Appendix C

East and North Hertfordshire NHS Trust

Quality Account
2015-16

Please note some sections in blue will require further update

To be amongst the best

Contents

www.facebook.com/pages/East-and-North-Hertfordshire-NHS-Trust/15001842484

http://twitter.com/enherts

https://plus.google.com/117135604279206909718

https://www.youtube.com/user/Enherts

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

Part 1

1a Statement on quality from the Chief Executive

2015 has been a year of recognizing and acknowledging achievements. Services moving into the New QEII Hospital in June marked the final stage of 'Our Changing Hospitals' Programme. The year has also seen achievements resulting from new ways of working. For example the Trust has achieved the best survival rate of trauma patients in the East of England Trauma network and is in the top quarter nationally; and the National Audit of Inpatient Falls shows the Trust as having the 7th lowest number of falls per 1,000 bed days out of the 136 NHS providers. These are amongst many tremendous achievements that have come about through our staff developing services to put our patients first and aiming to be amongst the best.

It is also important to recognize the challenges posed by the unprecedented demand for services, particularly in emergency care where services have been stretched more than ever resulting in long waiting times for some people. Despite this, our patients have told us that staff have endeavoured to keep them safe and well cared for.

The year has also been significant as we welcomed the Care Quality Commission (CQC) in undertaking their review of quality. The outcome of 'requires improvement' reflects fairly our services, some of which are outstanding and others requiring some considerable investment and partnership working to get right. I am particularly pleased that the CQC rated the Trust as 'good' for 'caring'.

The results of the CQC visit has set a benchmark against which we can plan and measure further improvements. As we progress into 2016/17 we will continue to implement our People Strategy and our strategies for quality. We will look towards greater use of electronic systems to support efficient practices and we welcome working with partners in the community and neighbouring Trusts to develop further the plans for better integrated care and specialist services.

Finally I would like to thank our staff, not only for their tremendous dedication towards delivering and improving services but for their team spirit. Our staff survey shows that the level of satisfaction with work and care is better than average. I am also delighted that more of our staff and teams are being recognized nationally for their work and achievements.

The Chief Inspector from the CQC said "this is a Trust on an upward trajectory". I'm very proud of what the staff have achieved and we will continue to reach our ambition of being amongst the best. To the best of my knowledge the information in this document is accurate.

Add picture & signature of Chief Executive

1b About us

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

The Trust concluded its “Our Changing Hospital” programme in 2015, having invested £150m to enable the consolidation of inpatient and complex services on the Lister Hospital site, delivering a reduction from two to one District General Hospitals. An additional £30m investment enabled the development of the new Queen Elizabeth II Hospital (QEII) in Welwyn Garden City.

The trust has a turnover of approximately £386m and employs 4,759 whole time equivalent members of staff.

During 2015/16 106 thousand patients were admitted; 570 thousand people attended out-patient appointments and 141 thousand attended the Emergency Department.

Our hospitals

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

Therapy and Pathology Services are provided by different organisations.

The **Lister Hospital** is a 700-bed district general hospital in Stevenage offering general and specialist hospital services for people across much of Hertfordshire and south Bedfordshire. It provides a full range of medical and surgical specialties. General wards are supported by critical care (intensive care and high dependency) and coronary care units, as well as pathology, radiology and other diagnostic services. There are specialist sub-regional services in urology and renal dialysis.

Feedback from NHS Choices gives the Hertford County Hospital 3.5 stars out of 5.

NHS Choices users' overall rating
Based on **392** ratings for this hospital

Cleanliness	Staff co-operation	Dignity and respect	Involvement in decisions	Same-sex accommodation
(388 ratings)	(394 ratings)	(394 ratings)	(382 ratings)	(302 ratings)

I would return to lister for further pregnancies as I am very confident they can handle any emergency thrown their way! Thanks again CLU! (Maternity)

The doctor explained everything in terms I could understand and no question was too much trouble. What wonderful staff the Lister have. I was so nevous, thank you for everything you did to help me x Emma C (Endoscopy)

From the time I entered reception until I left the discharge ward, every member of staff I met with, from clinical assistant to consultant, were excellent. Polite, kind, helpful, friendly and sympathetic. Thorough with explanations and willing to answer questions. That was a 5 star performance. (Urology)

Given my work, the repair of the tendons are crucial and I am overwhelmingly pleased to say that the operation seems to have been a success. Well done Plastic Surgery colleagues

Thanks to all the staff on Bluebell ward, the general surgical team and the staff in theatres. My daughter was in the hospital for 5 days with appendicitis and was well treated and well cared for. (Childrens services)

To all the staff on duty in the day surgery today - Thank you for giving up your Saturday and for the exceptional effort you went to for all the children on the ward today. Your kindness, attentiveness, humour and general friendly but professional manner did not go unappreciated

30 min drive turned up to eye clinic to be told they were very busy and to sit in waiting area. This was 11:20. At 12:00 I was informed they could not see me until 4:15. I asked if this was an appointment to see the doc at 4:15. Yes was the answer. 30 min drive home and 2 hours wasted, surely they could have told us this when we rang

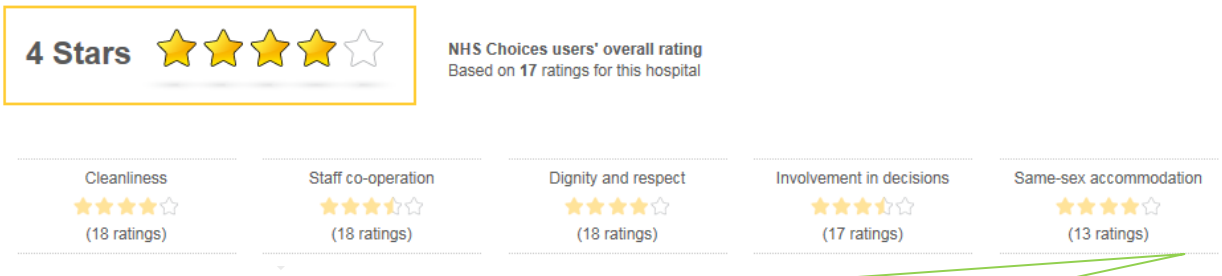
I saw a Consultant on 21st Jan 16 and was told that I need to have more ex Ray's done. But to which is 12th Feb 16 I gave had not notification to go for these ex Ray's. The Consultant knew I was and still am in a lot of pain. I have tried to contact the hospital with no success. What is the use of a hospital that foes not look after its patience

Booked her in for extraction and told me to take the form to treatment centre and the procedure would be done as an urgent so 6-8 weeks wait. After 7 weeks of hearing nothing phoned treatment centre who advised that consultant had ticked routine and not urgent so she wouldn't be seen for 18 weeks! (Oral surgery)

Hertford County Hospital provides outpatient and diagnostic services including:

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

Feedback from NHS Choices gives the Hertford County Hospital 4 stars out of 5.



The staff work efficiently and cheerfully which is due to the conditions and environment they work in. They do their up most to make a sometimes stressful, worrying hospital visit a more relaxed event. This hospital provides a blood testing service and many people use it on their way to work. The staff work quickly to ensure these people are not delayed too much

Excellent service - lovely people and seen quickly. Did a hearing test for my 4 year old while we were there also which we weren't booked in for. Got a quick and lovely follow up letter

I had a short wait in the dermatology dept before being seen by the super-experienced Consultant who was ably assisted by a nurse. I was treated with care and dignity and made to feel that I was in safe hands. A biopsy was done immediately and barely a week later I was informed that I have a rare type of cancer. I am now being treated for this. The NHS at its best

The **Mount Vernon Cancer Centre,** based in Northwood in Middlesex, provides tertiary radiotherapy and local chemotherapy services. The cancer centre operates out of facilities leased from Hillingdon Hospitals NHS Foundation Trust and the Trust continues to work with Hillingdon to progress the redevelopment plans for the future provision of services at the Cancer Centre.

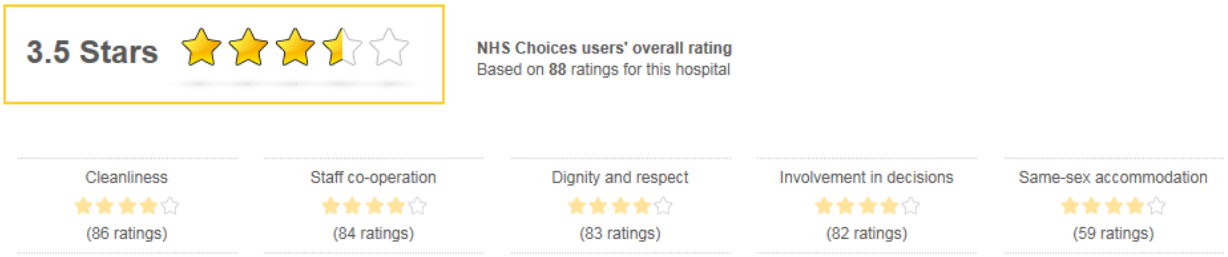
The Cancer Centre is at the forefront with the latest technology offering comprehensive radiotherapy service via nine linear accelerators and has Cyberknife and TrueBeam technology.

Other services include:

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

Feedback from NHS Choices specifically for the Cancer Centre is not collected.

The new **Queen Elizabeth II (QEII) Hospital** is located in Welwyn Garden City. A new hospital, on the site of the original, opened in June 2015. It offers a full range of outpatient, diagnostic (radiology, pathology and endoscopy), therapy and ante/post-natal services, as well as having a 24/7 urgent care centre for adults and children of all ages with minor injuries and illnesses. The Vicki Adkins Breast Unit remains on site and day treatment continues.



Really stunning service from the Urgent Care Centre at QEII last night. My wife had what turned out to be a nasty ankle sprain but we were worried it was broken. Saw nurse in 10 minutes, Xray straight after, then a bit of a wait for a very knowledgeable nurse follow-up and all done in under 2 hours

The person that took me to the changing rooms was very polite and informative and kind. The ultrasound technician shook my hand and made me feel very comfortable calling me by my Christian name and told me that they would be working behind me but if I wanted them to come round to the front to explain anything they would. I can't praise them enough, bedside manner goes a long way and they both excelled in it. (Radiology)

I had a blood test two weeks ago (sent by Neuro consultant) and have not heard the results. So I phoned and phoned and phoned day after day - why are there only answer phones for the Neurology secretaries, and why do they never call back?

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

The Trust offers community services for children and young people.

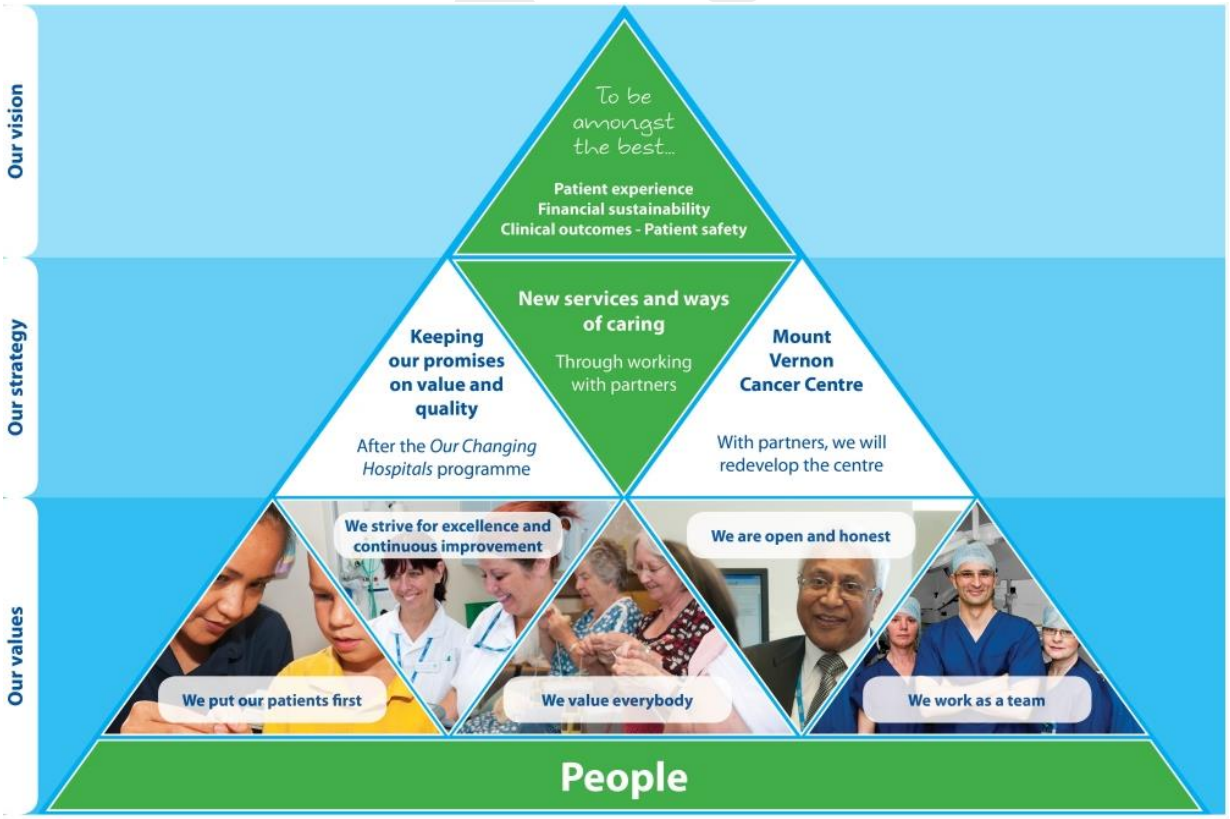
A strategy for quality

The Trust continues with its vision *"to be amongst the best".* This vision is supported by a set of objectives including *"Keeping our promises about quality and value".* This is important to us following our commitment to the public to improve outcomes resulting from delivery of Our Changing Hospitals Programme.

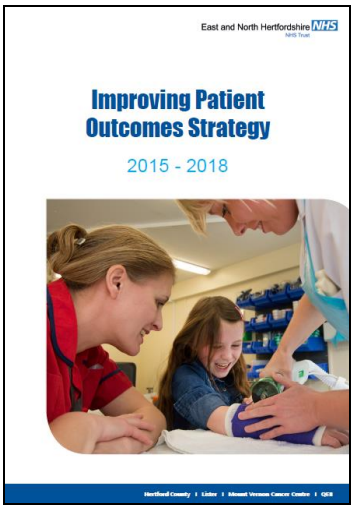
Key to the delivery of the vision and objective are a set of core values known as 'PIVOT'.

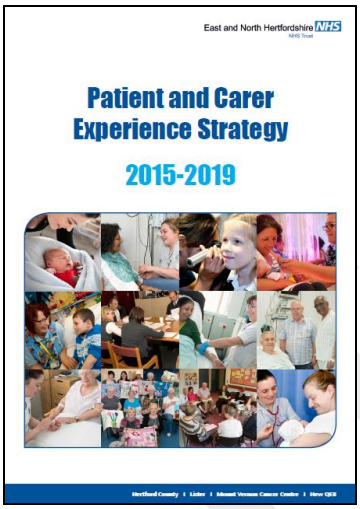
These values are incorporated into everyday working of staff and business of the organisation.

A diagrammatic representation of this strategy, with the objectives and values is shown in the picture below, recognising the importance of staff to deliver the overall vision.



In the 2014/15 Quality Account the launch of the **People Strategy 2014-19** was reported. During 2015/16 this has been supplemented by the launch of a range of strategies including the **Improving Patient Outcomes Strategy 2015-18** (focusing on patient safety and clinical effectiveness) and the **Patient and Carer Experience Strategy 2015-19**. More information on the aims of these strategies is given in throughout this report.





Together these strategies provide a framework for the plans to improve quality over the next three to four years and underpin the overarching Quality and Risk Management Strategy (2015) which outlines how quality is incorporated into the everyday business of the organisation.

Measuring and monitoring improvements

To deliver our vision of being amongst the best we must be able to know how we and others are performing; agree realistic improvement plans in terms of what can be achieved by when; and be able to measure the on-going performance.

Within the Trust we collect information in a number of ways:

- Routine collection via the Patient Administration System – by inputting information about each individual's episode of care eg. diagnosis or length of stay we can generate a vast range of trends that can help in the future planning of services
- Surveys – results of national or local surveys help us to find out what our service users and staff think of our services
- Feedback from complaints and concerns
- Clinical audits – telling us if we are delivering services according to best practices
- National data collections for specific conditions
- Special reviews or service evaluations

Examples of these collections are given throughout the report.

Some of this information provides local trends only; but the majority is collected in the same way by other organisations so can be used to compare the outcomes of services. This is known as *benchmarking* from which we can see the organisations that are performing best and can learn from them.

Using the data available the Trust's clinical and management teams can agree a set of items to be measured, known as *indicators*. They will also agree what to aim for and by when – this is the *target or aim*. Some of these indicators and aims are mandated by NHS England. Where indicators are new then methods to measure them may need to be set up.

The information and progress towards meeting the aims are routinely presented in reports, dashboards, graphs etc. They are monitored by various teams and committees for example:

- By committees, including the Trust Board, who monitor progress
- By departments who review the outcomes and plan changes where necessary
- By the executive team who scrutinise the information, offering praise or challenge as necessary
- 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

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

Supporting teams to improve quality

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

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

- Clinical advisors eg infection prevention team or the safeguarding team providing specialist advice and support
- Information providers supplying data for service evaluation
- Education teams ensuring staff are up to date with training
- Catering, telephony, estates, supplies and cleaning staff who keep the day-to-day services running so that clinical teams can undertake their duties effectively
- Information technology teams keeping the IT systems running and supporting new ways of working such as tele-health
- Human resources who support the recruitment and many other staff management processes
- Those who support service evaluation and compliance such as the team and staff from the Company Secretary's office

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

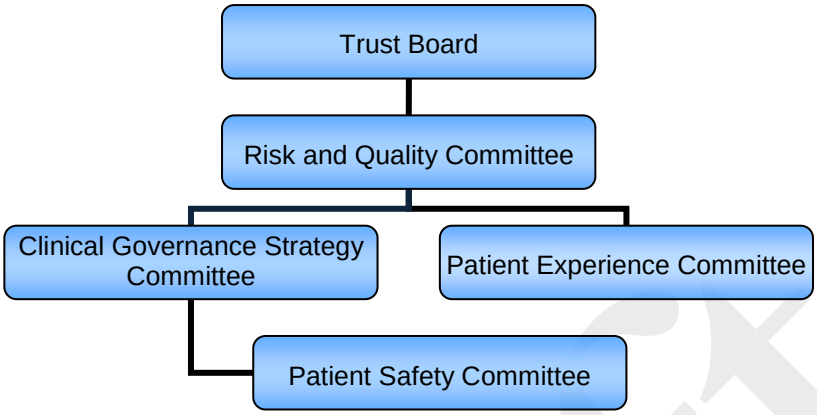
Committee structure

The Trust Board has overall responsibility for the delivery of quality. It scrutinises a range of quality indicators during its meetings which are held in public. The Risk and Quality Committee (RAQC) has delegated responsibility for oversight of all aspects of quality. The committee holds executive directors to account on relevant aspects of their portfolio.

The main sub-committees for monitoring quality are the:

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

These each receive scheduled reports from departments, committees or individuals tasked with quality improvement, for monitoring and assurance purposes. A process of escalation enables any concerns or significant achievements to be shared with the parent committee thus concerns raised by the clinical teams can be highlighted.



CareQuality Commission

- The trust had a committee and subcommittee structure to enable the board to be sighted on the issues within the trust and external impact factors.
- The Risk and Quality committee met regularly. This was chaired by a non- executive director and was attended by the executive leadership team. We attended a meeting of the committee whilst the inspection was in progress and found that it was well attended and that there was a good level of challenge from the non-executive directors.
- There were processes in place to share learning and good oversight of quality metrics with well-developed information set particularly in relation to nursing indicators.
- There was good executive oversight of quality performance and this was a key part of the monthly meetings the executive held with the divisions.
- In the main we found that there were governance systems in place to escalate issues and risks to the trust board.

However

- We found the standard of the divisional risk registers to be variable and we were not assured that there was always effective divisional ownership and scrutiny or corporate oversight of this. We found the corporate risk register had some missing information and some areas of duplication.

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 (RHD)

Each month (except January and 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 such as audit findings, care reviews and incident investigations, and where necessary to make plans for improvement.

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

Local inspections

The safety and compliance teams, together with clinical staff, undertake scheduled visits to clinical areas as part of a safety and compliance inspection programme.

During 2015/16 inspections of the following services were undertaken:

- Maternity services
- Medical services
- Mount Vernon Cancer Centre
- QEII Hospital
- End of Life
- Critical Care

In addition two mock inspections were undertaken following the format of the CQC inspection methodology.

These inspections were used to raise awareness of the inspection process; identify areas of good practice and identify where improvements were required. The involvement of clinical staff provides an opportunity for peer review and to share learning.

Engagement

As reported last year we take the views of our patients, their families/carers and the public seriously to help us better understand what they think about our hospitals, staff and services. Examples of how we seek and listen to service user views are:

- Surveys
- 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

In November students from four Welwyn Hatfield schools spent the morning working alongside senior NHS managers at the Lister hospital on ways the services could be run more effectively for young people.

David Brewer, The Trust's head of engagement, said:

"It is crucial that young people have a say in the way in which hospital services for them are delivered – and it was great to see so many useful ideas being suggested today. The Trust has a very successful campaign called #TheFutureIsMembership that so far has enabled us to recruit over 1,000 youth members."

CareQuality Commission

The trust was very proactive in engaging with the local community and had exceptional engagement with young people.

1c Care Quality Commission inspection

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

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

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

Our ratings for Lister Hospital

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

Our ratings for QEII

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

Our ratings for Hertford County Hospital

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

Our ratings for Mount Vernon Cancer Centre

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

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

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

The Trust had anticipated this rating, acknowledging that after Our Changing Hospitals there was a lot to be proud of, but also more work to be done. Within the CQC report many different areas of outstanding practice were highlighted which reflects the dedication shown by staff to service improvement. These are shown in Appendix 1.

