 90% compliance is required by September 2014 when the new appraisal process becomes fully into use.

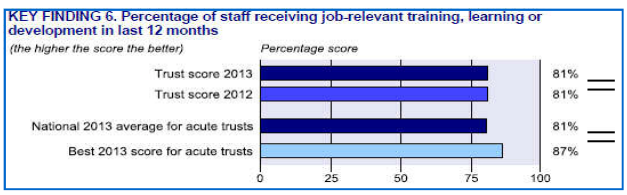
Compliance is measured monthly and at March 2014 was 38.28%. This does not meet the current aim of 58.9% although further analysis indicates that most people are short on one or two key areas as shown in the graph below.



Recently it has been possible to merge the training data with electronic staff records. This enables managers to easily see which staff are not up to date and take action accordingly.

The National Staff Survey 2013 shows the Trust is:

- in the **best 20%** for delivering equality & diversity training
- **above average** for health and safety training
- average for having job-relevant training.



Appraisals

A new appraisal process has been introduced. This requires the appraisee to demonstrate that they:

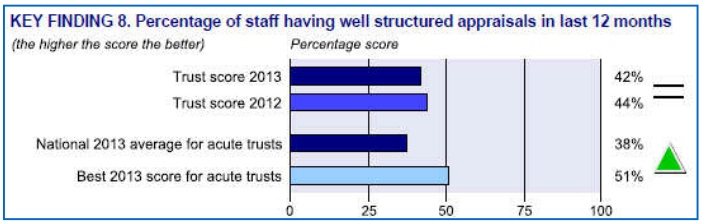
- Are up to date with mandatory training
- Working in line with trust values

Managers are required to set clear measurable objectives for their staff and to undertake 6 monthly progress reviews.

The review was necessary to address concerns about low appraisal rates. This new system, which aligns with pay, should not only result in improved appraisal rates but also ensure all mandatory training is undertaken.

Compliance is measured monthly and at March 2014 was 45.33% against a plan of 90%.

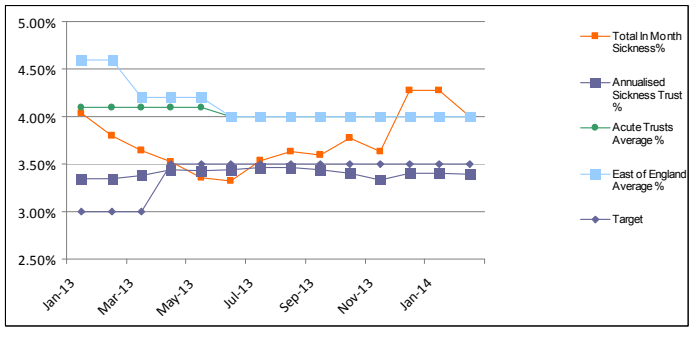
The National Staff Survey 2013 indicates that the Trust is **above average** for having well structured appraisals.



Staff sickness

The Trust continues to maintain low sickness rates with the 2013/14 position at 3.41% against a plan of less than 3.5%.

The graph below shows the favourable comparison with East of England Trusts and average acute Trusts.



Staff awards

Two hundred and forty staff and volunteers attended the Trust's annual

Celebration of Excellence awards 2013.

Around 170 nominations for awards were received which made choosing the winners particularly difficult. The winners of the ten awards can be found on various pages throughout this report.

> *The doctor and his operating team are wonderful, caring professionals and the standard of sympathetic care and support from each member of staff was outstanding.*
> *Queens Wing, February 2014 (Source: NHS Choices)*

Question	Trust 2011	Trust 2012	Trust 2013	National 2013	Comparison to national
Role makes a difference to patients	92%	91%	**90%**	91%	**Worse**
Level of satisfaction with work and care	80%	84%	**81%**	79%	**Better**
Good communication with managers	31%	26%	**27%**	29%	**Worse**
Undertaking training	76%	81%	**81%**	81%	**Same**
Equality & diversity training	53%	74%	**74%**	60%	**Best 20%**

Staff surveys

Staff surveys are undertaken annually as part of the National Staff Survey programme and as part of an internal scheduled survey programme. This valuable information contributes to the assessment not only of culture but also of specific matters requiring attention.

National staff survey

A selection of some of the survey results are given in the table above. A comparison of the Trust scores in 2013 compared with all other participating Trusts is shown in Appendix 1.

Of the 28 questions asked the results showed the Trust to be above average in 11 areas compared with other acute Trusts in areas including motivation at work and recommending the Trust.