Upon receiving the report in April the Trust's new Chairman Ellen Schroder said:

"There is still plenty to be done, of course, as we implement the action plan that has been agreed with the NHS locally following the inspection report being shared more widely with our partners. Whilst committed to making improvements, we must remember that there is also a great deal to celebrate with our staff, who work so hard every day to ensure that our patients receive high quality care at all times. We very much welcome the Care Quality Commission's report as it helps us now to focus our efforts on ensuring that we improve our services even further for the benefit of both patients and our staff."

The report was published in April and the summary findings are given in Appendix 2. Although many improvements have been implemented since the inspection staff are developing action plans to address both areas that need strengthening as well as continuing to address the specific concerns raised by the CQC shown below.

The Trust must:

- Ensure all required records are completed in accordance with trust policy, including assessments, nutritional and hydration charts and observation records.
- Ensure there are effective governance systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients including the timely investigation of incidents and sharing any lessons to be learned.
- Ensure effective systems are in place to ensure that the triage process accurately measures patient need and priority in the emergency department.
- Ensure that the triage process in maternity operates consistently and effectively in prioritising patient needs and that this is monitored.
- Ensure that all staff in all services complete their mandatory training in line with trust requirements.
- Ensure that patients who require urgent transfer from MVCC have their needs met to ensure their safety and that there is an effective process in place to handover continuing treatment.
- Ensure there is oversight and monitoring of all transfers.

Detailed action plans, with implementation by September 2016, to address the concerns above have been produced. These actions include:

- Daily monitoring of the new triage process already set up in the Emergency Department
- A three times per day review of the activity in maternity triage to assess implementation of the revised process put in place after the inspection
- Review of the training programme to ensure ease of access
- Revision of the risk register reports and the way these are shared and challenged with the Divisions
- Strengthening of auditing of documents with follow-through; and review of the existing training programmes with elements relating to documentation
- Monitoring the database of Mount Vernon transfers to other centres to ensure continuity of care and to ensure the new protocol is followed

1d Managing Demand and Capacity

Running an efficient hospital relies upon managing the flow of patients from arrival to discharge, given the number of beds, staff and facilities that are available. It is complex and requires the optimum performance from staff, processes and infrastructure. This capacity to deliver relies upon:

- Staff who are present, trained, competent and working as a team
- Buildings and facilities that are clean, fit-for-purpose and functioning
- Equipment that is safe to use
- Clear pathways of care which describe what will be done, by whom, by when and how
- Effective clinical support functions such as pharmacy and pathology to deliver medicines and test results
- Effective IT systems which store and share information about a person's care; and support decisions
- Effective administrative functions to support patient flow (ensuring people are in the right place at the right time) and also to evaluate its effectiveness ie the quality of the service

Each year there is an expected number of patients, and therefore an expected number of operations or births etc. Each condition also has an expected length of stay. Given this information it is possible to predict the overall demand for services. Ideally the capacity, ie. the points noted above, can cope with the demand.

However, the population is increasing, people are living longer, and long term conditions and dementia are becoming more prevalent. This means an increase in demand for emergency services, medical management of conditions, operations, therapies and also care homes.

With a finite number of hospital beds and limited care homes available hospitals are squeezed when the number of patients requiring admission is higher than the numbers that can be discharged. We see the effect of this with long waits in the emergency department, delayed transfers of care and cancelled operations where no beds are available.

> All the staff worked very hard to assess and help their patients but they appeared to be hindered by a distinct lack of staff and consultation rooms. On this occasion the waiting times were horrific and totally unacceptable and the staff were overwhelmed with the amount of people asking to be seen. (Emergency Department)

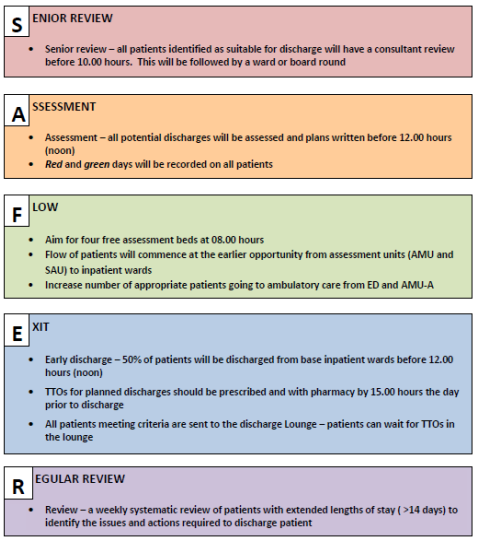
Management of this requires new ways of working - doing things differently. The Trust is achieving this through initiatives to better manage emergency attendees and through increased collaboration with partners in the community and other Trusts to prevent admissions.

Emergency care

The Emergency Department has seen significant growth in emergency admissions and an unprecedented growth in the volume of arrivals by ambulance to the Trust. A number of projects are underway within the Emergency Pathway Programme. To alleviate some of the pressures the Emergency Department has:

- Flexed capacity by opening an extra 14 beds and increased staffing
- Implemented new triage and care processes
- Introduced progress chasers and extended the clinical navigators role to promote better movement of patients through the departments

- Developed Ambulatory Care to provide day treatment without an overnight admission



SAFER bundle

Use of the SAFER bundle helps to support more timely discharges, therefore creating improved patient flow.

This specifies what staff need to do, and by when, to ensure that patients are reviewed and discharged effectively

I attended A&E on Monday night due to a deterioration in my mental health. I arrived by ambulance and the department was very busy with people waiting in the corridor. The ambulance staff had been excellent with me and explained my situation to the nurse in charge of Majors.

I had to wait in the corridor for over three hours but the nurse in charge was very apologetic and made sure that those waiting were as comfortable as possible. The ambulance staff with me were first class and very understanding, taking me to get fresh air when needed, taking me to the toilet and making sure I was as comfortable as possible.
When there was a space I was taken to a bed in the DART area where I was seen by a nurse and then a Doctor. Bloods were taken, the psychiatric team contacted and then I was discharged seven hours after arriving at the department.

All the staff were extremely busy and under a lot of pressure but I felt that I was treated with dignity and respect and that my needs were met. I have had a number of negative experiences in the past in A&E and get extremely anxious but the staff on this occasion especially the nurse in charge dealt with me in a positive way and helped me be a lot anxious.
I am very grateful especially to the ambulance staff and the nurse in charge for all the help that they gave me as they went above and beyond when extremely pressured. (Anon)

Collaboration

Integrating care with services outside of the Trust is a priority for us. Working with partners the Trust is developing patient centered care in a more co-ordinated way with care being delivered in the most appropriate locations ie. Home and where expertise is concentrated. During 2015/16 we saw the development of:

- A 7 day multidisciplinary respiratory service
- A Hyper Acute Stroke Unit for patients across East & North Herts and West Essex
- An Interface Geriatrician service which includes GP access to specialist telephone advice and daily rapid access clinics

The Trust is exploring other collaborative opportunities that offer clinical benefits that are also financial sustainable. For example, working with West Essex and the Princess Alexandra Hospital in Harlow on interventional radiology and development of a vascular surgery hub.

An Integrated Care Programme Board and System Resilience Group are overseeing the collaborative work programme.

Part 2

2a	Priorities for improvement for 2016/17
2b	Statements of assurance from the Board
2c	Performance against national core indicators
2d	Review of quality performance in 2015/16

2a Priorities for improvement for 2016/17

Identifying priorities

In order to seek views about priorities for 2016/17 the following actions were undertaken:

- Existing priorities and indicators were reviewed to ensure they were relevant. This formed part of the debate during the consultation stages
- 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 all priorities
    - Risk and Quality Committee for all priorities
- Review of complaints and PALS concerns
- Review of feedback from NHS Choices
- Review of feedback from national patient and staff surveys
- Feedback from the Care Quality Committee inspection
- Staff engagement through the development of their business and improvement plans

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

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 liaison with the Clinical Commissioning Group throughout the year
- Review of CQUIN and operating plan aims

Following this review it has been agreed to:

- Maintain three of last year's priorities – medication management; mortality and stroke standards
- Retire the safety thermometer scores as the most significant improvements have been made over previous years and the processes are embedded. These indicators are routinely monitored as part of the Director of Nursing reports to the Risk and Quality Committee
- Retire delays because of the reductions noted via the complaints and PALS concerns. This will continue to be monitored in the same way as the safety thermometer

- Maintain communication as a priority but adjust the way this is measured. The existing indicators will continue to be monitored by the Patient Experience Committee or via the Director of Nursing reports to the Risk and Quality Committee

SAFETY PRIORITIES

No	Indicator	Why this is important	How this will be measured	Lead Director/s
1	Improve medication management	Medication audits show that initiatives to improve medication management are working. We wish to make further improvements in this area.	• Survey results (medication purpose & side effects) • Incident reporting • Medication omission audit • Medicines Optimisation Strategy milestones • Medication Thermometer • Time to antibiotics	Medical Director & Director of Nursing and Patient Experience
2	Introduce Human Factors	There is increasing emphasis placed on this developing area nationally. It is also a priority identified within the Improving Patient Outcomes Strategy	• Deliver a new style serious incident investigation training • Undertake a human factors review of 2 clinical areas • Monitor concerns relating to NEWS and poor escalation	Medical Director

EFFECTIVENESS PRIORITIES

No	Indicator	Why this is important	How this will be measured	Lead Director/s
3	Continue to reduce mortality	This is a significant priority for the Trust. Whilst the HSMR remains better than national average the SHMI still remains a concern	• HSMR • SHMI (inc adjustment for palliative care) • Audit of Unexpected Critical Care admissions • No. of cardiac arrest calls • Observation Compliance • Mortality review	Medical Director
4	Continue to improve stroke standards	There remain delays in transferring people to the stroke unit. Additionally the Trust wishes to evaluate the impact on standards of the increased activity associated with acceptance of patients from the Harlow area	• 3 hr thrombolysis • 4 hrs to stroke unit • 90% time on stroke unit • 60 minute to scan	Director of Operations

EXPERIENCES PRIORITIES

No	Indicator	Why this is important	How this will be measured	Lead Director/s
5	Improve communication	Communication failure remains one of the most common subjects identified via feedback mechanisms. As the culture programme strengthens we wish to evaluate the impact upon user feedback.	• Improvement in survey results (involved in decisions, consistent info, providing understandable answers, name of contact) • Reduction in complaints & PALS concerns (rate) • Implementation of the Accessible Information Standard	Director of Nursing & Patient Experience; Director of Operations
6	Improve nutrition and hydration	The Food and Drink Strategy was launched in 2015. Improving nutritional care is the first ambition	• Feedback from patients about new menus • In-patient survey results • Delivery of strategy milestones • Delivery of the Healthy Eating CQUIN	Director of Nursing & Patient Experience

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

- Bi-monthly reports to the Risk and Quality Committee (Medical Directors Mortality Report, Director of Nursing & Patient Experience Safety Report, Director of Operations updates)
- Monthly 'Floodlight' report to the Board
- Quarterly thematic reviews of mortality at the Clinical Governance Strategy Committee
- Patient Experience Committee
- Medication Forum
- Patient Safety Committee
- Nutrition Group

2b Statements of assurance from the Board

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

Review of services

During 2015/16, the East and North Hertfordshire NHS Trust (ENHT) provided and/or sub-contracted 27 NHS services. The ENHT has reviewed all the data available to them on the quality of care in 27 of these NHS services. The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by the ENHT for 2015/16.

Participation in clinical audits

During 2015/16 52 national clinical audits and 8 national confidential enquiries covered NHS services that ENHT provides.

During that period ENHT participated in 42 (81%) national clinical audits and 8 (100%) national confidential enquiries of the clinical audits and national confidential enquiries which it was eligible to participate in.

The two tables below show:

- The National Clinical Audits and National Confidential Enquiries that ENHT was eligible to participate in during 2015/16
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2015/16, and for which data collection was completed during 2015/16, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

National Audits	Eligible	Participated	% Cases Submitted
AAA Repair (National Vascular Registry)	Yes	Yes	100% -Continuous
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	100%
Audit of the Use of Blood in Haematology	Yes	Yes	100%
Bowel Cancer Audit Programme (NBOCAP) 2015-16	Yes	Yes	100% Continuous
BTS Acute Community Acquired Pneumonia (01/12/14-31/05/15)	Yes	Yes	Circa16%[1]
BTS Emergency Use of Oxygen	Yes	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	Yes	100%
Carotid Endarterectomy (National Vascular Registry)	Yes	Yes	100% -Continuous
Falls Liaison Service (FFFAP Programme)	No	No service	
Head and Neck Cancer Audit (DAHNO)	Yes	Yes	100% -Continuous
ICNARC Case Mix Programme	Yes	Yes	100% - Continuous
Lower Limb Amputation (National Vascular Registry)	Yes	Yes	100% - Continuous
Lower Limb Angioplasty/Stenting (National Vascular Registry)	Yes	Yes	Circa 10%[2]
Lower Limb Bypass (National Vascular Registry)	Yes	Yes	30%[3]
Lung Cancer Audit (NLCA)	Yes	Yes	100% - Continuous
Major Trauma (Trauma Audit & Research Network) (TARN)	Yes	Yes	60%[4] - Continuous

National Audits	Eligible	Participated	% Cases Submitted
National Audit of Dementia	Yes	The audit starts in April 16	
National Audit of Diabetes Foot Care Audit	Yes[5]	Lack of input from podiatrists	
National audit Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	100% - Continuous
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Cataract Audit (Ophthalmology)	Yes[6]	No funds	
National Complicated Diverticulitis Audit	Yes	Yes	100%
National Diabetes Core Audit	Yes	Yes	100%
National Diabetes In Patient Audit (NaDiA)	Yes	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%
National Heart Failure	Yes	Yes	100%
National Hip Fracture Database (FFFAP Programme)	Yes	Yes	100%
National Inflammatory Bowel Disease (IBD) audit	Yes	Yes	100% - Continuous
National Inpatient Falls Audit (FFFAP Programme)	Yes	Yes	100%
National Joint Registry	Yes	Yes	100% - Continuous
National Oesophagus Cancer Audit (NOGCA)	Yes	Yes	100% - Continuous
National Paediatric diabetes (NDPA) Core Audit	Yes	Yes	100%
National Parkinson's Disease	Yes	Yes	100%
National Percutaneous Coronary Intervention	Yes	Yes	100%
National Pregnancy in Diabetes (NPID) Audit	Yes	Yes	100%
National Prostate Cancer (NPCA)	Yes[7]	Yes	Partial submission
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
NHSBT Lower GI Bleeding	Yes	Yes	100%
NHSBT Patient Blood Management in Scheduled Surgery	Yes	Yes	100%
NHSBT UK Transplant Registry	No	Not relevant	
Paediatric Asthma (BTS)	Yes	Yes	100%
Paediatric Intensive Care Audit Network	No	Do not have PICU	
Paediatric Pneumonia	No	Not on the final forward plan	
Prescribing Observatory for Mental Health (POMH)	No	Not relevant	
Procedural Sedation in Adults (CEM)	Yes	Yes	100%
PROMS (Patient Reported Outcomes Measures) Elective Surgery	Yes	Yes	Figure not published yet
Pulmonary Hypertension	No	Service not provided	
Renal Registry	Yes	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100% - Continuous
UK Cystic Fibrosis Registry	No	Do not treat patients	
Vital Signs in Children (CEM)	Yes	Yes	100%
VTE Risk in Lower Limb Immobilisation (CEM)	Yes[7]	We did not participate as there is no protocol/pathway in place	

[1] Not able to complete 29% of cases due to acute data missing in patient's notes for the relevant episode of care. Action proposed to clear backlog of cases for review
[2] & [3] Data submission started later in the year due to problems with resources
[4] Issues with IT report not capturing all cases. Solution to rectify in process with mini HES sequel, IC10 codes & action plan to clear backlog
[5] National Diabetes Foot Care audit did not take place as specialty did not have required input from the community podiatrists

[6] National Cataract audit did not take place due to lack of funds necessary for the installation of the audit software
[7] There is a delay in submission to the National Prostate Cancer audit. An improvement plan is being prepared to clear the backlog and increase efficiency
[8] VTE Risk in Lower Limb Immobilisation audit did not take place as the protocol & the pathway are currently being revised in the Trust

National Confidential Enquiries	Eligible	Participated	% Cases submitted
NCEPOD Acute Pancreatitis	Yes	Yes	100%
NCEPOD Provision of Mental Health in Acute Hospitals	Yes	Yes	80%[1]
NCEPOD Non Invasive Ventilation	Yes	Yes	In progress[2]
NCEPOD Adolescent Mental Health	Yes	Yes	In progress[3]
MBRRACE-UK Perinatal Intrapartum Stillbirths	Yes	Yes	100%
MBRRACE-UK (Late Fetal Losses, Stillbirths and Infant Deaths)	Yes	Yes	100%
MBRRACE-UK (National Confidential Enquiry into Maternal Deaths)	Yes	Yes	No deaths
MBRRACE - UK Perinatal - Antepartum in Term normally formed Infants	Yes	Yes	100%

[1] One clinical questionnaire (out of 5 selected by the NCEPOD) was not completed due to missing data in patient's notes for the relevant episode of care
[2] At this stage, only the list of eligible patients was sent over to the NCEPOD
[3] At this stage, only the list of eligible patients, obtained through a prospective audit, was sent over to the NCEPOD

National Audits

The reports of 35 national clinical audits were reviewed by the provider in 2015/16 and the following are some of the actions ENHT intends to take to improve the quality of healthcare provided.

National audit	Actions to be taken
Early Onset Neonatal Sepsis Management	• Adapt Gentamicin doses as per NICE guidelines • Documentation of time decision made to treat infection • Antibiotic to be given within one hour of decision to treat
National Audit of Cardiac Rehabilitation	• New venue at Chesfield Downs for low impact exercise group • Collaboration with University of Hertfordshire to offer better venue in East Herts • Prioritising MI assessment appointments above elective PCI or CABG to reduce waiting time
National Paediatric diabetes (NDPA) Core Audit	• Increased Staffing - HCA, Medical, PDSN, Clinical Psychologist
BTS Community Acquired Pneumonia Audit	• Highlight perceived delay to treatment caused by getting chest XRays on AMU - ? Need dedicated porter • Screen saver to promote use of CURB-65 score to optimise antibiotic therapy • Pneumonia proforma to be uploaded to Electronic Patient Record (EPR) to promote use of CURB-65 score, optimise use of antibiotics and 4 hr target for antibiotic therapy.

Local audits

The reports of 191 local clinical audits were reviewed by the provider in 2015/16 and the following are some of the actions ENHT intends to take to improve the quality of healthcare provided.

Local clinical audit	Actions to be taken
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision-making & documentation at Michael Sobell House (Cancer Centre)	• On-going training and support to medical staff about CPR discussion • Discuss DNAR status in multidisciplinary meetings • Ensure CPR document is signed by nursing staff • DNAR discussion/decision to be added to discharge summary
Wholesaler dealers license (CSS)	• Stock found on floor to be removed (three boxes in total) • Ensure training records are up to date and are in HR files • Review signage throughout stores area • Temperature mapping required in robot room • Robot risk assessment to be completed in new robot room
Nasogastric (NG)tube placement in Intensive Care Unit / High Dependency Unit (Surgery)	• NG Stickers to be put in the notes by doctors for confirmation of safe position (Even if placed by nurses) • E-learning module (new doctors and Trainees)/Competency • NG tube teaching introduced in the course for the ICU Novice trainees • NG tube documentation column on new ICU charts
Think Family Audit (Women's & Children's)	• All adults who attend Emergency Department (ED) to be asked if they have children/dependants. All staff in ED to be given update training on mandatory sections to complete on EPR • Levels 2&3 Safeguarding children training to include Think Family & importance of documenting family structure for all attendances • Pocket sized checklist to be formulated and distributed to all nurses and doctors in ED with guidance on mandatory questions to ask at Triage/assessment • To explore developing the EPR system to have a Yes/No section for dependants/children as mandatory. If yes - state who

Research and development

The number of patients receiving NHS services, provided or sub-contracted by the ENHT in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 1584.

The Trust has a long history of being research active with particular strengths in Cancer, Renal, Cardiovascular Disease and Diabetes. Particular highlights have included:

- **Prostate Cancer** - The Trust recruited 135 patients to the 'STAMPEDE' trial which is evaluating the treatment of prostate cancer. Out of 107 national centres, the Trust was ranked 14th highest overall in terms of entering patients and the best of the five NHS trusts involved in the East of England. The results of the trial were published in the Lancet and concluded that "*Docetaxel treatment should become part of standard of care for adequately fit men commencing long-term hormone therapy for advanced prostate cancer*".

- **Commercial Research –** The Trust supports a high number of commercial trials covering numerous diseases. The NHS National Institute for Health Research (NIHR) has singled out consultant medical oncologist, Dr Paul Nathan for his global contribution to cancer research**.**
- **Renal Research** – A large number of projects are devised, supported and delivered by this team. For example, external funding was obtained from the NIHR Research For Patient Benefit scheme to study "*Supportive care for dialysis patients: attitudes and perceptions*". The attitudes and perceptions of 325 patients in relation to supportive care and end-of-life care planning were assessed. The results were published and now inform local care.
- **Cardiovascular Research** – The cardiology team have a large portfolio of research studies involving studies on cholesterol lowering, angioplasty, stenting, heart failure and arrhythmias. For cardiovascular research, the Trust was the highest recruiter of commercial studies in the East of England, and the second highest overall in England including both commercial and non-commercial research.

During 2015/16 The Trust has significantly strengthened its leadership through the appointment of Dr Phillip Smith as Associate Director of Research and Development. Dr Smith, supported by a highly professional team, provides a single point of contact for all research matters at the Trust.

Looking forward the Trust has produced a Research Strategy for 2016-19 which aims to enhance patient experience and outcome by offering research opportunity for all patients and all staff. To achieve this, the Trust will build on its reputation as an internationally recognised centre of excellence for research and patient outcome where patients and public are engaged with, participate in, and benefit from research and innovation. This strategy was devised through numerous engagement exercises including the review of comments from 499 respondents to an online survey.

Goals agreed with commissioners

A proportion of the ENHT's income in 2015/16 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 (CQUIN) payment framework.

CQUIN is a way of improving quality by providing a financial incentive. The Trust receives either a full or part payment depending upon the results it achieves. In 2015/16 £x million of income was dependent upon achieving CQUIN targets. During the year we secured xx% of the CQUIN target generating £x million of income.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at www.enht-tr.nhs.uk

The Trust main CQUINs for 2015/16 are set out in the table below, together with their full monetary value and details of whether or not these quality improvements were met.

Add more detail above & to table once funding finalised.

	CQUIN	Weighting	Value awarded (£000s approx)	Achievement
1	Acute Kidney Injury			
2a	Sepsis Screening			
2b	Sepsis Antibiotics			
3a	Dementia FAIRI			
3b	Dementia Training			
3c	Dementia Carers			
4	Unscheduled Care			
5	Workforce			
7	Stroke			
7	Acute Chest Team (Q3 – 20%)			
8	Safer Discharge -Enhanced discharge summaries			
9	Pharmacy			
		100%		

Statements from the Care Quality Commission

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is *registered with no conditions* – until March 2016.

The ENHT has not participated in any special review or investigation by the CQC during 2015/16. However the Trust underwent its routine inspection as part of the overall inspection of all Trusts with the details reported in section 1c.

The outcome of the inspection included the requirement to address regulator actions under regulations 12, 17 and 19. These are:

Lister Hospital Site:

- **regulation 12 (safe care and treatment)** – ensure effective triage processes are embedded within the emergency department and maternity service
- **regulation 17 (good governance)** – risk were not always identified and all mitigating actions taken in all services. Records were not always completed and stored in accordance with Trust requirements
- **regulation 18 (staffing)** – ensure all staff have mandatory training in accordance with Trust requirements

Mount Vernon Cancer Centre:

- **regulation 12 (safe care and treatment)** – ensure process are in place to ensure the continuing treatment for patients requiring urgent transfer
- **regulation 17 (good governance)** – recognition of risks of transferring acutely unwell patients out of the hospital via an ambulance and recording of these.

The Trust has developed an action plan to address the areas of concern and to ensure continual improvement. This is being monitored by our CQC Quality Development Board, Risk and Quality Committee and Board.

Data quality

The ENHT submitted records during 2015/16 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	99.7%	99.98%
Out patient care	99.9%	99.96%
Accident & Emergency care	98.7%	98.46%

Information Governance

The ENHT's Information Governance Assessment Report overall score for 2015/16 was 78% and was graded 'not satisfactory' (red).

This was due to two measures assessed as a level 1 - coding and clinical information assurance on business continuity management. Action plans are in place to deliver a minimum of a level 2 for all measures in 2016/17. The section below provides further detail on the coding actions. Information Governance training remains a priority for the Trust and the e-learning package is supported by an increased number of face to face training sessions delivered on the Trust's Statutory and Mandatory training day and a number of other training and awareness activities across the organisation.

Clinical coding error rate

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

	Monitor
Primary diagnoses incorrect	30%
Secondary diagnoses incorrect	30%
Primary procedures incorrect	25%
Secondary procedures incorrect	20%

Following the new Head of Coding's review of the Trust's coding position a number of areas have been identified for initial focus. ENHT will be taking the following actions to improve data quality:

- Identification of additional resource to support accurate coding of stroke
- Focus on accurate coding of stents in relation to vascular surgery
- Standardisation of documentation for respiratory patients.

Additionally, the following current supporting activities will support coding improvements:

- The education of junior doctors regarding the importance of accurate coding continues with physical hand-outs, emailed information and inclusion in the Grand Round presentation
- Standardisation of Ward round processes and documentation. It is felt that this will greatly assist in our drive to improve the quality and accuracy of coding
- Training by the coding team in the use of ICD10 5th edition which will be used for all patients discharged from 1st April 2016

2c Performance against national core indicators

In this section the outcomes of nine mandatory indicators are shown and comparisons made with other organisations nationally where applicable.

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

This benchmarked data is the latest published on the Health and Social Care Information Centre (HSCIC) website.

1. Mortality

There are 3 main types of mortality indicator.

a) Crude mortality

Crude mortality is a simple analysis of the percentage of patients who die in hospital against the total number of discharges from hospital. It makes no adjustment for patient acuity (how unwell they are). Crude mortality data is available within one day following the end of the month. The table below shows the improvements over the last year compared with the three year average.

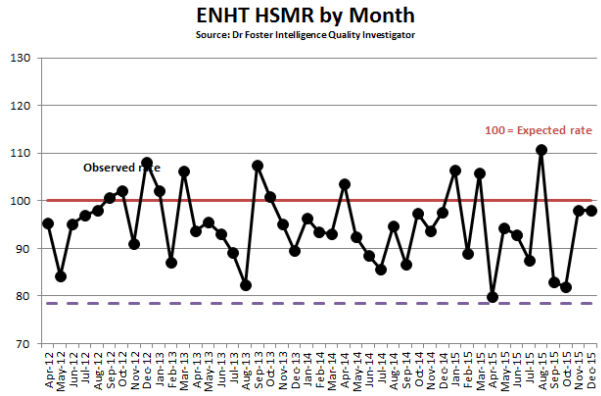
Time period	Crude mortality rate
3 year average rate	1.71%
Latest rolling year (March 2015-Feb 2016)	1.62%
2015/16 year to date (at 31st March 2016)	1.6%

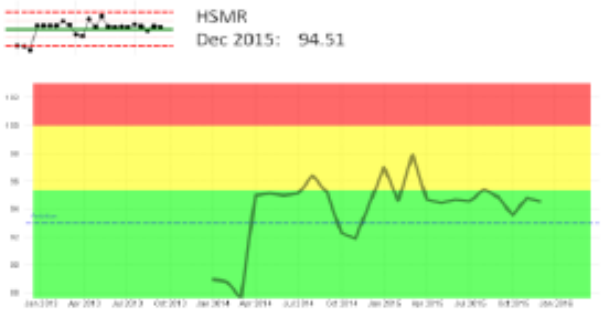
b) Hospital standardised mortality ratio

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

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

The Trust's HSMR position for the last twelve months to December 2015 was **94.51** and is rated statistically as "lower than expected".





c) Summary Hospital-level Mortality Indicator

The Standardised Hospital Mortality Index (SHMI) measures hospital mortality outcomes for all diagnosis groups along with deaths in the community up to 30 days after discharge. SHMI data is 7-9 months in arrears.

The SHMI is not adjusted for palliative care. This means that trusts that have palliative care facilities such as hospices are likely to have a higher SHMI than the England average.

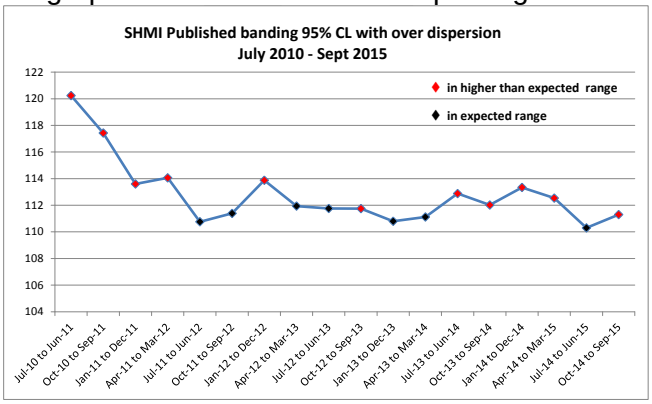
Similar to the HSMR a score of 100 represents the average. The most recent HSCIC data for the period October 2014 to September 2015 shows the SHMI at 111.3. This places the Trust in the "higher than expected" range.

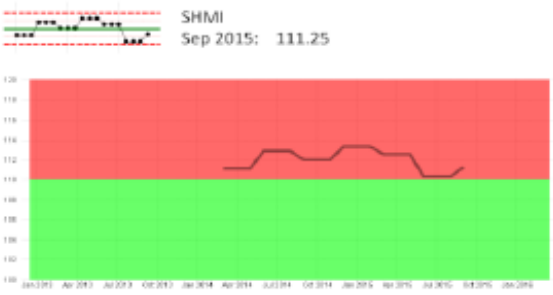
	Mortality	ENHT Previous Periods		ENHT Current Period	National Current Period
		Apr 14-Mar 15	Jul 14-Jun 15	Oct 14 - Sept 15	
a	Summary hospital-level mortality indicator ("SHMI") value	1.125	1.103	**1.113**	1
	SHMI banding	Higher than expected	As expected	**Higher than expected**	-
b	Percentage of patient deaths with palliative care coded at diagnosis or specialty level	45.3%	44.6%	**44.2%**	26.6%

The methodological differences between the HSMR and the SHMI models provide some challenges for the Trust as the reported performance is significantly divergent. The ENHT considers that this data is as described for the following reasons:

- The Trust manages a hospice at Michael Sobell House in MVCC and also provides a 7-day palliative care service in the Lister Hospital
- There is raised mortality associated with respiratory conditions such as chronic obstructive pulmonary disease, urinary tract infections and acute cerebrovascular disease
- The Lister has a significantly higher proportion of patients with end-stage respiratory and cardiac disease who are admitted to die in the Trust compared to the norm in England

The graphs below indicates the improving SHMI value since 2011.





The ENHT has taken a number of actions to improve the SHMI rate, and so the quality of its services. These are detailed in the sections below.

The five diagnoses resulting in the highest number of deaths during the period of the SHMI publication period ending September 2015 are Pneumonia, Acute Cerebrovascular Disease (which includes stroke), Urinary Tract Infections, Chronic Obstructive Pulmonary Disease (COPD) and Acute and Unspecified Renal Failure. Details of stroke initiatives are included in Part 2d of this report.

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

Improvements in the Respiratory HSMR levels continue to be seen.

A 7-day multi-professional Respiratory service was launched in April 2015. Respiratory Consultants and Specialist nurses work full days on Saturday and Sunday. The service covers ward rounds and provides the Acute Chest team (ACT) service. Admission has been prevented in up to 8% of patients seen by the ACT.

Further developments include:

- Telephone consultations for GPs to access respiratory consultants for advice on how to best manage people in the community
- Initiatives to address the significantly higher proportion of End Stage respiratory patients admitted to ENHT

The roll out of a Community based Respiratory Service across the locality will result in further significant improvements in future.

Urinary Tract Infection (UTI)

Data available in March 2016 shows UTI mortality at 80 (HSMR) and 108 (SHMI).

Initiatives undertaken within the last few years are now resulting in a reduction in mortality. The Trust continues to work with the CCG to enable patients to be treated in their care homes rather than in hospital. At present difficulties in the administration of intravenous antibiotics is posing a challenge to this aspiration.

The Interface Geriatrician service has two consultants who provide care on the ward for acutely admitted older patients, a rapid access clinic daily and access to telephone advice to GPs.

Acute Kidney Injury (AKI)

The following developments are of note:

- The formal launch of an AKI team, including the appointment of an AKI nurse specialist, to promote recognition and reduce delay to diagnosis and intervention
- Development of a Trust AKI Working Group
- Dedicated AKI teaching to pharmacists has commenced together with the development of the STOP policy being undertaken in collaboration with pharmacy and the heart failure service
- Review of 115 patients by the specialist AKI nurse to identify any shortfalls in care eg poor recognition. Teaching will be put in place during 2016/17
- The Trust is working with The Pathology Partnership (TPP) to secure an interface between the Trust and TPP electronic systems for automatic population of AKI data in line with the National AKI algorithm.

Sepsis

Data available in March 2016 shows sepsis mortality at 107 (HSMR) and 100 (SHMI).

The 2015/16 CQUIN set two targets relating to sepsis. The achievement against these is shown in the table below.

	Oct-Dec 2015	Jan – Mar 2016	Met
Screening ≥90% of all ED patients	91%	91%	✓
Administering antibiotics within 1 hour to ≥90% of all appropriate patients receive	63%	84.7%	✗

Initiatives taken and underway during the year to improve sepsis management include:

- Recruitment of two sepsis nurses to support screening in the Emergency Department
- Approval of a Patient Group Direction allowing specific nurses to prescribe antibiotics in specific circumstances
- Rewrite of the Adult Transfer Checklist which includes reference to the NEWS observation score and immediate actions required to ensure that critical information and action is not lost during a handover
- Ward and clerking proformas have been reviewed and revised to improve the identification and management of surgical patients with sepsis.

Mortality Review Process

Reviews of 546 case notes of those who died in our hospitals has been undertaken during the year. There are 25 trained mortality reviewers in place. The reviewer enters data into the mortality database and highlights any areas of concern. If there are areas of concern the notes are returned to the patients team for discussion and the results considered by the Clinical Governance Strategy Committee to identify any learning.

2. Patient Reported Outcome Measure

	Patient Reported Outcome Measure	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		Apr 13 – Mar 14	Apr 14 – Mar 15	Apr 15-Sept 15 (provisional)			
a	Groin hernia surgery	0.100	0.072	0.102	0.08	0.135 North Lincolnshire & Goole	0.008 Gateshead Health
b	Varicose vein surgery	Number too low for analysis		Number too low for analysis	0.103	0.129 South Manchester	0.037 Worcestershire Hospitals
c	Hip replacement surgery	0.444	0.428		0.454	0.519 University Hospital Coventry	0.359 United Lincolnshire
d	Knee replacement surgery	0.317	0.312		0.334	0.412 Northumbria Health	0.207 Sherwood Forest

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

- During the summer 2015 the PROMS process within the Pre-operative Assessment Unit was reviewed. It was found that the process did not maximise the potential for capturing the data
- Some patients receive treatment by a 3rd provider so the importance of completing the questionnaire may not be as rigid as Trust staff promote

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

- Revising the PROMS process so that the questionnaires are given to patients at the screening stage

Further liaison with the 3rd provider and the national PROMS team is required to improve the processes to ensure data is captured in a timely way across sites. The most recent data available to the Trust demonstrates a 77% compliance rate with completing the questionnaires.

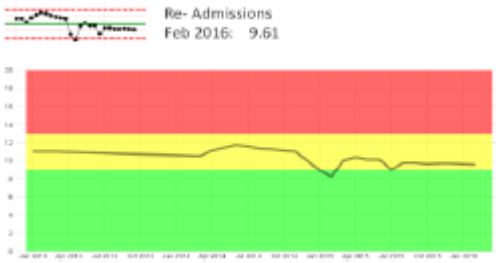
3. Readmissions

The most recent data published by the HSCIC is for 2011/12, hence the information in the table below replicates that shown in last year's Quality Account.

	Readmissions	ENHT Previous Period	ENHT Current Period	National Current Period	Best Performer (Large Acute)	Worst Performer (Large Acute)
		2010/11	2011/12			
a	Percentage of patients aged 0 to 15 readmitted within 28 days of discharge	13.52	**13.65**	10.23 (Large acute)	6.4	14.94
b	Percentage of patients aged 16 and over readmitted within 28 days of discharge	10.56	**11.11**	11.45 (England)	9.34	13.8

More recent Trust data is given below in the table and the graph showing trends since 2012.

Emergency readmissions to hospital within 28 days of discharge			
12/13	**13/14**	**14/15**	**15/16 YTD**
11%	10.52%	10%	9.61%



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

The readmission rate, while still elevated at 9.61 against a target of 9, has seen a slight reduction for non-elective admissions.

Readmission information is gathered for all divisions. Whilst readmission within the surgical and women's divisions is low the average is raised due to a higher readmission rate within the medical division.

The ENHT has taken the following actions to improve the score, and so the quality of its services by auditing medical readmissions which suggests that 31% of readmissions were deemed to have been avoidable, of which 14% were attributable to the Trust. This is an improvement compared to the figure of 21% in the 2011 readmission audit.

Work to improve the readmission rate is being undertaken as part of the Emergency Department Pathways Project. Furthermore Community End of Life care planning and support network was identified as an area for further work in 2016/17.

4. Responsiveness to Personal Needs

This indicator is the average weighted score of 5 questions relating to responsiveness to inpatients' personal needs as measured in the national in-patient surveys.

	Responsiveness to Personal Needs	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		2012/13	2013/14	2014/15			
a	Responsiveness to the personal needs of patients	66.3	64.9	**67**	68.9	86.1 Royal Marsden	59.1 Croydon Health

The measurement is based upon patients reporting they are involved adequately in decisions about their care; they have privacy and understand their medications; they know who to contact after discharge if there is a problem or if they have any worries.

The ENHT considers that this data is as described for the following reasons. The improving result reflects the initiatives put in place to improve overall the patient experiences.

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

- Continuously taking action in response to feedback
- Delivering the milestones outlined within the new Patient Experience Strategy
- Implementing local initiatives within the clinical divisions in light of local feedback

5. Recommending the Trust (Staff)

	Recommending the Trust	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		2013	2014	2015			
a	% of staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends	66%	67%	**67%**	70% Acute Trusts	93% Papworth Hospital	46% Isle of Wight & Mid Yorkshire Hospitals

The ENHT considers that this data is as described for the following reasons. The Trust continues to develop and recognise staff, instilling a sense of pride.

"*Plenty to be proud of…nothing to hide*" was a key element in the run up to the CQC inspection – one which resonated with staff.

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

- Implementing the initiatives outlined in the People Strategy
- Driving forward the staff engagement programme so that staff feel they are important contributors to the success of the organisation
- Promoting the Trust values, in particular 'putting patients first'

"*Plenty to be proud of…because everybody matters*" takes us into 2016/17.

6. Family and Friends Test (Patients)

It is a national requirement that patients are asked to comment whether they would recommend the Trust to family or friends. This is known as the Friends and Family Test (FFT).

Patients are asked whether they are 'extremely likely', 'likely', 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely' to recommend the Trust.

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

	Family and Friends Test	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		Nov 2015	Dec 2015	Jan 2016			
a	Friends & family test—score of inpatient	96%	97%	**97%**	96%	100% Great Ormond Street Hospital	73% Sheffield Childrens Hospital
b	Friends & family test—score of patients discharged from the accident & emergency department	83%	83%	**84%**	86%	100% Liverpool Womens Hospital	56% North Middlesex University Hospital

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

The percentage of adult inpatients who would recommend the Trust is the same as the national average. The percentage of in-patients who would not recommend the Trust is extremely small at less than 0.9%.

The percentage of adult patients who would recommend the accident and emergency services are slightly lower than the national average. Interestingly the percentage who would not recommend the services is around 11%. This reflects the experiences people are having in the Emergency Department due to significant demand as highlighted elsewhere within the report.

Findings for the first three quarters of the year are given in the table below.

Inpatients & Day Case

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	94%				40%	
Q1 Apr-Jun-15	96.40	↑	0.79	↓	43.96	↑
Q2 Jul-Sept-15	96.11	↓	0.78	↓	40.95	↓
Q3 Oct-Dec-15	96.50	↑	0.88	↑	37.64	↓
Q4 Jan-Mar-16	96.49	↓	0.84	↓	44.14	↑

Accident and Emergency

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	78%				19%	
Q1 Apr-Jun-15	81.53	↓	10.89	↑	15.00	↓
Q2 Jul-Sept-15	80.40	↓	12.46	↑	13.69	↓
Q3 Oct-Dec-15	82.42	↑	11.09	↓	18.32	↑
Q4 Jan-Mar-16	80.17	↓	12.70	↑	18.74	↑

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

- Encouraging people to raise concerns at source for timely resolution
- Displaying FFT scores on each ward for patients and the public to see which brings about local ownership
- Implementing the initiatives detailed within the Patient Experience Strategy and People Strategy

7. Venous Thromboembolism

	Venous Thromboembolism (VTE)	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		Apr-Jun 2015	July-Sept 2015	Oct-Dec 2015			
a	% of patients who were admitted to hospital and who were risk assessed for VTE	95%	96.3%	**96.7%**	95.5%	100% York Teaching Hospitals	61.5% Aintree

The ENHT considers that this data is as described for the following reasons. The data is collected by staff who review the medication charts – where the VTE assessment information is held. The information obtained via this local audit is reported to the national collection system.

The percentage has been similar for a number of years with ongoing efforts to improve the position.

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

- Providing instruction / training on VTE assessment for new and training grade doctors during induction
- Feeding back results from checks of VTE during local safety inspections
- Divisional reporting of monthly data to ensure clinical staff are informed

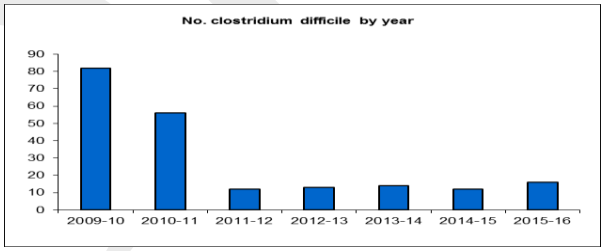
- Monitoring of the completion of assessments at ward level with compliance information displayed on ward boards.

8. Clostridium Difficile

	Clostridium Difficile	ENHT Previous Period		ENHT Current Period	National Current Period	Best Performer	Worst Performer
		2012/13	2013/14	2014/15			
a	The rate (per 100,000 bed days) of cases of C.difficile infection reported within the Trust in patients aged >= 2	5.7	6.2	**5.7**	15.1	0 (4 specialist hospitals; 3.8 at Chelsea 7 Westminster)	62.2 Royal Marsden Hospital

More recent data from Public Health England for 2015/16 to January shows the rate per 1000 bed days as 6.81 (excluding 1 case which is believed to be trust acquired but does not meet PHE criteria). This is the second best performing Trust in the East of England (average 15.16).