6 questions were rated as average and 11 were below average which included areas such as working long hours and equal opportunities.

The first ARC sessions in spring 2014 are being used to gather feedback from staff from which to develop the action plan.

Local staff survey

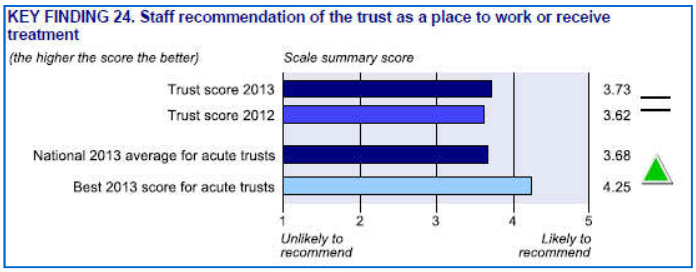
Known as the 'Finger on the Pulse' survey these online surveys aim to acquire regular anonymous information from staff about their work experiences. The information is reviewed and action plans updated where indicated.

Recommending the Trust

Although not required nationally until April 2014 the Trust has been asking its staff, via the quarterly surveys, whether they would recommend the Trust to friends and family if they needed treatment.

The average score for the year is 3.73 which meets the plan for the year.

A similar question is asked in the National Staff Survey and findings (below) indicate that the Trust is **better than average** compared with other Trusts.



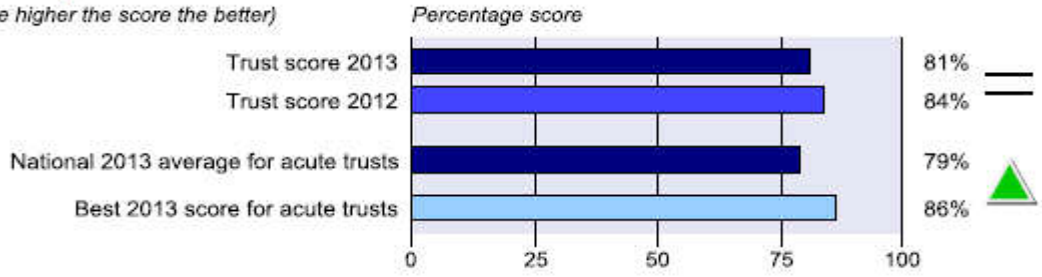
Equality Delivery System

The Equality Delivery System (EDS) 2 is being implemented. Dignity at Work advisors have received training and the Trust mediation service has been expanded. For more details please refer to http://www.enherts-tr.nhs.uk/about-the-trust/equality-diversity