The ENHT considers that this data is as described for the following reasons. The Trust has had 16 cases of C. difficile in the year. Of these 2 were considered to be preventable and 14 were unpreventable with no lapses in care associated with the acquisition. Root cause analysis investigation of these incidents has shown some delays in sending specimens to be tested, so some of the cases of reported C. difficile may not have been hospital acquired. There have also been incidences of poor documentation of parts of the *C.difficile* pathway. Positive findings are that antibiotics prescribing is good and there is no evidence of cross-infection having occurred. This continues the pattern of low occurrence as shown in the graph below.



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

- Strict hand hygiene control and adherence to infection control care bundles
- Application of the antibiotic stop policy
- Undertaking root cause analysis investigation of each case to identify causes and use this information for learning and sharing across the organisation
- Reviewing policies and ensuring guidance is clear
- Early isolation of patients suspected of having the infection

9. Number of Patient Safety Incidents

	Number of Patient Safety Incidents	ENHT Previous Period	ENHT Current Period	National Current Period	Highest Performer	Lowest Performer

		Apr 14-Sept 14	Oct 14-Mar 15	Apr 15 – Sept 15			
a	The number of patient safety incidents reported within the Trust	2527	2551	**2799**	-	-	-
b	The rate of patient safety incidents reported within the Trust (- per 1000 bed-days)	24.41	23.55	**26.61**	National data not given	74.67 Northern Devon Healthcare	18.07 United Lincolnshire NHS Trust
c	Number of severe harm or death (Acute Trust – non specialist)	15	15	**17**	2851	2 James Padget East Cheshire	89 Calderdale & Huddersfield
d	Percentage of severe harm or death (Acute Trust – non specialist)	0.6%	0.6%	**0.6%**	0.5%	0.1% Various	2.9% South Warwickshire

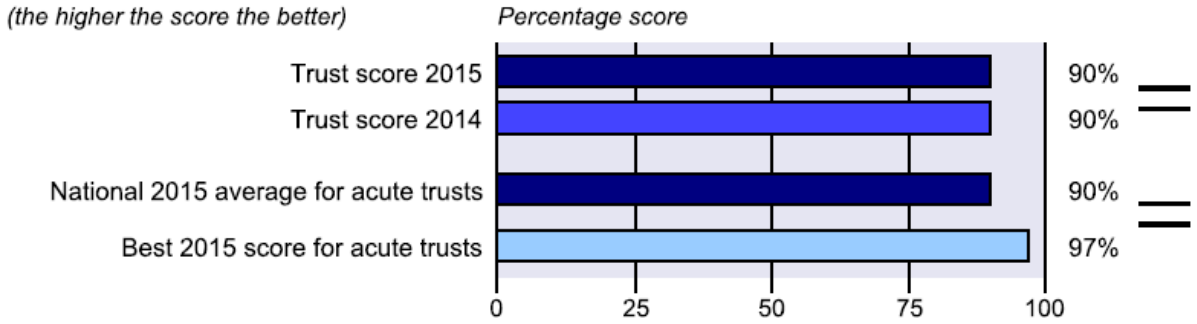
The ENHT considers that this data is as described for the following reasons. The Trust has historically been a high reporter of incidents. More recently changes to the reporting system, service reconfiguration and operational pressures has resulted in a reduction in the number of incidents that are being signed off by managers. So despite the number of incidents being reported being high, reflecting a good safety culture, if they are not signed-off in a timely way they are not able to be uploaded to the national system for benchmarking purposes.

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

- Continuing to support staff in dealing with any concerns
- Providing ongoing training
- Enhancing the performance monitoring of incidents not signed off by department managers within the required timescales

The national staff survey (2015) shows the Trust as performing at national average levels for staff reporting incidents.

KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



Further information on incidents is given in Part 3 of this report.

CareQuality Commission

There had been investment in training of staff to undertake root cause analysis investigation of incidents with work on going in relation to human factors training.

In some areas staff did not always report incidents.

2d Review of quality performance in 2015/16

In the 2014/15 quality account a list of priorities for delivery during 2015/16 was given. Progress against each of these priorities is given in the sections below.

PRIORITY 1 – IMPROVING SAFETY

Comparison table and achievement in-year

		12/13	13/14	14/15	15/16 YTD	Aim for 15/16	Met
1.1a	Safety thermometer score for falls, pressure ulcers, UTI and VTE (no of harms)	N/A	6.4%	4.9%	2.5%	Collect	✓
1.1b	Number of inpatient falls	1244	988	919	861	<876	✓
1.1c	Number of in-patient falls resulting in serious harm	14	16	14	11	<=24	✓
1.1d	Number of preventable hospital acquired pressure ulcers	113	45	54	23	<=36	✓
2.1	Survey results: - medication purpose - side effects	8.4 5	8.2 4.4	8.4 4.8	Awaited	Improve	✓
2.2	Medication incidents - rate per 100 discharges - % leading to harm	1175 N/A N/A	987 1.24 11.96	799 0.91 11.76	Awaiting full year	N/A >1.24 <11.96	N/A
2.3	Undertake medication omission audit					Undertake	✓
2.4	Implement Medicines Optimisation Strategy objectives for year					Implement	✓
2.5	Medication safety thermometer					Introduce	✓

1.1a Safety thermometer

The national safety thermometer audit measures the proportion of patients with harms from falls, pressure ulcers, catheter associated urinary tract infection and venous thrombosis. Undertaken since January 2012 the audit has involved over 31,000 patients. The results show shows a reduction in patient harms from 6.4% in 2012/13 to 4.9% in 2014/15 and was at its lowest at 2.5% in February 2016.

The Trust is on track to meet the target to reduce the number of new catheter associated urinary tract infections reported in the classic safety thermometer audit.

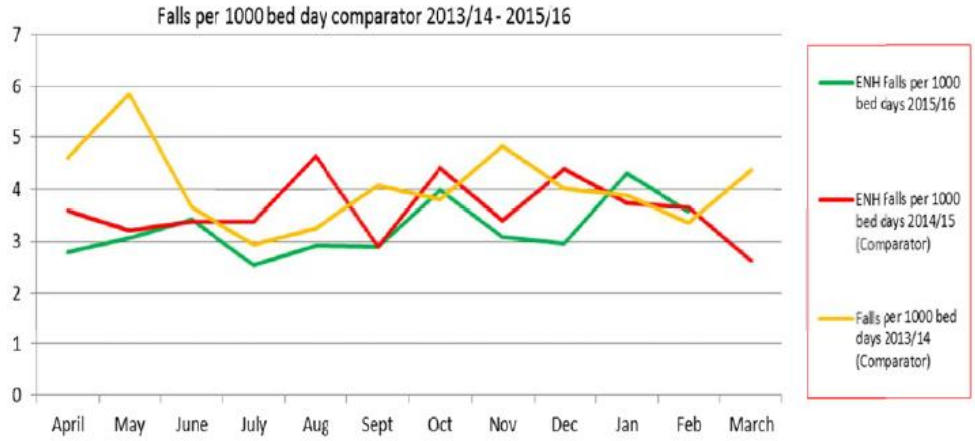
The new generation safety thermometer audits for medication, maternity and children and young people are now being undertaken monthly. Please see section 2.5 below for information on the medication safety thermometer.

1.1b Falls

There have been 861 inpatient falls in the period April 2015-March 2016 and achieved the target 5% reduction compared to 2014/15.

ENHT is amongst the 10% best performing Trusts with an average 3.23 falls per 1000 bed days compared to the average of 6.63 (2015 National Audit of Inpatient Falls).

The chart below demonstrates the rate of falls per month (per 1000 bed days) since April 2013.



1.1c Falls resulting in serious harm

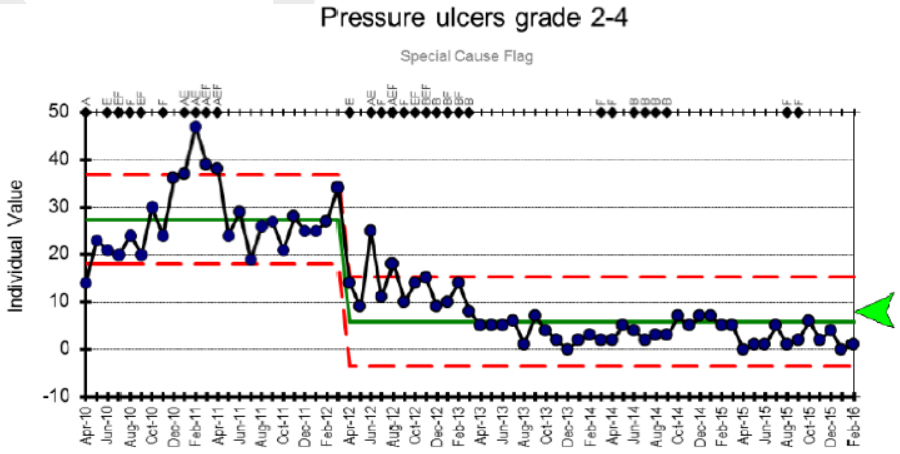
During 2015/16 there were 11 severe harm falls with one incident in which a patient's death was directly attributed to the fall.

All severe harm incidents and any incident where a fall has contributed to the cause of death of a patient are investigated as Serious Incidents. A root cause analysis (RCA) investigation is undertaken with findings shared amongst relevant members of the multi-disciplinary team. Any findings with Trust-wide learning are included with in the Rolling Half Day ' learning points'. All falls-related serious incidents are discussed during the bi-monthly Falls, Fragility and Bones Group where any trust-wide changes to practice are agreed.

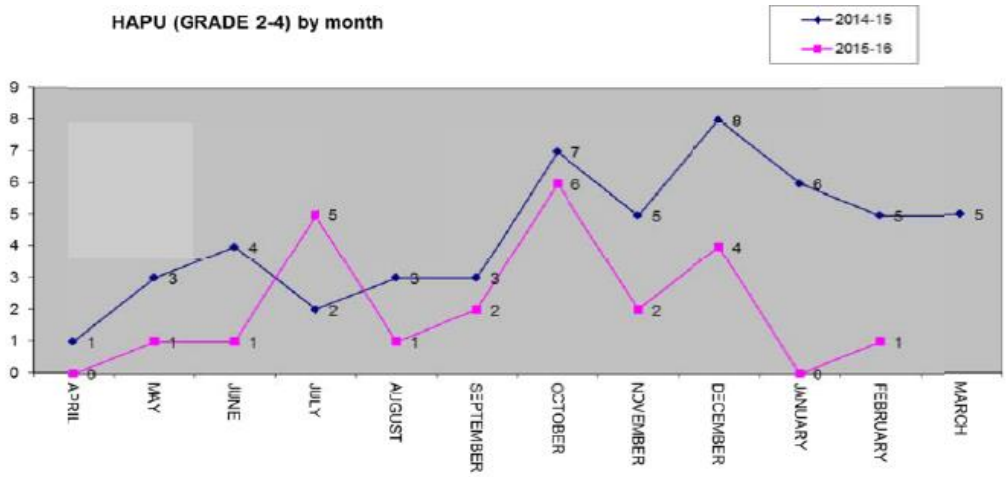
1.1d Pressure ulcers

Between April 2015-February 2016 23 grade 2-4 avoidable hospital acquired pressure ulcers were reported. This is a significant reduction in the number reported in the previous year.

The chart below shows hospital acquired pressure ulcer data since April 2010. The reduction seen in April 2012 can be attributed to the time when the Tissue Viability Team validated pressure ulcer data. Since then avoidable hospital acquired pressure ulcers are shown.



The chart below shows the number of avoidable hospital-acquired pressure ulcers during the last two years which demonstrates this improving picture.



With the closer scrutiny of pressure ulcers a different harm has been identified – that of a moisture lesion. The Tissue Viability Team have reviewed the care of patients with moisture lesions which has resulted in changes of supplier for continence aids and cleansing products and information provided to staff regarding the correct selection and use of products.

Heel mirrors are in regular use which enables staff to inspect more clearly the skin condition in this hard to see area.

The Lead Tissue Viability Nurse delivered a lecture at the Wounds UK national conference in November 2015 and has since been asked to speak at three further conferences on pressure ulcer prevention and management.

2.1 Medication - feedback

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

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

The results from the national in-patient survey are shown below.

	2013	2014	2015	National range (2015)
Explained purpose	8.2	8.4	Awaited	
Side effects	4.4	4.8		

Add summary when national results are published.

2.2 Medication incidents

The aim was to increase the reporting rate while reducing the rate of harm. A high reporting organisation is seen to be a positive characteristic demonstrating the willingness to report and learn from incidents. A reducing harm rate shows improvement in practices. From the chart below it can be seen that:

- the actual rate of incidents reported has been rising during the year
- the level of harm resulting from medication incidents has been falling during the year and is lower than the baseline. The figures below show the quarterly results.

% of medication incidents:	2014/15		Q1	Q2	Q3	Q4
- per 100 discharges						
Aim	*1.24*		>=1.24%			
Actual			0.88%	1.16%	1.21%	Add

- resulting in harm						
Aim	*11.96%*		<11.96%			
Actual			10.14%	8.9%	8.39%	Add

Add when finalised

Medicines were not always stored and handled safely in some areas we brought to the attention of the trust who took immediate action to address our concerns.

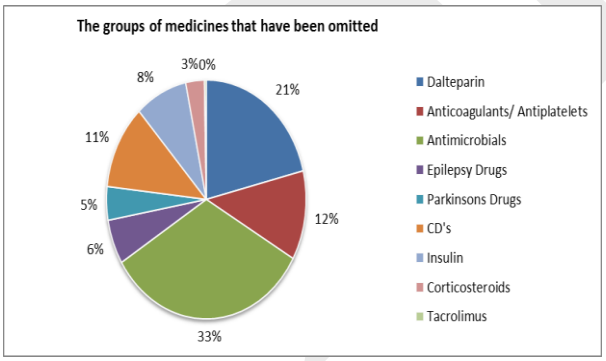
2.3 Medication omission audit

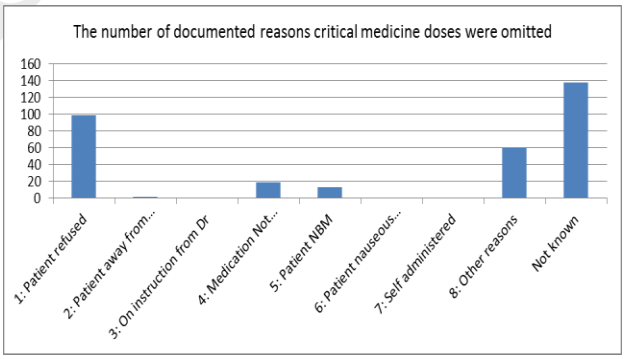
Medication is considered to be delayed if it is administered more than 60 minutes, but less than 2 hours late. An omitted dose is defined as one given more than 2 hours late.

Annual audits of omitted and delayed medication have been undertaken since 2014 with the results shown in the table below. Results from the December 2015 audit show significant improvement since the first audit was undertaken.

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

The actual types of medications omitted are given in the pie chart below together with the reasons why the medications were not given.





It is difficult to be precise about the reasons for the improvement (reduction). It may result from the revision of the critical drugs list and its placement on every ward. Staff may be more aware of which drugs are critical and so are more diligent about administration, even if they have to be delayed. This may account for the increase in the number of delayed drugs.

The medication most frequently omitted were antibiotics (33%) and anticoagulants (combined 33%) as seen in the chart above. It is noteworthy that antibiotics are prescribed more frequently than other medication so this must be taken into account when considering the findings. The audit also noted that an omitted drug was mostly omitted just the once. There were 8 occasions where more than 6 doses were omitted.

Whilst the results show an improving picture the focus is now on ensuring that the reasons for not administering the medication are documented. The audit showed that where medication

was not given the reasons for this were not documented in 42% of cases. It is important that this is understood to enable actions for improvement to be taken.

2.4 Implement Medicines Optimisation Strategy

The Trust Medicines Optimisation Strategy was published in July 2014. It was developed using the NHS Trust Development Authority Medicines Optimisation and Pharmaceutical Services Framework and the Royal Pharmaceutical Society's 'Principles for medicines optimisation.'

The framework helps Trusts to evaluate current practices and identifies areas of existing good practice and where development is required. Year on year actions as detailed within the strategy are implemented to continuously improve upon the original baseline score of 115/144. Actions undertaken in 2015/16 have increased the score further to 125/144. Achievements in the last 12 months include:

- An improvement in the results of the annual audit on delayed and omitted critical medicines as shown in section 2.3
- The pharmacy department reaching its target of 80% of patients having their medicines reconciled within 24 hours of admission when admitted during the working week
- Introduction of the medication safety thermometer as detailed in section 2.5
- The BIMS discharge letter template has been updated to include information when medication has been stopped or changed. This has improved the accuracy of communication on medicines between primary and secondary care

The learning from the CQC inspection on medicines management and the resulting development action plan will support the strategy in 2016/17.

2.5 The Medication Safety Thermometer

The Medication Safety Thermometer is a national standardised audit tool focusing on medication related errors. It quantifies the number of such errors, integrates measurement for improvement into daily practice, directs improvement efforts, and measures improvement in patient care over time. It collects data on the following:

- Allergy status
- Medicines reconciliation
- Omission of critical medication
- Identifying harm from high-risk medicines (anticoagulants, opioids, insulin, & intravenous or sub-cutaneous sedatives)

Data is collected by nurses and pharmacists on one day each month on 100% of patients on six medical wards, five surgical wards and two wards at Mount Vernon Cancer Centre. The data is entered onto the national thermometer web-tool which generates charts summarising Trust results and compares them with data from other Trusts. Results for February 2016 show:

	Trust	Other Trusts
Allergy status	96.9%	96.8%
Medicines reconciliation within 24 hours of admission	76.1%	80.6%
Omission of critical medication	9.5%	6.8%
Undertaking a huddle[1]	0.2%	0.8%

[1] This is where medical/nursing/pharmacy staff have a brief and focused discussion on how specific high-risk errors occurred and how to prevent them from re-occurring.

The pharmacy team has access to the Summary Care Records which has increased the medicines reconciliation rate. To improve the performance further individual ward data is being

produced. Educational and practical support will then help the ward managers to evaluate and improve their team's performance.

PRIORITY 2 – IMPROVING CLINICAL OUTCOMES

Comparison table and achievement in-year

		12/13	13/14	14/15	15/16 YTD	Aim for 15/16	Met
3.1	HSMR (3 month arrears)	97	88.96	92.31	**94.8**	<=95.3	✓
3.2	SHMI	111.39	111.76	112.9	**110.3**	<=110	✗
3.3	SHMI (adj palliative care)	102.04	100.43	100.51	**98.69**	<=96	✗
3.4	Unexpected admissions to critical care	N/A	Audit completed	Completed	**Underway**	Complete audit	✓
3.5	Cardiac Arrests	219	174	203	**Awaiting**	<174	✗
3.6	Observation compliance	96.02	95.88	95.49	**93.61%**	N/A	-
3.7	Mortality review	N/A	N/A	N/A	Undertaken	Undertake	✓
4.1	3 hour thrombolysis for stroke	8.1%	10.08%	7.36%	**7.32%**	>=12%	✗
4.2	Admission to stroke unit within 4 hours of arrival	46.5%	66.25%	51.89%	**61.88%**	>=90%	✗
4.3	90% time in dedicated stroke unit	79.8%	72.71%	73.87%	**82.57%**	>=80%	✓
4.4	60 minute to scan				**89.47%**	>=50%	✓

3.1 – 3.3 and 3.7

Please refer to Part 2c, section 1 on indicators relating to mortality.

3.4 – 3.6 Management of the deteriorating patient

This suite of three indicators represents how staff recognise and deal with a patient whose condition is deteriorating.

- Compliance with recording observations
- Number of cardiac arrest calls
- Unexpected transfers to critical care

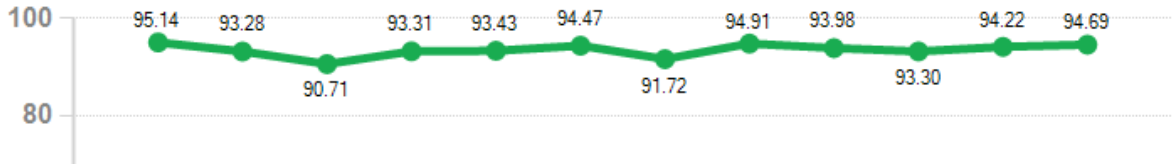
Observation compliance

To effectively identify and manage deteriorating patients it requires strict adherence to undertaking timely and complete observations eg. blood pressure measurement; and prompt escalation to senior staff to instigate actions where deterioration is recognised.

Staff use an observation chart which allows the results of observations to be 'scored' using the National Early Warning Score (NEWS). Action is taken according to the score, for example obtaining assistance from the ward doctor or the critical care outreach team within a certain timeframe.

Routine audits of observations are undertaken as part of the scheduled nursing audit programme. The audit checks that observation charts are correctly completed.

During 2016/17 the average compliance based on 7278 questionnaires was 93.61%. The monthly trend is shown in the graph below.



Education continues for a range of staff as part of scheduled training programmes, and the Critical Care Outreach Team promote full compliance during their visits to wards when seeing very ill patients. The electronic patient record in the Emergency Department captures observations electronically. The Trust will continue during 2016/17 to progress the implementation of an electronic solution throughout the organisation.

CareQuality Commission

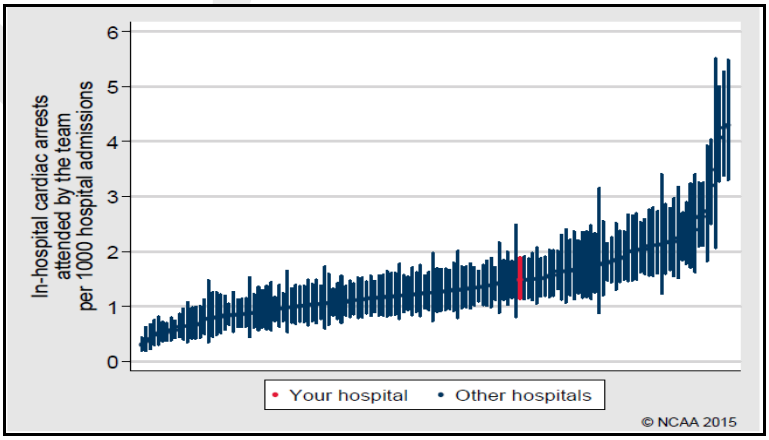
In some areas patient's records such as observation and fluid balance charts were not always correctly completed.

Cardiac Arrests

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

National Cardiac Arrest Audit data for April – September 2015 show that the cardiac arrest team attended 80 cardiac arrest calls of which 64 (60 patients) were in-hospital cardiac arrests. This represents 0.15% of admissions during that time and is an improvement upon the 2014/15 figures.

Compared with other Trusts attendance of the team, per 1000 hospital admissions, shows that we perform slightly better than average.



25% of the patients receiving resuscitation were discharged home. This compares favourably to the national average of 18%.

Unexpected admissions to critical care

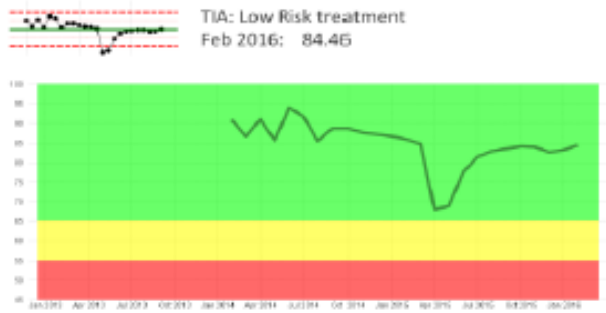
If a patient deteriorates to the point where treatment on the ward is insufficient the patient will be admitted to the Critical Care Unit. This may result from either rapid deterioration or a failure to act upon the earlier signs of the patient deteriorating, ie a worsening NEWS score as seen by the observations.

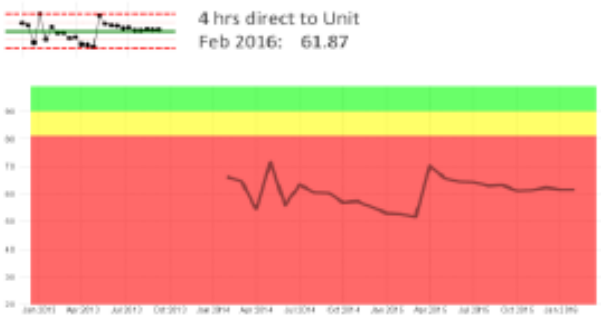
Add 2016 audit results and commentary once data is analysed (expected May).

	2014	2015	2016
Consultant review within 24 hours of admission	75%	95%	
Compliance with NEWS observations	91%	100%	
Deteriorating patients were not escalated to the nurse	50%	51%	
Increase in frequency of monitoring acted upon	50%	61%	

4.1-4.4 Stroke

Progress against the stroke standards are detailed in the charts below.



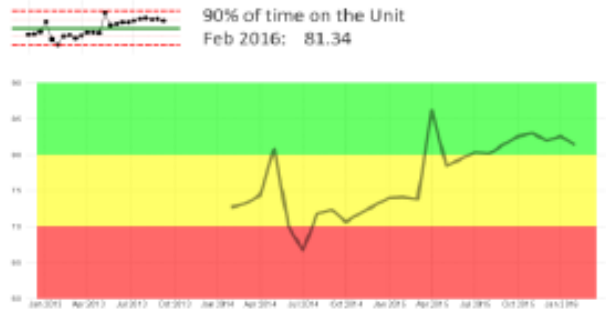


Delivery of these standards are directly linked with performance in the Emergency Department where multiple demands for care compete and delays in identification of people with a stroke can occur.

In addition a shortage of available stroke beds directly affects the admission to the stroke unit standard. Although designated a stroke unit it is not uncommon for non stroke patients to occupy stroke beds due to overall demand for beds in the hospital.

Development of services as stated below will help to address these challenges.

Time on the stroke unit and scanning times are consistently meeting the standards as shown in the graphs below.



In January the Hyper Acute Stroke Unit at Princess Alexandra's Hospital (PAH) closed and since then all Acute Stroke patients from Hertfordshire and a few from West Essex have been brought to the Lister Hospital. The number of attendees from PAH is higher than the number predicted.

To improve the services the following actions have taken place:

- The 24/7 stroke nurse service commenced at the end of March to help identify patients immediately on presentation to the Emergency Department. This will help to address the breaches that have historically occurred out of hours
- A Stroke psychologist is being recruited in conjunction with Hertfordshire Community Trust
- 7 Day therapy has recently been introduced as the team moves towards the implementation of a seven day service
- Appointment of a dedicated stroke service coordinator in December

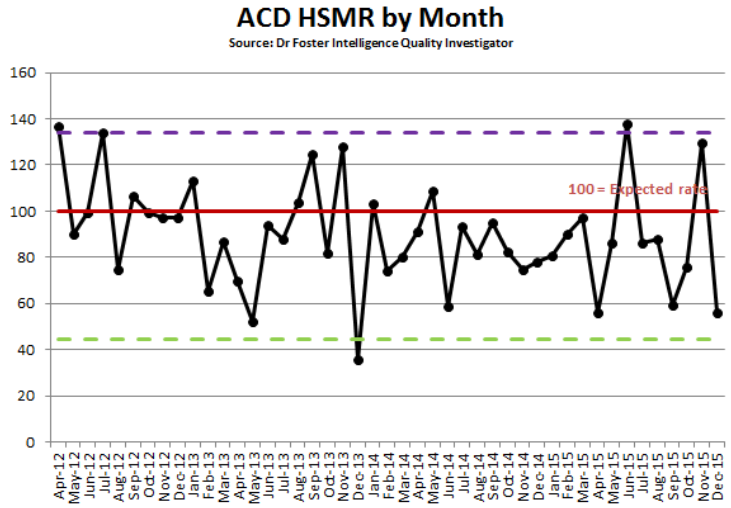
An audit of all FAST (Face, Arm, Speech, Time) negative patients, who turn out to have strokes, commenced in March. This will help the education of multi-agency teams to identify strokes as a high proportion of 'fast' negative patients turn out to have strokes.

Plans for stroke nurses to request CT scans is progressing which should alleviate the current issue of breaches in the time to scan standard being caused by delays in making scanning requests by ED.

The Trust is also seeking to improve thrombolysis performance by working on a pilot to commence CT perfusion scanning for patients that wake having suffered a stroke during the night. Few Trusts offer this currently.

Published at the end of 2015 the National Sentinal Stroke Continuous Audit (Jul-Sep Q2) report shows significant improvement across 10 levels. With an improvement in our SSNAP level from a D in Quarter 1 to a C in Quarter 2 we are now ranked above peers within the East of England.

The Stroke mortality (SHMI) has been a cause for concern but the HSMR shows a broadly downward HSMR trend for Stroke admissions over the past three years as shown in the graph below.



It is expected that the initiatives above will improve mortality in the future.

PRIORITY 3 – IMPROVING PATIENT EXPERIENCES

Insert national in-patient survey results once received.

		12/13	13/14	14/15	15/16	Aim for 15/16	Met
5.1	Improvement in survey results (involved in decisions, consistent info, providing understandable answers, name of contact)	See results below			Awaited	N/A	-
5.2	Monitoring ward staffing levels	N/A		Introduce	Monitored	Monitor	✓
5.3	Communication - reduction in complaints & PALS concerns (rate)	See results below			Awaiting year end data	Reduce	
5.4	GP Survey	N/A		Completed	Completed	Complete	✓
6.1	Delays - reduction in complaints & PALS concerns (rate)	See results below			Awaiting year end data	N/A	
6.2	Improvements in national surveys (waiting list, waiting for bed, OPD waiting time)	See results below			Awaited	N/A	-

5.1 Survey scores - communication

Five questions that feature in the national in-patient survey relating to communication have been monitored since 2012. The results are shown below together with the scores for three of these questions assessed by almost 1000 people using the Trusts electronic (Meridian) survey.

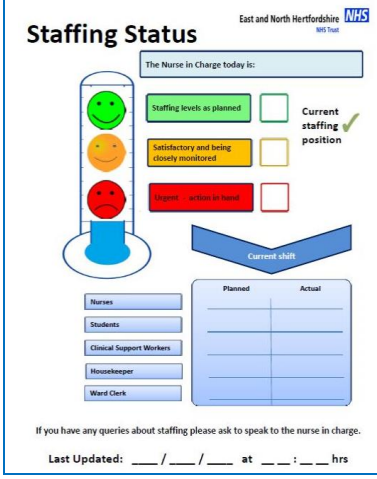
Question	National survey				Meridian survey (9685 responses)
	2012	2013	2014	2015	
Were you involved as much as you wanted to be in decisions about your care and treatment	6.9	6.8	7.3	Awaited	84.26%
Did a member of staff say one thing and another say something different	7.9	7.7	7.7		N/A
When you had important questions to ask a doctor, did you get answers that you could understand	7.9	7.8	7.8		87.02%
When you had important questions to ask a nurse, did you get answers that you could understand	8.1	7.8	8.3		90.52%
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital	7.9	7.6	7.8		N/A

Add results for 2015 national survey once released in June.

5.2 Monitoring ward staffing levels

The Trust is committed to ensuring that the skills and numbers of nursing staff, which includes registered nurses, midwives and Clinical Support Workers (CSWs) meet the needs of patients to provide safe and effective care.

Safe staffing levels are monitored and managed daily. Senior staff review staffing levels for all wards and agree actions where the levels are below the optimum. Details of staffing levels are published on the NHS Choices website and are shown on the status boards on the entrance to all wards.



Staffing levels are graded:

- Green shifts = staffing levels as planned
- Amber shifts = satisfactory staffing levels which are being monitored. In this case the matron will be alerted and staff will prioritise their work and adjust their workload through the shift accordingly. Any changes in the dependency of patients remains under continual review so that further adjustments can be made if necessary
- Red shifts = urgent situation but action is in hand. The matron is alerted and actions taken such as moving staff, utilising supernumerary staff or reducing the number of patients on the ward. Red shifts are escalated to the executive nursing team for oversight.

The table below shows the percentage of shifts triggering 'red'.

Month	April 2015	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 2016	Feb	Mar
% shifts that triggered red	5.08	3.32	1.85	2.67	4.89	4.24	5.47	3	3.16	4.13	7.1	8.6

Staff availability can be influenced by many factors and it can be seen in the chart above that the percentage of red shifts has increased towards the latter part of 2015/16. A reduced supply of staff resulting from sickness or vacancies; or increases in demand such as when additional beds are opened to deal with high numbers of admissions affect the overall staffing levels. During 2015/16 we have seen an increase in the number of patients requiring 1:1 care (known as specialing). We have also seen an increase in the number of clinical areas being opened to cope with the rise in patient numbers, although this in turn creates a demand for additional staff. Significantly changes to the payment arrangements of agency staff were introduced such that agency fees were capped. Whilst ultimately better in the longer term because it incentives temporary staff to join a staff bank it has resulted in a short term reduction in the availability of temporary staff at short notice. The introduction of the specialing team in January has helped to reduce the need to provide cover by temporary staff.

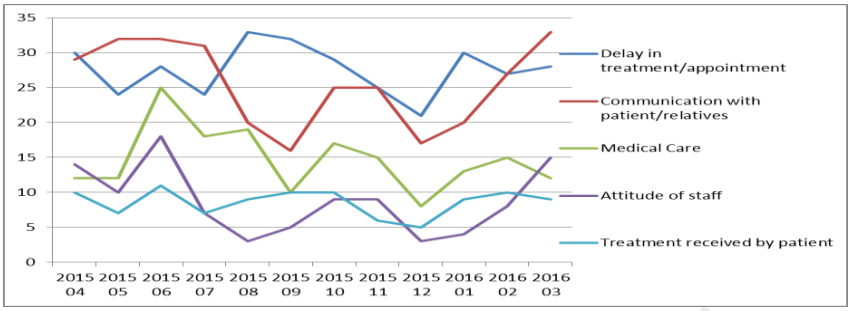
Staffing levels have been reviewed with other data such as falls and pressure ulcers to see if there has been any reduction in quality as a result of the rise of red shift. From the analysis there is no evidence that quality has been compromised.

CareQuality Commission

Nurse staffing levels were variable during the days of the inspection, although in almost all areas, patients' needs were being met.

5.3 and 6.1 Complaints and delays - complaints & PALS concerns

The graph below shows the categories accounting for the greatest number of complaints for 2015/16.



Communication

The rate of formal complaints or concerns reported to the Patient Advice and Liaison Service (PALS) regarding 'communication' is given below. The rate is the number of complaints / concerns per finished consultant episode.

	2012/13	2013/14	2014/15	2015/16			
				Q1	Q2	Q3	Q4
Complaints	0.15%	0.16%	0.19%	0.38%	0.28%	0.24%	xx
PALS	0.22%	0.28%	0.48%	0.65%	0.69%	0.38%	xx

Add Q4 once data finalised then summarise.

Delays

The rate of formal complaints or concerns reported to the PALS regarding 'delays' is given below.

	2012/13	2013/14	2014/15	2015/16			
				Q1	Q2	Q3	Q4
Complaints	0.3%	0.25%	0.33%	0.33%	0.36%	0.27%	xx
PALS	0.82%	0.66%	0.96%	1.4%	1.31%	0.52%	xx

Add Q4 once data finalised then summarise.

5.4 GP Survey

To seek the opinions of Primary Care colleagues the Trust undertakes an annual GP survey. 19 people responded to the 2015 survey.

The results were mixed although the majority of respondents indicated that they had not seen an improvement in the provision, timeliness and quality of discharge summaries or clinic letters over the last six months. The Trust will continue to work with the commissioners and GPs to improve this.

Interestingly respondents indicated that they were not aware of:

- The dedicated GP phone line in the Outpatient Contact Centre
- Consultant emails and other forms of electronic communication

They also indicated that they did not use the dedicated GP phone line, the Primary Care Customer Relations Service or the Interface Geriatricians Service.

Recognising that the number of respondents is small it remains valid that some primary care staff were not aware of, or use, some of the services available to them. This has a direct impact upon patient care and the trust will endeavour to address these findings.

6.2 Survey scores – delays

The results of four questions relating to waiting times from national surveys since 2012 and the electronic (Meridian) surveys are given below.

Question	National survey				Meridian survey (9685 responses)
	2012	2013	2014	2015	
How do you feel about the length of time you were on the waiting list	7.7	7.8	7.5	Awaited	N/A
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward	6.9	6.9	6.9		N/A
How long after the stated appointment time did the appointment start	N/A	N/A	N/A		67.18
On arrival were you told how long you would have to wait	N/A	N/A	N/A		43.3

Note: the scoring methodology used in the surveys are the same but the national scores are demonstrated out of 10 rather than 100 thus a national score of 8.5 is the same as a local score of 85.

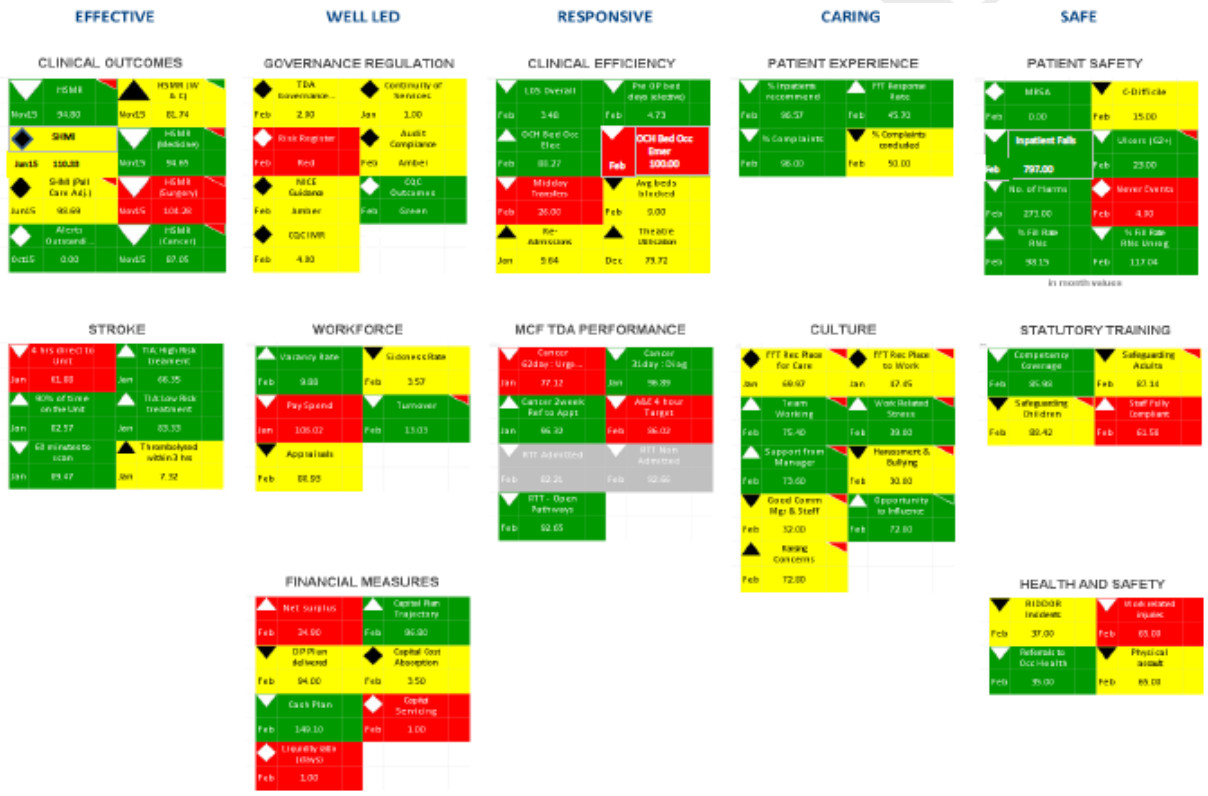
Add results for 2015 national survey once released.

Part 3

3a	Review against selected metrics
3b	Shining the spotlight: • Safety • Clinical effectiveness • Patient experiences
3c	Our staff
3d	Performance against national standards

3a Review against selected metrics

The Trust Board routinely reviews a selection of metrics at each of its meetings. An overview, known as the Floodlight, is given below. This shows the 'at a glance' performance in relation to five areas which includes the components of quality – safe, experiences (caring) and effective.



Intelligence monitoring

The CQC Intelligence Monitoring Reports (IMR) categorised Trusts into six summary bands to represent the level of risk. Band 1 represents the highest risk and band 6 represents the lowest risk of non-compliance against the essential standards. This was based on a number of nationally reported surveys and indicators. The last release of the IMR was in May 2015 and categorised the Trust as being Band 4. IMR's are no longer routinely reviewed and published by the Care Quality Commission. In future the CQC will issue data packs to Trusts in relation to an inspection only.

3b Shining the spotlight

Patient safety

Safety indicator set

Indicator	12/13	13/14	14/15	15/16 YTD	Aim for 15/16	Met
Never events	2	1	1	**4**	0	✖
MRSA Elective Screening (all elective inpatient admissions)	99.9%	99.86%	Change in methodology	**99.93%**	100%	✖
MRSA Bacteraemia	2	2	5	**0**	0	✓

Never events

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

In 2015/16 the Trust reported 4 never events:

- Wrong route administration of medication – intravenous medication was administered via the intrathecal route. At a point in a patients care the tubing that connects the bag of medication with the patient became disconnected. It was reconnected incorrectly. As a result of this incident restrictions now apply to those who can care for intrathecal medications; ensuring they are competent. The training has been enhanced and monitoring records improved.
- Wrong site surgery – an operation was commenced on the wrong finger. Although the finger was marked before the procedure there were difficulties in hand placement during the operation which meant the marking was out of sight at the time the operation started. As a result of this incident the pre-operative marking of fingers and toes is now circumferential ie. all the way around the digit rather than on the top side only.
- Retained swab – a vaginal swab was left in place after a planned normal birth proceeded to an emergency caesarean section. New processes now include swab counts relating to catheterisation and the introduction of additional checks when one procedure is changed to another.
- Retained swab – a surgical swab was left in place following an orthopaedic operation. The swab count was not undertaken correctly in this case. As a result of the incident wider organisational actions are being implemented which includes a human factors review of theatres and a review of practices against the national standards for interventional procedures.

Serious incidents

73 serious incidents were declared in the calendar year 2015. However 8 of these were downgraded as they were not considered to fulfil the definition of a serious incident. Therefore 65 serious incidents occurred compared to 82 in the previous year.

The number and categories of serious incidents are given in the table below, with comparative data from 2013.

Serious Incidents	2013	2014	2015
Falls	14	15	9
Infection Control	13	7	8

Pressure ulcers	16	26	16
Other	24	34	32
	67	**82**	**65**

'Other' incidents include delayed or missed diagnosis, information governance and process failures. All are analysed thoroughly using root cause analysis techniques and actions put in place to help prevent a reoccurrence.

Duty of Candour

This is the duty to 'be open' with people when something has gone wrong – to explain what has happened; to offer a sincere apology; to involve the patient / family in what will happen next.

We are open and honest

Processes have been in place since 2010 to promote 'being open' such as:

- Training at induction and during mandatory updates for doctors
- Forced fields on the incident reporting system to explain how staff have been open when things have gone wrong
- Written communication with patients / families when a serious incident has occurred
- Range of documents and advice

The CQC inspection identified that improvements were required regarding staff awareness and application of the duty as shown below. Actions to address this are planned for 2016/17.