Aligning the national staff survey results with Trust values

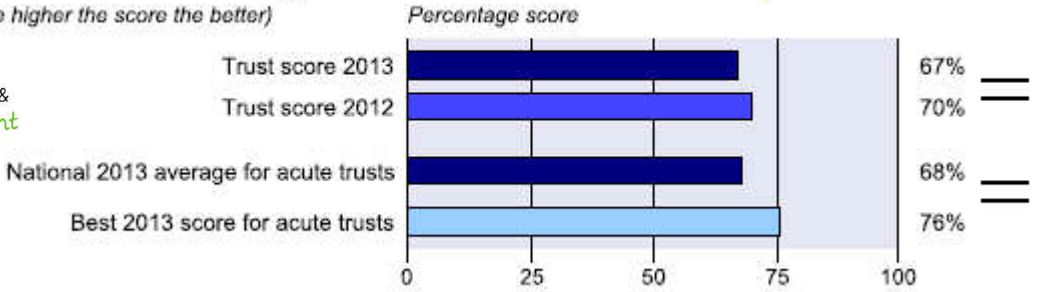
We put our patients first

KEY FINDING 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver



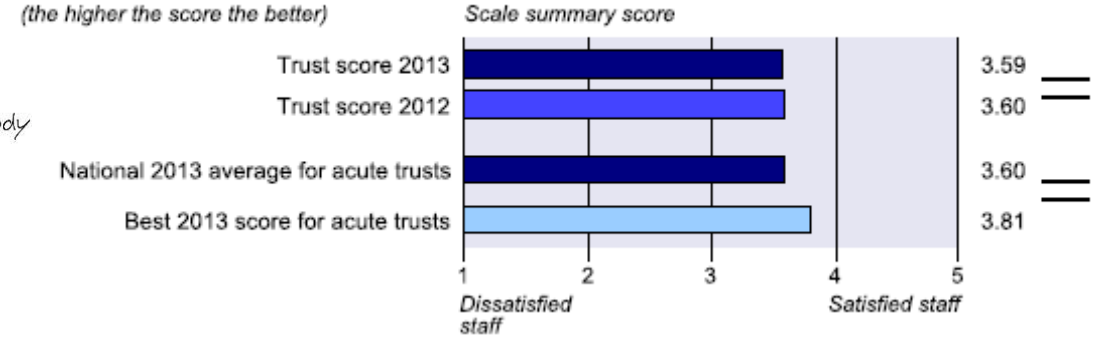
We strive for excellence & continuous improvement

KEY FINDING 22. Percentage of staff able to contribute towards improvements at work



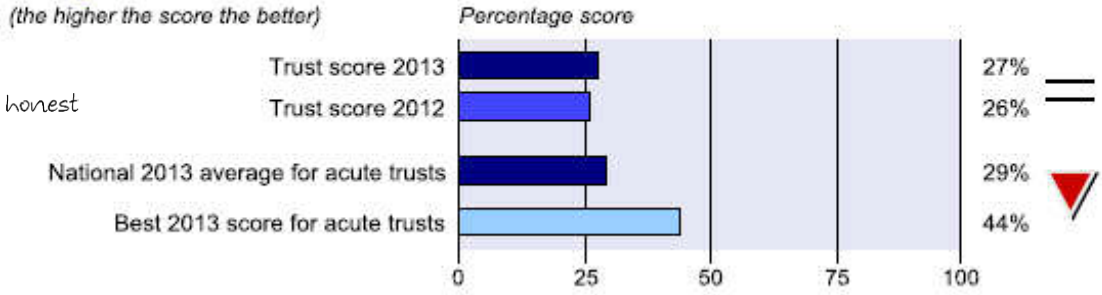
We value everybody

KEY FINDING 23. Staff job satisfaction



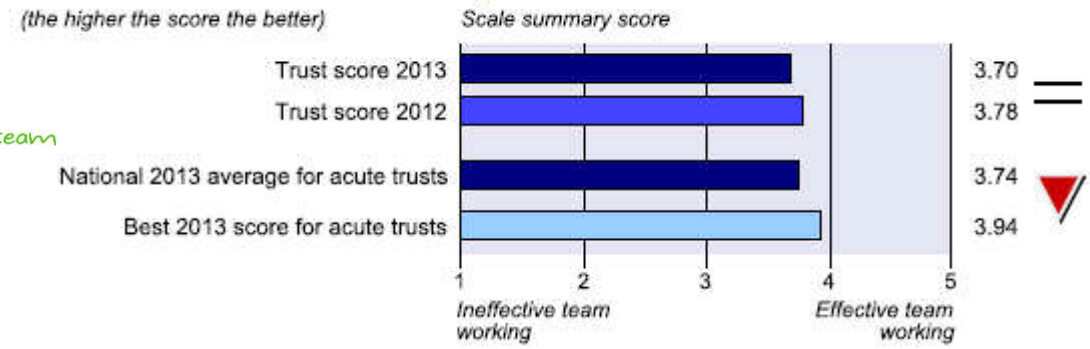
We are open and honest

KEY FINDING 21. Percentage of staff reporting good communication between senior management and staff



We work as a team

KEY FINDING 4. Effective team working



3c Our Hospitals

The East and North Hertfordshire NHS Trust employs over 5,400 staff and has an annual income of approximately £358m. It provides secondary (hospital) and limited tertiary (specialist) care services from four sites.

Lister Hospital

The Lister Hospital is a 480-bed district general hospital in Stevenage offering general and specialist hospital services for people across areas of Hertfordshire and south Bedfordshire. It provides a full range of medical and surgical specialties. General wards are supported by critical care (intensive care & 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.

Lister Treatment Centre (previously known as the Surgicentre)

In September the Trust took responsibility for managing services provided within what was formally known as the Surgicentre.

Renamed the Lister Treatment Centre the services are now integrated fully with the Trust services. Since September the activity level (see section 3a, effectiveness), hence income generated, has increased. This means that more people are benefitting from the service.

Queen Elizabeth II Hospital

The Queen Elizabeth II hospital in Welwyn Garden City is a district general hospital offers a range of general hospital services for people in parts of east and south Hertfordshire.