Care Quality Commission

Generally there were processes in place to support the requirements of the duty of candour However, some of the staff we spoke with at Lister Hospital and QEII did not know what duty of candour meant for them in practice.

In the community C&YP service, nurses and doctors were able to describe how complaints and concerns were being managed which assured us they were implementing the principles of the Duty of Candour and kept families and children informed about how their concerns and complaints were being managed and outcomes were shared.

The trust had a being open policy in place that outlined the expectations. However we found that there was not consistent understanding of this policy by all staff.

Sign up to SAFETY LISTEN LEARN ACT

Sign up to Safety is a national initiative to improve safety by identifying improvement projects and implementing them locally; but also sharing learning nationally via web links and conferences actions. The Trusts safety initiatives are closely aligned with:

- The Improving Patient Outcomes Strategy
- The Trusts culture programme
- Plans to enhance collaboration with partners
- Plans to enhance the Duty of Candour

Details of progress is given throughout this report.

SPEAKOUTSAFELY	The Trust supports the Nursing Times' Speak out Safely campaign. This means we encourage any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity.

Deteriorating Patient Action Plan

In Section 2d processes to monitor the deteriorating patient were described. Underpinning this work is the Deteriorating Patient Action Plan which describes a range of initiatives to help prevent deterioration. During 2015/16 the following actions have been put in place:

- Increased teaching and competency recording around NEWS assessment
- Establishment of a process ensuring agency staff are NEWS competent
- Revision of Foundation Year training to make the ALERT course mandatory (this is Acute Life Threatening Events Recognition & Treatment)
- Implementation of an on-line on call rota so that staff have up to date contact details for staff on-call
- Roll-out of end of life pathways – this helps to identify the end of life and manage the care appropriately so the person has a dignified death, rather than continuing futile attempts to treat
- Increasing awareness around Do Not Attempt Cardio-pulmonary Resuscitation for better management of patients where resuscitation is not in their best interests
- Revision of a transfer checklist to ensure observations and critical instructions are shared during transfer within the hospital

Clinical effectiveness

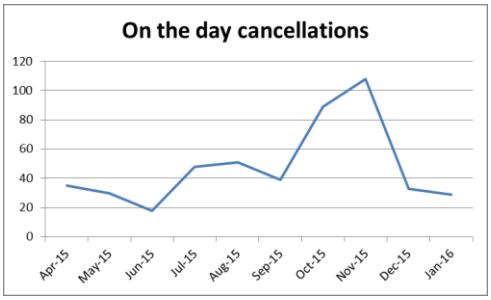
Clinical effectiveness indicator set

Indicator	12/13	13/14	14/15	15/16 YTD	Aim for 15/16	Met
Total average beds blocked per day (Before 2015/16 this was Delayed transfers of care)	2.83	3.19	2.52	**9 (New methodology)**	<=8	✘
Length of stay (days)	4.94	3.91	3.53	**3.50**	<=4.5	✓
Cancelled operations (on the day & not rebooked within 28 days)	1.44%	0.62%	1.41%	**1.71%**	<=0.8%	✘

The challenges facing the Trust as outlined in section 1d are having a direct effect upon the ability to discharge patients efficiently. The Trust continues to work with community partners to enhance care within the community and to prevent admissions where treatment at home or in other non-hospital settings could be given.

Cancelled operations

The number of on the day cancellations that have occurred during 2015/16 are given in the graph below.



Hospital initiated cancellations are due to a failure of the hospitals infrastructure such as a lack of beds, equipment failure, missing medical records, sterile services issues or staff absence. These account for approximately half of cancellations.

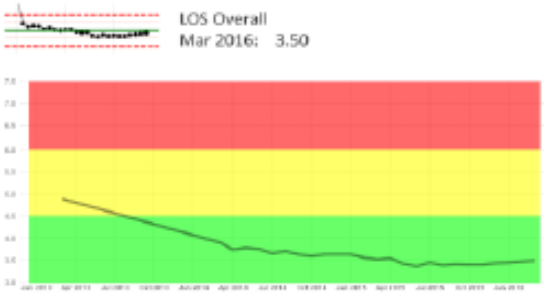
Patient cancellations are where it is not possible to operate on a patient as they have failed to attend, have cancelled at short notice or are not medically fit for surgery.

Prevention of patient cancellations by improving the preoperative assessment and waiting list processes are underway. The plans were progressing well until October when high numbers of patients were admitted as emergencies so there were insufficient beds available to admit patients for planned surgery.

Actions underway to help reduce cancellations include:

- Standardising pre operative phone calls to assess fitness of patients and to confirm availability and intention to arrive
- Formally reviewing each cancellation to identify the root cause and address these
- Generation of a standby list of fit patients willing to be brought forward
- Roll out of the Netcall system in outpatients which generate patient reminders
- Moving towards a system where all operations are booked verbally with patients
- Ensuring all medical records and equipment is present the night before surgery
- Improving bed management arrangements to ring-fence planned surgery beds

Reducing Length of Stay



Length of stay continues to reduce as care pathways become more standardised.

The Trust will be working towards greater use of enhanced recovery to further support this.

Improving Patient Outcomes Strategy

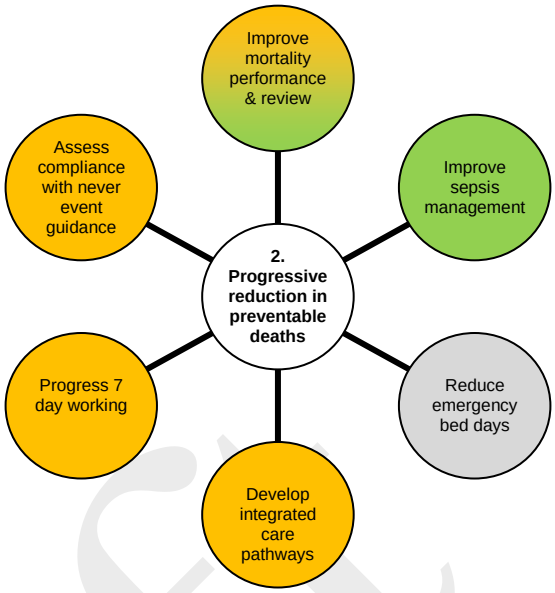
In July the Trust Board ratified the Improving Patient Outcomes Strategy 2015-18. This outlines the trusts ambitions to:

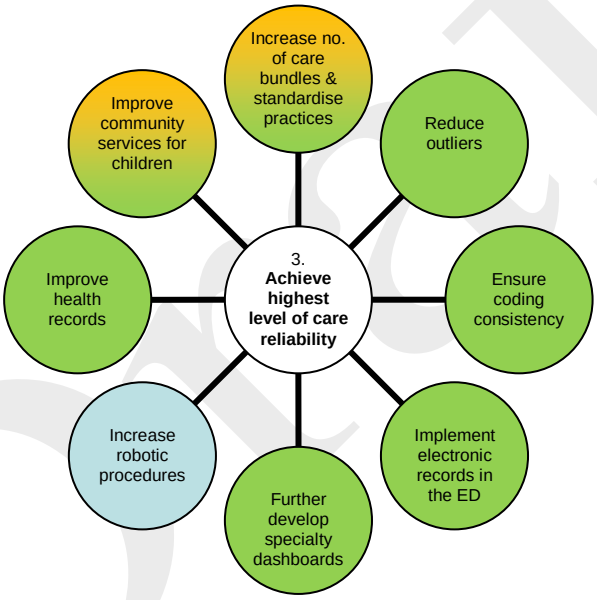
1. Seek out and reduce harms
2. Achieve progressive reduction in preventable deaths
3. Achieve the highest level of care reliability
4. Improve capability within the workforce for continuous improvement
5. Work in partnership with staff, patients and stakeholders to improve outcomes

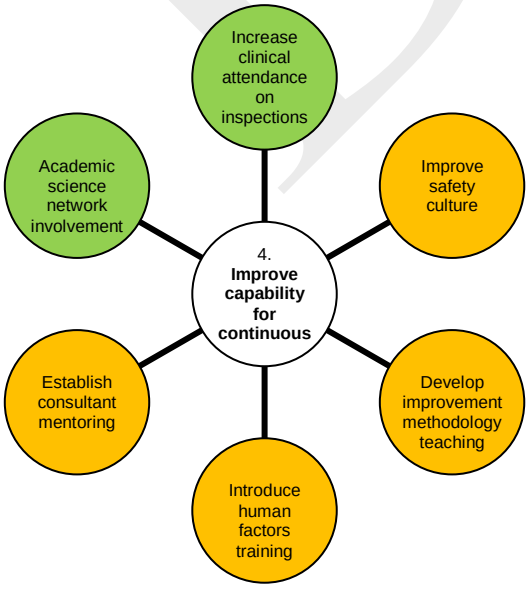
A set of objectives for 2015/16 were developed for each of these ambitions. These are shown in the diagrammes below with the colour coding indicating progress.

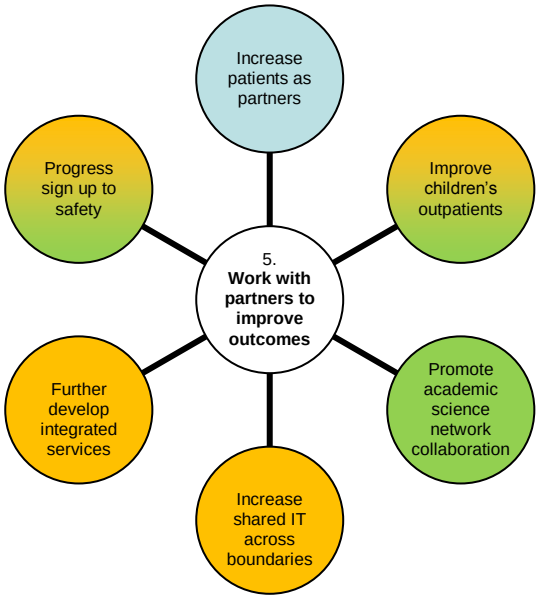
Update once Q4 position confirmed.


Reduce harms (falls, pressure ulcers, safety thermometer
Safer staffing
Improve medicines management
1. Seek out and reduce harms
Prevention of readmission
Better observations & actions


Improve mortality performance & review
Assess compliance with never event guidance
Improve sepsis management
2. Progressive reduction in preventable deaths
Progress 7 day working
Reduce emergency bed days
Develop integrated care pathways


Increase no. of care bundles & standardise practices
Improve community services for children
Reduce outliers
3. Achieve highest level of care reliability
Improve health records
Ensure coding consistency
Increase robotic procedures
Implement electronic records in the ED
Further develop specialty dashboards


Increase clinical attendance on inspections
Academic science network involvement
Improve safety culture
4. Improve capability for continuous
Establish consultant mentoring
Develop improvement methodology teaching
Introduce human factors training


Increase patients as partners
Progress sign up to safety
Improve children's outpatients
5. Work with partners to improve outcomes
Further develop integrated services
Promote academic science network collaboration
Increase shared IT across boundaries

Emergency Department	In May 2015 the electronic inpatient management system was enhanced to become an Electronic Patient Record (EPR). The EPR is used within the emergency and assessment units at present and continues to be developed. It enables details of assessments to be captured thereby ensuring more people have timely access to information and supporting auditing requirements.
Urology	In June 2015 the Lister robotic urology service was named a Network Institution by the Vattikuti Foundation, joining just two other centres in Europe. This places the service as one of a few select centres of excellence in robotic urology surgery worldwide. Through multi institutional collaboration the care of patients will benefit further as the frontiers of minimally invasive surgery are extended. This adds to the department's achievement as the only centre in the UK accredited by the Royal College of Surgeons to provide training to consultants-in-training who aspire to specialise in robotic urological surgery.
Endoscopy	The Joint Advisory Group (JAG) review in January 2016 gave full accreditation to the endoscopy services at the New QEII. The report commented that "The new facility meets all of the JAG criteria in relation to privacy and dignity, single sex and decontamination"
Diabetes	Diabetes care has improved: • Diabetes Outreach Team is available 7 days per week • New Mens Health Nurse Service and New Genetic and pre-conception Diabetes services • Reduction in diabetes related mortality • Reduced admissions and inpatient length of stay • 120 adult and 57 Children and Young People on pumps –higher than the national average
Care bundles	Care bundles are a set of best practice guidelines for the management of certain conditions. Three care bundles have been written in 2015: • Pneumonia • COPD • Heart Failure
7 Day services	The Trust has analysed its capacity to deliver five of the ten national standards to extend services into the evenings and weekends. If the additional £2.4m becomes available the Trust aims to deliver these standards by March 2017.

CareQuality Commission

Pain assessment and management was effective in most areas.

Most patients' nutritional needs were assessed effectively and met.

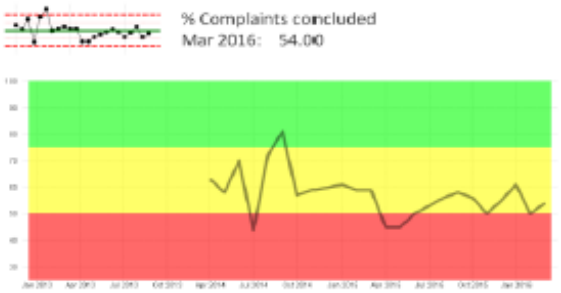
Working towards providing a seven day service was evident in most areas.

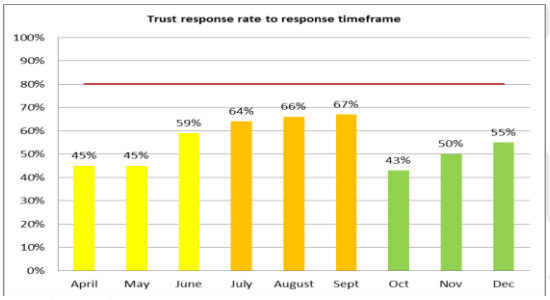
Patient experiences

Patient experiences indicator set

Indicator	12/13	13/14	14/15	15/16	Aim for 15/16	Met
Number of complaints	969	864	1181	**1072**	<previous year	✓
Number of PALS concerns	1724	1728	2306	TBC	N/A	-
Complaints – response within agreed timeframe	58%	49%	59%	**54%**	>75%	✗
Complaints per level of activity - per bed day (Before 2015/16 this was per finished consultant episode)	1.08%	0.9%	1.32%	**0.48%** (New methodology)	N/A	-

Complaints

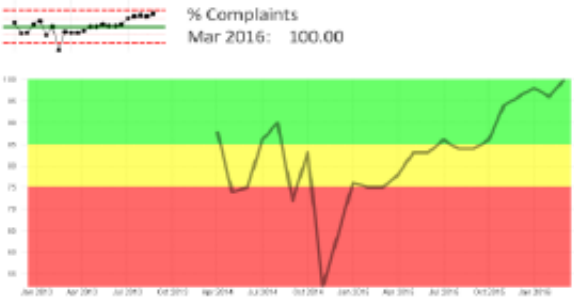




The Trust continues to endeavour to resolve complaints within the agreed timeframes.

This is currently being achieved in 54% of occasions against a plan of 75%.

A review of the staffing capacity was undertaken during the year and consequently changes made to enhance capacity.



Good improvement is seen for acknowledging complaints within 3 working days. This was achieved in 100% of occasions by year end, against a plan of 85%

The table below shows the relationship between the number of complaints against the increasing number of patients; with the rate of complaints averaging at 0.5%.

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Complaints	92	91	104	92	84	79	96	80	65	80	100	109
Occupied bed days	50054			50119			55095			55586		
% per bed day	0.6	0.5	0.6	0.5	0.5	0.4	0.5	0.4	0.3	0.4	0.5	0.5

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

Plastic Surgery

- An additional consultant has been recruited to increase capacity to reduce waiting times in outpatient clinics and for procedures.

Clinical Support Services

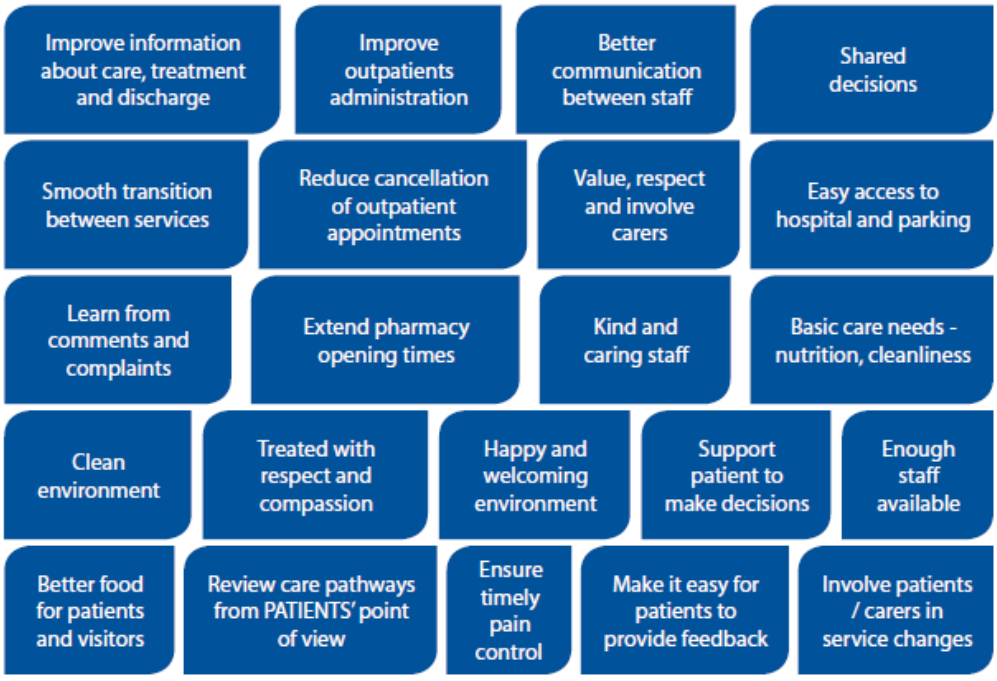
- More sensors have been installed across the Trust to assist with locating medical records.
- Additional electronic devices are being provided to assist in the location of medical records not previously tracked.
- Additional training is being offered to refresh and retrain staff in the tracking of medical records.

Maternity

- The Division is looking at providing additional emergency ultrasound scans over the weekend period for ladies experiencing suspected miscarriages.
- The Early Pregnancy Unit has moved to a separate building. Patients had previously complained about having to be seen with other pregnant ladies when they were experiencing difficulties with their own pregnancies.

Patient Experience Strategy 2015-19

In developing the strategy the Trust took note of what members of focus groups told us was important to them:



As a result of these consultations the strategy has three ambitions:

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

The strategy details how these ambitions will be met and an annual evaluation of progress towards these ambitions published on the Trust's website.

Gathering feedback

Feedback from patients is gathered in many ways:

- Patient stories at the Trust Board
- Surveys
    - Via electronic devices (Meridian) in wards and departments
    - Participation in national surveys
- Reviewing complaints and PALS concerns (at the individual level and looking for trends)
- Focus groups
- Walkabouts on wards and departments by senior staff

Patient/Carer Stories

The Trust regularly listens to patient stories and shares learning from these with the clinical teams. The monthly Trust Board meetings start with a patient story. This can be told by the patient or carer attending the meeting in person or by sharing the story in writing or listening to a recording. The Board welcome hearing about both positive and negative experiences and the clinical teams share the learning from the experience and agree actions to be taken.

Electronic surveys

The Trust uses electronic devices, called Meridian, to record the views of patients during their stay with us. The questions are wide ranging and enable us to evaluate services and whether our patients would recommend our Trust (see Friends and Family Test).

The number of electronic surveys completed electronically each month on Meridian exceeds 1000. The results are communicated to staff via ward reports and where necessary staff are asked to make improvements. In February it was reported that:

- Patients feel they had been treated with respect and dignity
- Patients received understandable answers to their questions from nursing staff

National in-patient survey 2015

xxx patients responded to the survey, with a 40% response rate (47% nationally). The results since 2013 are shown together with how the Trust scores compared with the national averages.

Question group	2013	2014	2015	Average national score (2015)
Emergency / A&E department	8 =	8.1 =	Awaiting	
Waiting lists & planned admissions	8.6 =	8.6 =		
Waiting to get to a bed	6.9 =	6.9 =		
Hospital & ward	7.8 =	7.7 ↓		
Doctors	8.2 =	8.1 =		
Nurses	8.1 =	8.2 =		
Care & treatment	7.2 =	7.4 =		
Operations & procedures	7.8 ↓	8.2 =		
Leaving hospital	6.9 =	6.9 =		

Overall views & experiences	5.1 =	5.4 =		

Maternity survey

During the summer of 2015, a questionnaire was sent to all women who had given birth in February 2015. Responses were received from 169 patients.

Question group	2014	2015
Labour & birth	9.3 =	9 =
Staff during labour and birth	8.7 =	8.5 =
Care in hospital after birth	7.9 ↓	7.8 ↓

Birth

	Would recommend		Would not recommend	
	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%			
Q1 Apr-Jun-15	97.54	↑	0.61	↑
Q2 Jul-Sept-15	95.77	↓	1.50	↑
Q3 Oct-Dec-15	95.68	↓	1.57	↑
Q4 Jan-Mar-16	96.27	↑	0.75	↓

Postnatal

	Would recommend		Would not recommend	
	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%			
Q1 Apr-Jun-15	87.48	↓	2.01	↓
Q2 Jul-Sept-15	88.37	↑	2.05	↑
Q3 Oct-Dec-15	87.57	↓	2.88	↑
Q4 Jan-Mar-16	88.81	↑	2.61	↓

Both the maternity survey and the maternity friends and family test results align. The maternity team continue to work with women to seek improvements in post-natal care. For example, women said that they would like their partners to stay overnight. Reclining chairs have been purchased to enable partners to sleep.

End of Life Care

The Specialist Palliative Care Team (SPCT) has undertaken a review of its services based upon the CQC assessment methodology and summarised its achievements for the year in the table below. An assessment of the challenges is also given.

	Achievement	Challenge
Safe	Integrated Care Pathway (ICP) for the dying patient Mandatory training in care of the dying SPCT staffing adequate	Lack of clear identification of End of Life Care related incidents / complaints
Effective	Regional End of Life Care prescribing guidelines Policies and procedures to support ICP Competent multi-professional staff – chaplaincy, mortuary, SPCT	Discussion and documentation variable for DNACPR esp. related to mental capacity National audit performance poor Lack data to demonstrate outcomes
Caring	In the end of life care service, feedback from patients and those who were close to them was very positive	
Responsive	7 day SPC nursing service Access to full Multi-disciplinary team Good liaison with community services	Improve rapid discharge at the end of life
Well-led	Medical Director as executive lead	Better Governance processes

	Trust-wide Strategy developed Strategy group convened	Need robust data collection Better collaboration across sites

Significantly 50% of the East and North Hertfordshire population die in hospital which is higher than the national average. 2015/16 has seen significant work undertaken in creating the documentation, specialist capacity and training to improve end of life care. The focus is now moving towards more timely discharge of the dying person to their preferred place of death.

Additionally, the SPCT continue to work with clinical staff and the Resuscitation Committee on effective end of life discussions and decisions around resuscitation. This work aims to support earlier identification of the dying person and therefore earlier implementation of end of life care.

The Trust is one of ten acute hospitals selected to participate in a new programme to improve palliative care across the UK. The *Building on the Best* programme aims to support improvements in quality and experience of palliative and end-of-life care through better decision making and joint working with community partners.

Results of the national Care of the Dying Audit 2014/15, released in April 2016, show the Trust as performing extremely well against national averages.

	Trust %	**National %**
Evidence that it was recognised that the patient would probably die in the coming hours or days	78	83
Evidence that the patient would probably die in the coming hours or days had been discussed with a nominated person(s) important to the patient	80	79
Evidence that the patient was given an opportunity to have concerns listened to	90	84
Evidence that the needs of the person(s) important to the patient were asked about	80	56
Evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care	76	66
A lay member is on the trust board with a responsibility/role for end of life care	Yes	49
Did your trust seek bereaved relatives' or friends' views during the last 2 financial years	Yes	80
Formal in-house training includes specifically communication skills training for care in the last hours or days of life for: - **medical staff** **- nursing (registered) staff** **- nursing (non-registered) staff** **- allied health professional staff**	Yes	63 71 62 49
Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday	Yes	37
Does your trust have one or more end of life care facilitators as of 1 May 2015	Yes	59

Access to Information	The Trust won the national Patient Experience Network award for 'Access to Information' for its new system of patient information posters, which are located just inside the entrance to each ward and are easy to read, understand and can be kept up-to-date. The information covers a range of areas including daily staffing numbers, 'You said, we did' information, protected mealtimes and a visitor's charter.
Day surgery	The Trust's day case surgery team attained the *Purple Star* kite mark from Hertfordshire County Council's Health and Community Services.

You Said… We Did

All wards have a patient experience notice board where they display their latest survey results, Friends and Family Test results and any actions they have taken as a result of patient feedback – this is called 'You Said – We Did'. Examples of 'You Said – We Did' actions and quotes from patients are displayed and regularly updated in public areas of the Trust and on the Trust website along with our FFT results.

CareQuality Commission

"Overall we have judged the services at the trust as good for caring. In most areas patients were treated with dignity and respect and were provided with appropriate emotional support. We found caring in the community children's and young people's service and in chemotherapy at MVCC to be outstanding. However, caring required improvement in one area – the urgent and emergency care service at the Lister site where patients were not always treated with dignity and respect."

Most staff we spoke to were friendly and welcoming.

In most areas staff interactions with patients were positive and showed compassion and empathy. However, the privacy and dignity of patients in the emergency department at Lister Hospital was not always respected.

Gynaecology operation at the Treatment Centre

Wow! What fantastic service!

Yesterday I attended the Treatment Centre for a Diagnostic Laparoscopy. My admission time was 12:30, by 13:15 I had seen the Consultant, Anaesthetist and two nurses, one who took blood and the other who went through all my documents and helped me put bed socks on. (Wish I could say the latter nurses name as they were just so lovely)

At 14:00 I was taken to the operating theater where I again was greeted by the consultant and had a lovely chat with the anaesthetist... I then woke up an hour later in recovery. I had felt so at ease I didn't even notice that I was being given the General Anaesthetic!
The two nurses in recovery were really kind and were so quick to help me when I was in pain. They also helped clean me up - I really appreciated their support.
I was given a cup of tea and then taken back to my earlier bay where my bags awaited, along with a another cup of tea and a glass of water. The lovely nurse that admitted me sat with me whilst the consultant discussed the findings and a way forward. The consultant really listened to me and I felt safe and in capable hands.
Prior to being discharged I had to eat something and I was offered a range of sandwiches, my choice given to me with some biscuits and a cup of fruit tea. By 1830 I was allowed to go home, discharge was quick and I was taken through the medicines and aftercare documents.

I came home feeling really so thankful for the NHS and the service I was given. It was truely exemplary. Thank you and well done!

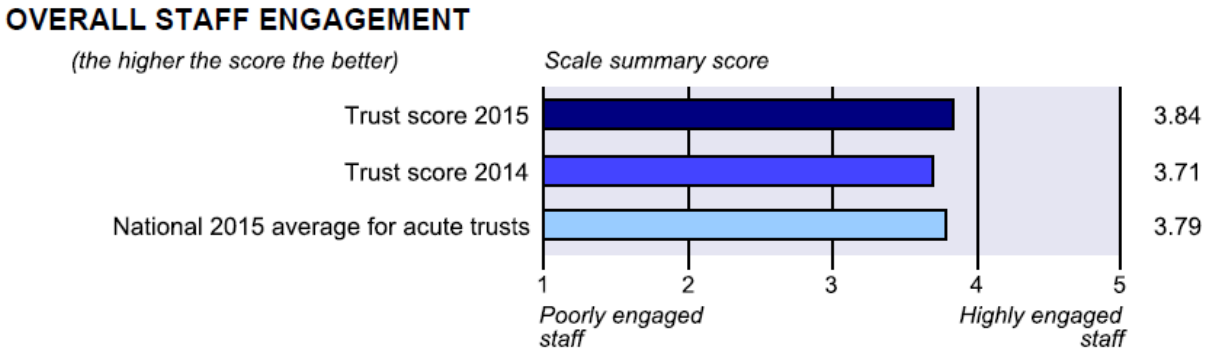
Initially, when we were at the first reception point in the main A+E, the receptionist was incredibly rude and made a comment about how many times my daughter had been at A+E. ...However, when we went into the childrens A+E, the staff couldn't have been more helpful and supportive.

3c Our Staff

At the annual Healthcare People Management Association's awards held on 18 June, the Trust won the best HR team award and were announced as the overall winners

Staff indicator set

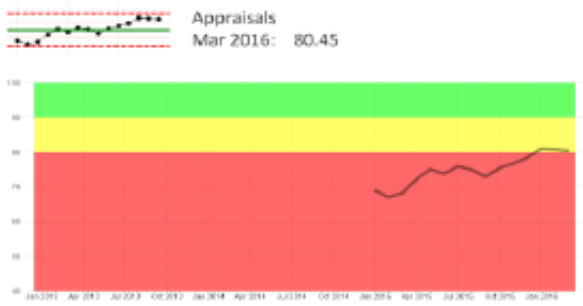
Key Indicators	12/13	13/14	14/15	15/16	Aim for 15/16	Met
Staff engagement	3.72	3.76	3.71	**3.84**	N/A	
Appraisal completions	70.2%	45.33%	68.33%	**80.45%**	>=90%	✖
Sickness rate (annualised)	3.6%	3.41%	3.55%	**3.55%**	<=3.5%	=
Turnover	9.9%	10.71%	12.91%	**12.8%**	<=13.49%	✓
Vacancy rate	8.6%	5.65%	7.11%	**9.95%**	<=10%	✓



The table below shows how the Trust compares with other acute trusts on each of the questions making up the 'staff engagement' score; together with the changes since the 2014 survey.

	Change since 2014 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	✓ Increase (better than 14)	✓ Above (better than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	✓ Increase (better than 14)	• Average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	✓ Increase (better than 14)	✓ Above (better than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	✓ Increase (better than 14)	✓ Above (better than) average

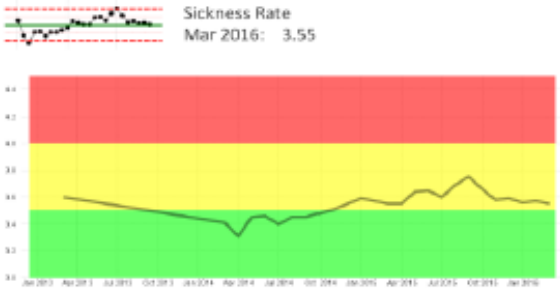
Appraisals



- The halting of automatic pay progression for staff who have not received an appraisal and are not fully statutory / mandatory training compliant was introduced in December.
- The pay halt also applies to managers of those staff

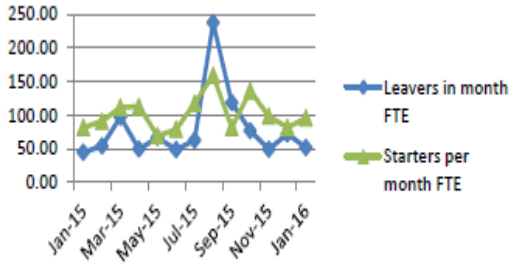
This has resulted in some staff not receiving their pay progression and therefore promoting a culture where not having an appraisal is not tolerated. An increase in appraisal rates has resulted.

Sickness



- Advice and support to both managers and employees to optimise health at work, reduce sickness absence and prevent work related ill health and injury
- Implemented both Absence Assist and the Employee Relations Advisory Service team to support with the management of sickness absence
- Continued review of all long term sickness cases
- Promotion of the Flu campaign with vaccination offered through October 2015 to February 2016
- Focused work in ward areas to support better management of sickness amongst nursing staff

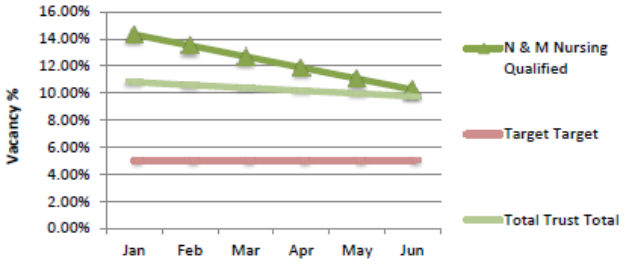
Turnover



When an employee leaves, we lose training, information and knowledge. However, turnover can also bring new skills and experience. The optimal rate of turnover at a sustainable level has been assessed at between 10 - 11%.

- Exit questionnaires and interviews have been conducted with those leaving the Trust to help divisions identify themes
- The Trust has identified a number of retention initiatives that require funding and these are currently being assessed by the Investment and Scrutiny Committee.

Vacancies



- A full workforce planning exercise has been undertaken for qualified nursing and CSW to more effectively plan for recruitment to future vacancies
- Advertising on local radio
- Streamlining the recruitment process for Student Nurses who have had their placements at the Trust
- Streamlining the recruitment process for the NHS Professional workers to transfer to the permanent work at the Trust
- Recruitment from overseas

The Community Hub, based at the Lister is a community-facing interactive space used to promote employment, volunteering, work experience, membership and apprenticeships.
Since opening in 2015 The Hub has received a number of enquiries into trust vacant posts.

Culture programme

The Culture Programme aims to improve staff engagement by embedding a customer-focussed culture, leading to improved patient and staff experience. Progress continues to be made in relation to delivery of the culture change programme including:

- Continuation of Executive 1:1 and team coaching culture programme
- Commencing the design and preparation for phase 2 of the coaching culture programme for Top 100 leaders.
- Talent planning conversations are being held in each division
- Continued delivery of core HR skills workshops for managers – 450 managers have now been trained.
- Design work continues for a more engaging and values focused "welcome" element of Trust induction including an induction information pack
- Bespoke customer care training programme in Outpatients, together with a workshop for Outpatients supervisors and managers
- Consultant mentoring is being arranged
- Master-classes in CHIMP management

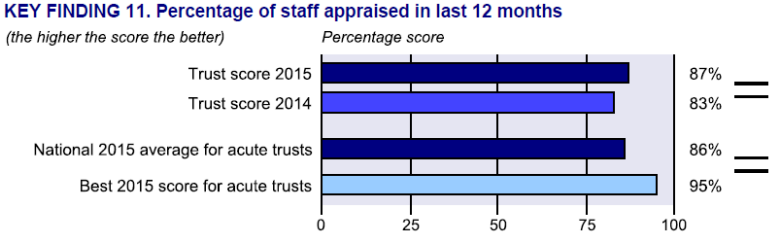
Staff surveys

Staff surveys are undertaken annually as part of a national programme. A selection of some of the national staff survey results are given below with the position showed compared with the national averages. Findings from the survey are also given later when aligning them to the Trust values and the full set of indicators is shown in Appendix 3.

Question	Trust 12/13	Trust 13/14	Trust 14/15	Trust 15/16	Comparison with national	National 15/16
Role makes a difference to patients	91%	90%	92%	**92%**	**Best 20%**	90%
Level of satisfaction with work and care	84%	81%	77%	**4**[a]	**Better than average**	3.93
Good communication with managers	26%	27%	26%	**32**	**Average**	32
Undertaking training	81%	81%	82%	No longer collected		
Quality of non-mandatory training	Not collected			**4**	**Best 20%**	4.03
Equality & diversity training	74%	74%	72%	No longer collected		
% staff experiencing discrimination at work			11%	**12%**	**Worse than average**	10%

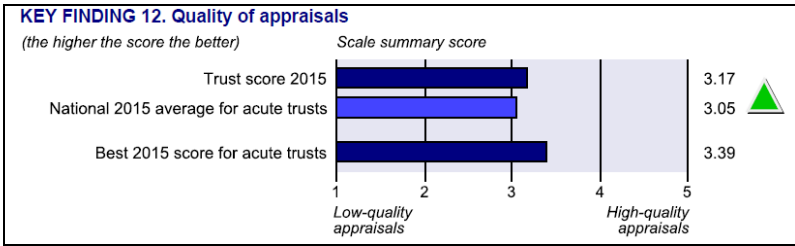
[a] change in measurement

The annual national survey is supplemented with in-house on-line surveys conducted every four months. These allow us to measure a range of cultural indicators and identify trends to make improvements much earlier than would otherwise have been possible.



The National Staff Survey 2015 shows an improved score for appraisals:

- Percentage of appraisal is similar to the national average (in 2014 was below average)
- Quality of appraisals is

	better than the national average (in 2014 was below average)

Improvements since the 2014 survey:

- Percentage of staff able to contribute towards improvements at work
- Staff satisfaction with level of responsibility and involvement
- Staff motivation at work
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
- Staff confidence and security in reporting unsafe clinical practice

Deterioration since the 2014 survey:

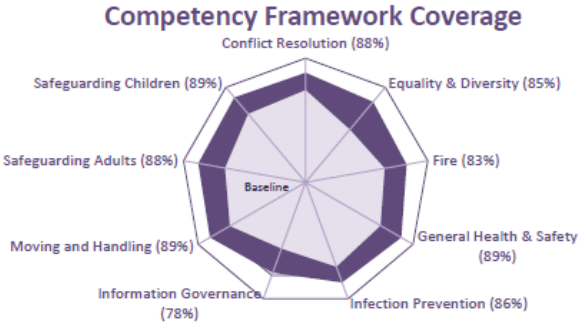
- Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

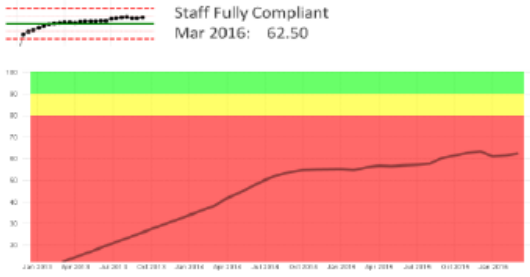
Statutory & Mandatory Training

There are 9 main subject areas comprising our statutory and mandatory training programme. These are known as 'competencies' and details are given in the spider diagram below.

At March 2016 62.5% of staff are fully compliant with meeting all 9 competencies. This position continues to improve as initiatives to promote compliance become embedded. The compliance rate at the end of 2014/15 was 54.8%. Information Governance and Fire competencies are required to be undertaken annually, with the others every two years, and therefore pose a greater challenge in achieving compliance.

The Trust continues to work towards a compliance of 90% or more.



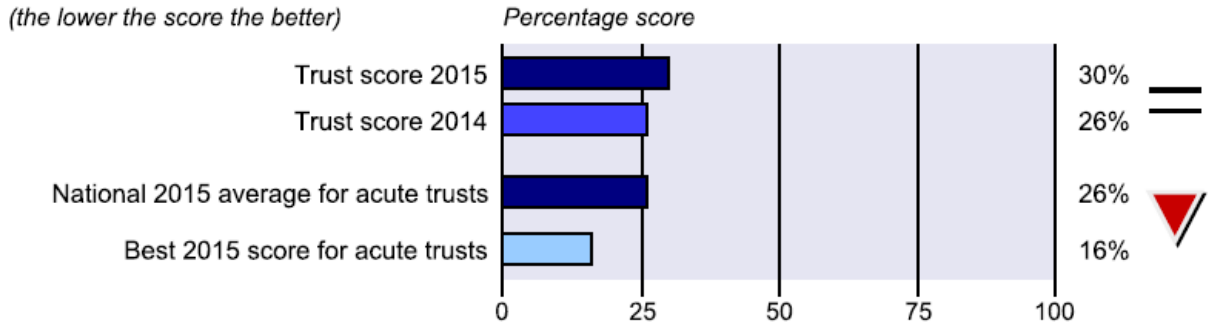


Bullying and harassment

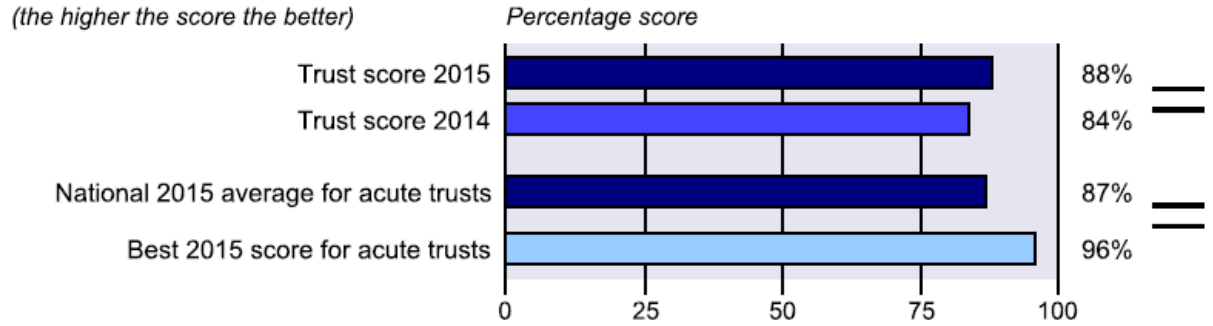
The 2015 NHS staff survey highlighted an ongoing issue with bullying and harassment at the Trust.

	Trust	National
% staff reporting they had experienced harassment, bullying or abuse from staff in the last 12 months	30%	26%
% staff who had experienced harassment, bullying or abuse had reported it	15%	37%
% staff who had never suffered bullying or abuse at work from managers	82.5%	85.3%
% staff said that they had never suffered bullying or abuse at work from colleagues	79.2%	80%

KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



The Trust introduced new processes in 2015 and developed existing processes to enable staff raise concerns of bullying and harassment. These include:

- Employee Relations Advisory Service (ERAS)
- Anonymous raising concerns platform 'Speak in Confidence' launched in September allows staff to select a manager who they wish to contact anonymously to raise their concerns with
- Bullying and Harassment survey 2016
- CORE management training for managers (497 managers trained)
- Drop in surgeries for staff
- Executive walkabouts
- Ask Nick sessions

This work is supported by a focus on reducing vacancy rates and increasing compliance with the new appraisal process which focuses on assessing behaviours and values.

Leadership and management capability is critical to the success of both increased staff engagement and reducing incidents of bullying and harassment. This will be delivered by the Trust's Leadership Development and Talent Management Strategy 2015-2020. In summary the projects include:

- Coaching programme – phase 1 & 2 (Executive Team & Top 120)
- ARC master classes
- Passport to Leadership
- Consultants and senior management mentoring

An independent bullying and harassment review has been commissioned to understand the concerns in more detail. The report will be available in the spring.

The trust board were a stable team and the CEO particularly was seen by staff as highly visible and approachable

The trust had recently gone through a significant change programme, two thirds of wards had moved and over half the staff involved in the change with one third of staff in new roles. Although the scale of this change had impacted on staff most felt it had been necessary and although unsettling had been in the main well managed.

The trust had developed a culture change programme and recognition programme called "ARC" standing for Accelerate, Refocus and Consolidate. Alongside this the trust had developed a staff health and wellbeing strategy with five key aims.

Staff side representative we spoke with told us that there were good constructive relationships between staff side representatives and the executive, particularly the director of HR who was seen as highly visible and having a willingness to listen.

The Trust had in place a whistle blowing policy and supported the Nursing Times' "Speak out Safely" campaign in encouraging any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity.

Senior Sister, Dagmar Louw from the New QEII has been named 'Team Leader of the Year' by the East and North Hertfordshire NHS Trust. Sister Louw added, "I am privileged to lead a team of exceptional nurses, who take great pride in their profession and genuinely care about their patients. This award is theirs as much as it is mine."