The general surgical and medical wards, which currently care for mainly non-emergency patients, are supported by the critical care (intensive care & high dependency) and coronary care units at the Lister Hospital (there is an intensive care service at the QEII Hospital).

The hospital also has a range of outpatient, pathology and diagnostic services and houses the fractured neck of femur service for the Trust.

Mount Vernon Cancer Centre

Mount Vernon Cancer Centre is a well renowned, highly specialised cancer centre based in Northwood in Middlesex. The centre offers chemotherapy to approximately 150 patients per week; cares for in-patients on 2 specialist wards and provides radiotherapy treatment including the use of Cyberknife and Truebeam technology.

Although services at the Cancer Centre are managed by the Trust the buildings are owned by Hillingdon Hospitals NHS Trust.

The Trust has produced a redevelopment strategy which outlines the intended provision of services in the future at the Cancer Centre. To this end the Trust is working with Hillingdon Hospitals Trust to secure land on the Mount Vernon site for the development of modern fit-for purpose facilities managed by the Trust.

Hertford County Hospital

Based in Hertford the hospital provides outpatients, ante/post natal, diagnostic and therapeutic services to the people of south-east Hertfordshire.

PLACE assessments

Patient Led Assessment of the Care Environment (PLACE) were undertaken on three hospital sites during May 2013. The results are given in the table below.

Category	Score
Cleanliness	97.26%
Privacy & dignity	87.86%
Condition of buildings	87.16%
Food & nutrition	76.20%

Our Changing Hospitals

'Our Changing Hospitals' is a major programme of change to services at the Lister and QEII hospitals. The design teams have worked closely with clinicians and the public to ensure the facilities maximise safety and patient experience whilst meeting the needs of our population for the foreseeable future.

The first three phases and some of phase 4 projects have been completed and were reported in last years Quality Account.

Progress on all phases is shown in the table below.

Phase	Status	
1. Surgicentre (now the Lister Treatment Centre)	✓	Opened September 2011
2. Maternity centralisation (includes neonatal services and gynaecology)	✓	Opened October 2011
3. Multi-storey carpark	✓	Opened September 2011
4. Ward 11A refurbishment	✓	Completed October 2011
4. Critical care expansion	✓	Opened October 2012
4. Mortuary refurbishment	✓	Completed October 2012
4. Ward 7A refurbishment	✓	Completed December 2012
4. Emergency Department expansion (Stage 1)	✓	Completed
4. MacMillan Chemotherapy expansion	In progress	Due June 2014
4. New ward block	In progress	Due July 2014
4. Health records centralisation	In progress	Due September2014
4. Theatres and endoscopy expansion	In progress	Due September 2014
4. Emergency Department expansion (Stage 2)	In progress	Due September 2014
4. Pathology	In progress	Due February 2015

New in 2013/14…

- A new MRI suite and ultrasound suites next to the outpatient's department opened
- A new emergency department extension opened which offers state of the art facilities and an improved environment to care for our patients

In the making...

- A new ward block which will house 62 in-patients – 50% in single ensuite rooms. The ground floor, co-located with the emergency department, will house acute assessment facilities for acutely unwell patients referred by GPs and transferred from the emergency department with the first floor primarily coronary care
- A new theatres and endoscopy block offering a suite of 4 endoscopy rooms, 3 of which will be suitable for radiological intervention; 2 main laminar flow theatres; a dedicated day surgery unit containing 2 operating theatres and recovery area; a link to the existing theatre areas to share recovery area facilities
- A new MacMillan Chemotherapy unit which will be more spacious for those attending for day treatment or for an outpatient appointment. Its design helps to improve privacy and dignity and offers dedicated space for counselling. The design team have worked with the clinical teams to design space to promote safety during the delivery of cytotoxic drugs
- Health records centralisation to improve access to health records and to reduce costs associated with off-site storage

- A reconfigured emergency department with separate entrances for blue light adults and children; an increase in the number of single treatment rooms to improve patient privacy and dignity; a new CT scanner that will serve the emergency department and the inpatient wards; an urgent care centre for the assessment and treatment of minor illnesses and injuries (approximately 60% of A&E attendances currently); a new fracture clinic, which includes radiology / digital radiology, medical photography and outpatients services

The Pathology service across the East of England is under review with plans for some services to be delivered by the Transforming Pathology Partnership, to which the Trust belongs. Due to the complexity of the project the associated building work will not be completed until February 2015.

By completion of phase 4 the Lister Hospital will become the main centre for inpatient and emergency services for all of east and north Hertfordshire, as well as parts of Bedfordshire.

New QEII Hospital

East and North Hertfordshire Clinical Commissioning Group is overseeing the development of the new QEII hospital in Welwyn Garden City.

Due to open in April 2015, the new QEII will provide a wide range of outpatient, therapy, diagnostic and ante/post natal services, as well as 24/7 Local A&E, rapid assessment and day treatment. The Vicki Adkins Breast Unit will remain on site.

Further information on the new hospital is available via http://www.enhertsccg.nhs.uk/newqeii

An artists view of the new hospital is shown below.

Sustainability

The Sustainability Development Strategy 2009-14 is being delivered through ten workstreams focusing upon emissions, waste reduction and sustainable purchasing. This year we've continued to progress these aims by:

- Promoting car sharing with dedicated parking areas
- Recycling shrink wrap packaging
- Recycling unused medicines
- Planting a 'green roof' on the new emergency department

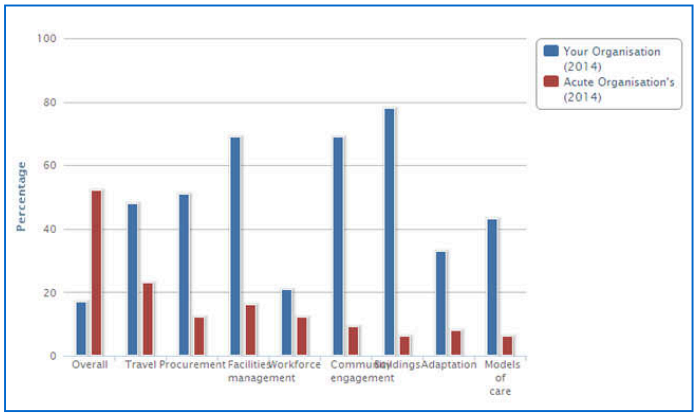
National pilot

The Trust piloted the recycling of inhalers. This was so successful it was rolled out nationally.

Good Corporate Citizenship

The good corporate citizen toolkit is used to assess an organisations corporate social responsibility. An assessment has been undertaken with results shown below benchmarked against other acute organisations.

The results show the Trust achieving lower scores on Corporate Approach to All Domains compared to other Acute Trusts within the East of England (17% against regional score of 52%). However, on all other elements the Trust scores significantly higher.



3d Performance against national requirements

Compliance Framework Priorities	11/12	12/13	13/14	Plan for 13/14	Met
Clostridium Difficile incidence	11	13	**14**	<=14	✓
MRSA Bacteraemia	3	2	**2**	0	✗
31-day second or subsequent treatment (Surgery)*	98.5%	97.6%	**96.8%**	>=94%	✓
31-day diagnosis to treatment for all cancers*	99.3%	97.8%	**97.7%**	>=96%	✓
31-day second or subsequent treatment (Anti Cancer Drug Treatments)*	99.9%	99.8%	**98.8%**	>=98%	✓
31-day second or subsequent treatment (Radiotherapy Treatments)*	99.4%	98.8%	**97.5%**	>=94%	✓
62-day urgent referral to treatment of all cancers*	87.5%	86%	**85.5%**	>=85%	✓
62-day referral to treatment from screening*	95.7%	93.2%	**92.1%**	>=90%	✓
18-week Referral to Treatment (RTT) target for Admitted pathways (95th percentile)*	21.3[1]	92.2%	**90.8%**	>=90%	✓
18-week RTT target for Non-Admitted pathways (95th percentile)	16[2]	97.1%	**96.62%**	>=95%	✓
18-week RTT target for patients on incomplete pathways (95th percentile)	-	94.9%	**94.84%**	>=92%	✓
All cancers: two week maximum wait from GP referral to first outpatient attendance*	99.3 %	98.5%	**97.8%**	>=93%	✓
2 week wait – Breast symptoms*	98.2%	96.3%	**96.5%**	>=93%	✓
Four hour maximum wait in A&E	95.9%	95.8%	**95.7%**	>=95%	✓

3e Statements from stakeholders

Overview

The Clinical Commissioning Group, Hertfordshire Healthwatch and Health Scrutiny Committee (Hertfordshire County Council) are invited to comment on the draft report. Their responses are given below.

To be added once received in May / June

3f Statements from auditors

To be added once received in June

Appendix 1 National Staff Survey 2013

KEY

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

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

Grey = Average.

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