Hazel Pike, a volunteer at Michael Sobell House hospice, has been named 'Volunteer of the Year' by the East and North Hertfordshire NHS Trust. Hazel was nominated by those she works with for the tremendous support she gives to both staff and patients at Michael Sobell House. We are very grateful for her support, and that of all our volunteers

The team of Play Specialists at the Lister hospital have been nominated by members of the public to win an award. They were announced winners at the Trust's 'Celebration of Excellence' for the fantastic work they do with children and young people when they are ill.

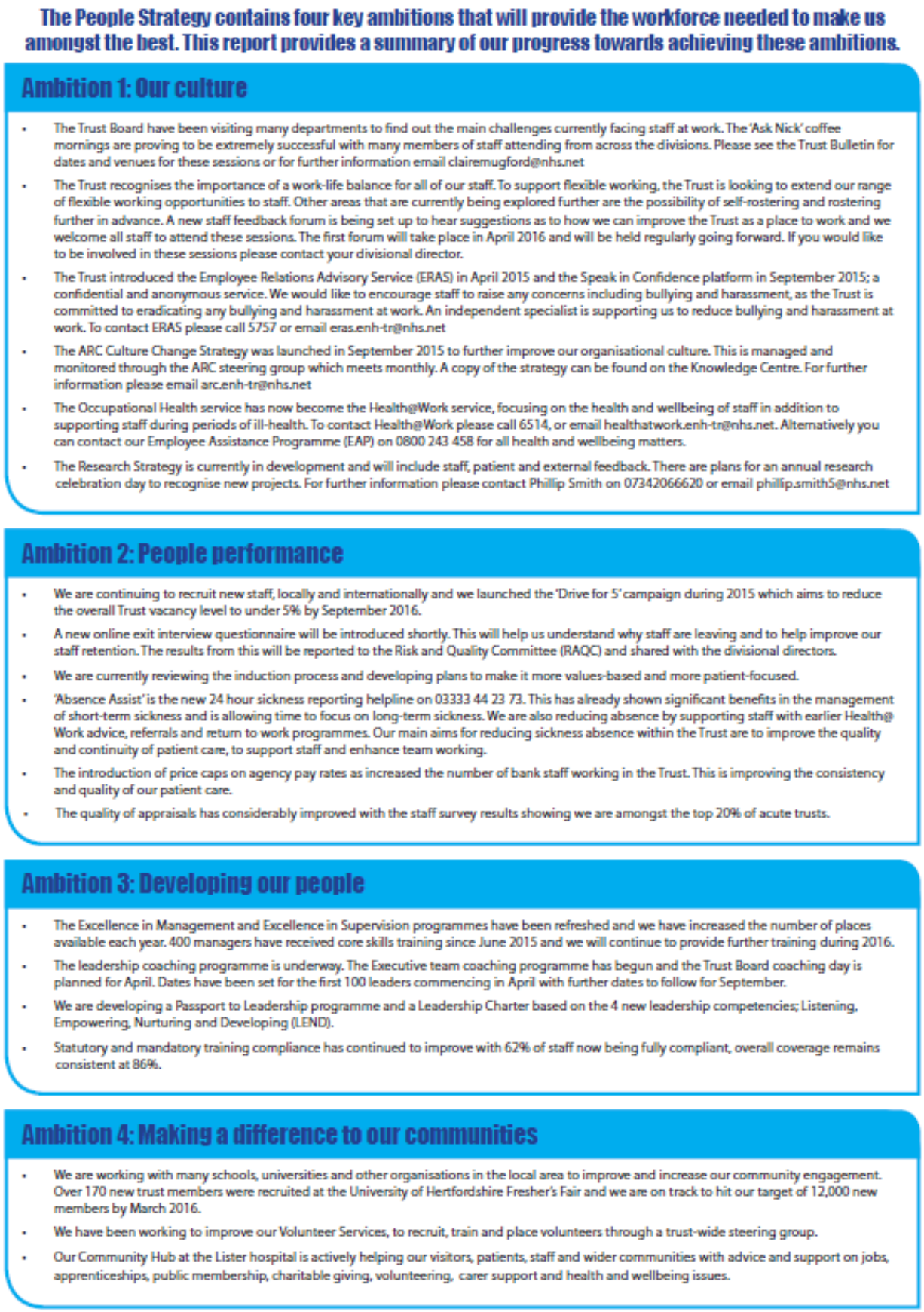
The play specialists have helped to raise over £250,000 to build a new play room, and their work has touched many lives - distracting, helping and reassuring young patients and their families.

David Ladenheim, pharmacist, was seconded to a national antimicrobial stewardship group resulting in the publication of two articles in national publications.

Elaine Dockree, one of the Trust's cancer nurse specialists has received one of the Roy Castle Foundation's two annual nurse of the year awards. The Foundation runs a campaign for patients to nominate nursing staff for an award, where their support has been valued.

Progress with the People Strategy

The poster below is a summary of achievements against the ambitions within the people strategy for 2015/16.



The People Strategy contains four key ambitions that will provide the workforce needed to make us amongst the best. This report provides a summary of our progress towards achieving these ambitions.

Ambition 1: Our culture

- The Trust Board have been visiting many departments to find out the main challenges currently facing staff at work. The 'Ask Nick' coffee mornings are proving to be extremely successful with many members of staff attending from across the divisions. Please see the Trust Bulletin for dates and venues for these sessions or for further information email clairemugford@nhs.net
- The Trust recognises the importance of a work-life balance for all of our staff. To support flexible working, the Trust is looking to extend our range of flexible working opportunities to staff. Other areas that are currently being explored further are the possibility of self-rostering and rostering further in advance. A new staff feedback forum is being set up to hear suggestions as to how we can improve the Trust as a place to work and we welcome all staff to attend these sessions. The first forum will take place in April 2016 and will be held regularly going forward. If you would like to be involved in these sessions please contact your divisional director.
- The Trust introduced the Employee Relations Advisory Service (ERAS) in April 2015 and the Speak in Confidence platform in September 2015; a confidential and anonymous service. We would like to encourage staff to raise any concerns including bullying and harassment, as the Trust is committed to eradicating any bullying and harassment at work. An independent specialist is supporting us to reduce bullying and harassment at work. To contact ERAS please call 5757 or email eras.enh-tr@nhs.net
- The ARC Culture Change Strategy was launched in September 2015 to further improve our organisational culture. This is managed and monitored through the ARC steering group which meets monthly. A copy of the strategy can be found on the Knowledge Centre. For further information please email arc.enh-tr@nhs.net
- The Occupational Health service has now become the Health@Work service, focusing on the health and wellbeing of staff in addition to supporting staff during periods of ill-health. To contact Health@Work please call 6514, or email healthatwork.enh-tr@nhs.net. Alternatively you can contact our Employee Assistance Programme (EAP) on 0800 243 458 for all health and wellbeing matters.
- The Research Strategy is currently in development and will include staff, patient and external feedback. There are plans for an annual research celebration day to recognise new projects. For further information please contact Phillip Smith on 07342066620 or email phillip.smith5@nhs.net

Ambition 2: People performance

- We are continuing to recruit new staff, locally and internationally and we launched the 'Drive for 5' campaign during 2015 which aims to reduce the overall Trust vacancy level to under 5% by September 2016.
- A new online exit interview questionnaire will be introduced shortly. This will help us understand why staff are leaving and to help improve our staff retention. The results from this will be reported to the Risk and Quality Committee (RAQC) and shared with the divisional directors.
- We are currently reviewing the induction process and developing plans to make it more values-based and more patient-focused.
- 'Absence Assist' is the new 24 hour sickness reporting helpline on 03333 44 23 73. This has already shown significant benefits in the management of short-term sickness and is allowing time to focus on long-term sickness. We are also reducing absence by supporting staff with earlier Health@Work advice, referrals and return to work programmes. Our main aims for reducing sickness absence within the Trust are to improve the quality and continuity of patient care, to support staff and enhance team working.
- The introduction of price caps on agency pay rates as increased the number of bank staff working in the Trust. This is improving the consistency and quality of our patient care.
- The quality of appraisals has considerably improved with the staff survey results showing we are amongst the top 20% of acute trusts.

Ambition 3: Developing our people

- The Excellence in Management and Excellence in Supervision programmes have been refreshed and we have increased the number of places available each year. 400 managers have received core skills training since June 2015 and we will continue to provide further training during 2016.
- The leadership coaching programme is underway. The Executive team coaching programme has begun and the Trust Board coaching day is planned for April. Dates have been set for the first 100 leaders commencing in April with further dates to follow for September.
- We are developing a Passport to Leadership programme and a Leadership Charter based on the 4 new leadership competencies; Listening, Empowering, Nurturing and Developing (LEND).
- Statutory and mandatory training compliance has continued to improve with 62% of staff now being fully compliant, overall coverage remains consistent at 86%.

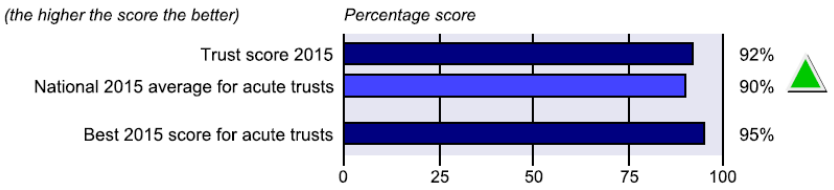
Ambition 4: Making a difference to our communities

- We are working with many schools, universities and other organisations in the local area to improve and increase our community engagement. Over 170 new trust members were recruited at the University of Hertfordshire Fresher's Fair and we are on track to hit our target of 12,000 new members by March 2016.
- We have been working to improve our Volunteer Services, to recruit, train and place volunteers through a trust-wide steering group.
- Our Community Hub at the Lister hospital is actively helping our visitors, patients, staff and wider communities with advice and support on jobs, apprenticeships, public membership, charitable giving, volunteering, carer support and health and wellbeing issues.

Aligning the national staff survey results with Trust values

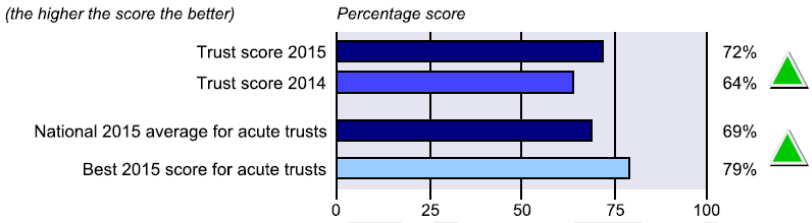
We put our patients first

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

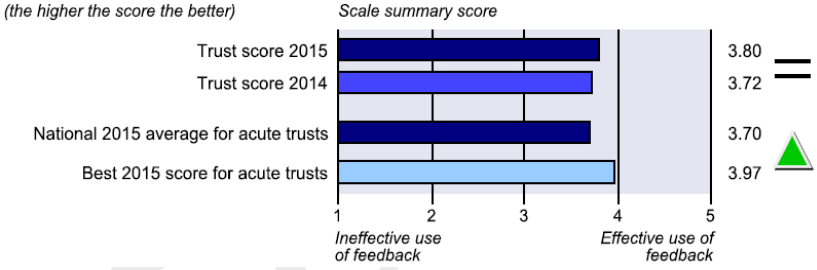


We strive for excellence & continuous improvement

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

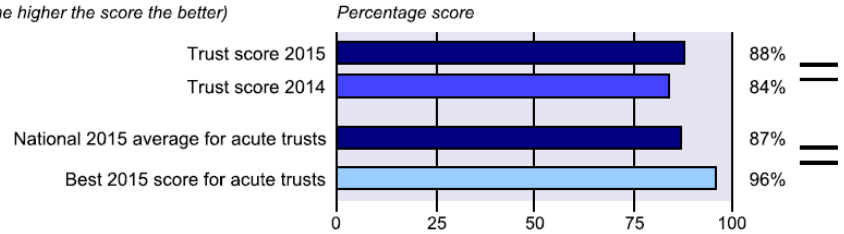


KEY FINDING 32. Effective use of patient / service user feedback



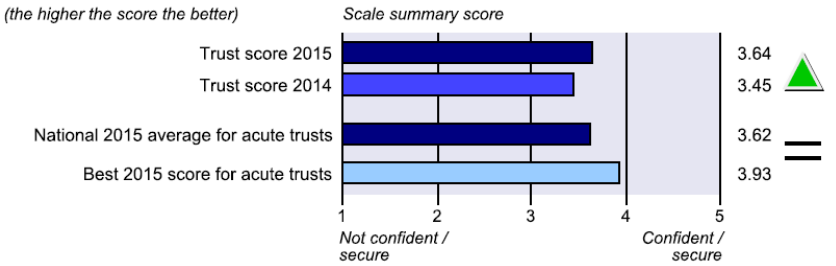
We value everybody

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



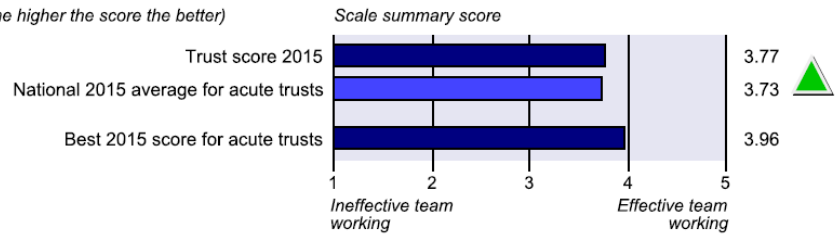
We are open and honest

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



We work as a team

KEY FINDING 9. Effective team working



3d Performance against national requirements

Monitor Compliance Framework

	Compliance Framework Priorities	13/14	14/15	15/16 YTD	Plan for 15/16	Met
Infection control	Clostridium Difficile incidence	14	12	16	<=14	✗
	MRSA Bacteraemia	2	5	0	0	✓
Referral to treatment times	% admitted patients treated within 18 weeks	90.8%	88%	Aggregated indicator from July 2015 as below		
	% non-admitted patients treated within 18 weeks	96.6%	95.6%			
	% open pathways (aggregated treatment within 18 weeks)	N/A	N/A	93%	>=92%	✓
	% incomplete pathways less than 18 weeks	94.8%	94.2%	92.7%	>=92%	✓
Cancer access – initial appointments	All cancers: two week maximum wait from GP referral to first outpatient attendance	97.8%	97.4%	96.4%	>=93%	✓
	2 week wait – Breast Symptoms	96.5%	94.4%	95%	>=93%	✓
Cancer access – initial treatment	62-day urgent referral to treatment of all cancers	85.9%	81.4%	76.9%	>=85%	✗
	62-day referral to treatment from screening	92.1%	93.7%	90.2%	>=90%	✓
	31-day diagnosis to treatment for all cancers	97.5%	96.8%	96.9%	>=96%	✓
Cancer access – subsequent treatment	31-day second or subsequent treatment (Surgery)	96.8%	94.6%	96.5%	>=94%	✓
	31-day second or subsequent treatment (Anti Cancer Drug Treatments)	98.8%	99%	98.5%	>=98%	✓
	31-day second or subsequent treatment (Radiotherapy Treatments)	97.5%	95.9%	95.4%	>=94%	✓
Access to A&E	Four hour maximum wait in A&E	95.7%	92.3%	85%	>=95%	✗
Access to patients with a learning disability	Self-certification that Trust meets access requirements for those with a learning disability			✓	Compliant	✓

Appendix 1 – CQC findings of outstanding practice

The trust's diabetes team won a prestigious national "Quality in Care Diabetes" award in the best inpatient care initiative category.

Following negotiations with the CCG the trust developed an outreach team to deliver seven day, proactive ward rounds specifically targeting high-risk patients. This included the delivery of a comprehensive set of interventions which included smoking cessation and structured education programmes for both the respiratory and diabetic services.

The day surgery unit had been awarded the Purple Star, which is a recognised award to a service for improving health care for people with learning disabilities. We saw patients with learning disabilities and their relative receiving high levels of outstanding care.

The ophthalmology department had implemented a minor injuries service. Patients could be referred directly from accident and emergency, their GP or opticians to be seen on the same day.

Ophthalmology nurses had undertaken specific training to enable them to carry out intravitreal procedures.

The Lister Robotic Urological Fellowship is an accredited and recognized robotic urological training fellowship programme in the UK by the Royal College of Surgeons of England and British Association of Urological Surgeons. This technique is thought to have significantly reduced positive margin rate during robotic prostatectomy and improved patient functional outcome.

We saw some examples of excellence within the maternity service. The foetal medicine service run by three consultants as well as a specialist sonographer and screening coordinator is one example; the unit offers some services above the requirements of a typical district general hospital such as invasive procedures and diagnostic tests. The unit has its own counselling room away from the main clinic and continues to offer counseling postnatally.

The service also offered management of hyperemesis on the day ward in maternity to minimise admission.

The radiotherapy service provides IMRT (Intensity Modulated Radiotherapy) to a higher percentage of patients than the England average. The service provided a good range in IGRT (Image Guided Radiotherapy). Together these are indicators of a high quality radiotherapy service.

The radiotherapy service had a strong reputation nationally as a major contributor to clinical trials.

The radiotherapy service was accredited to the ISO 9001 quality standard.

The cancer centre is one of the top ten centres in the country for research and innovation.

Care shown to patients undergoing chemotherapy and the community children's and young people's service was outstanding.

Effective multidisciplinary working was evident throughout all departments.

All staff were proud to work for MVCC and many described it as a special place to work.

The children's community nursing (CCN) service, children's continuing care (CCC) the specialist health visitors (HV,) community paediatrics and the school nursing service were identified as being creative and innovative in finding solutions to the complex care and support needs of CYP.

Children were truly respected and valued as individuals and encouraged to self-care and were supported to achieve their full potential within the limitations of their clinical condition.

Feedback from children who use the service, parents and stakeholders was continually positive about the way staff treated people. National audits for CYP in diabetes and epilepsy scored highly (100% for epilepsy and the fourth highest in the country for diabetes) for patient experience.

Parents said staff did everything they possibly could to support the child and the family which exceeded their expectations. Parents told us staff went the "extra mile" and gave examples of how staff had actively supported their child and the family throughout the care episode.

Appendix 2 – CQC summary findings

Safe - requires improvement

Although there was robust systems in place to manage risks these were not always effectively implemented. Risks identified were not always acted upon in a timely manner and opportunities to prevent or minimize harm were missed and feedback was not always provided on incidents reported.

Staff did not always report incidents appropriately, and learning from incidents was not always shared effectively.

Some of the staff we spoke with did not know what duty of candour meant for them in practice.

The triage system within the emergency department at Lister Hospital was not sufficient to protect patients from harm or allow staff to identify those with the highest acuity. Urgent action was taken to address this following it being brought to the trust's attention.

Urgent transfers out of MVCC were not reported on the trust wide incident reporting system. There was no process in place to follow up these patients so the service was not sighted on whether the patient's cancer treatment had been maintained. The trust was unsighted on this risk.

Infection control practices were not always followed. This was of particular concern within the emergency department at the Lister Hospital.

In some areas, patient records lacked sufficient detail to ensure all aspects of their care were clear.

Some patients were cared for on wards outside of their specialist care group, nursing staff told us they did not always feel equipped with the skills to care for these patients. We found that this group of patients were not always reviewed by a consultant when they should have been. However the trust took urgent action to address this.

We found poor medicines' management within the medical service which was brought to the attention of the trust who took immediate action to address our concerns. This resulted in the review of all medicine management procedures within the service with timely action plans.

Action identified as required following investigation of serious incidents on Bluebell ward were not being addressed in a timely or sustainable manner to ensure children were protected from avoidable harm. We brought this to the trust's attention and the trust took urgent actions to address this.

Mandatory training in some areas did not meet the trust's target.

Do Not Attempt Cardiopulmonary resuscitation forms were not always completed in accordance with trust procedures and national guidance.

Effective - requires improvement

There was limited awareness of Mental Capacity Assessments in some areas.

Only 30% of patients being treated at MVCC received antibiotics within two hours if they presented with suspected neutropenic sepsis. However, not all presented at MVCC, some were treated in other trusts.

There was evidence of local clinical audits and action required at ward level.

Patient outcomes were variable across the services.

Not all staff had had an annual appraisal.

There was not an effective system in place for clinical and operational formal supervision in all services.

There were effective systems in place to ensure that staff were registered to work with their professional body.

In the main, we saw good multidisciplinary working with good progress on the move to seven day working.

Caring - good

In most areas, patients were treated with dignity and respect and were provided with appropriate emotional support.

We found caring in the community children's and young people's service and in chemotherapy at MVCC to be outstanding.

However caring required improvement in the urgent and emergency care service at the Lister site where patients were not always treated with dignity and respect.

Responsive - requires improvement

There were frequent delays in patients being handed over from ambulance crews and some patients had long waits in ED due to lack of beds and delays in discharges throughout the hospital.

The emergency department did not consistently meet the four hour target to admit, refer or discharge and were generally performing worse than the England average.

Good initiatives were in place to improve care for those living with dementia; however, not all staff followed them in all services.

The trust did not collect information of the percentage of patients achieved dying in their preferred location. Without this information, the trust was unable to monitor if they were honouring patients' wishes and if work was needed to improve this.

Bed occupancy was high and the trust was working to improve the safety and timely discharge of patients. However, there were an increasing number of delayed transfers of care.

Working towards providing a seven day service was evident in most areas.

We found that outpatient and diagnostic services were generally responsive to the needs of patients who used the services.

Waiting times were within acceptable timescales, apart from at MVCC where long waits were commonplace.

Outpatient DNA (did not attend) rates were better than the average for trusts in England.

Clinic cancellations were below 2%. Patients were able to be seen quickly for urgent appointments if required.

Most staff showed an awareness for diversity and appropriate translation services were in place.

Well -led - requiring improvement

We found that in eight of the 17 core services we rated that leadership required improvement, in nine of the core services it was good and in one (Urgent and Emergency services at the Lister Site), it was inadequate.

The trust had undergone an extensive change programme “Our Changing Hospitals “staff told us although this had been unsettling they thought it had been well managed.

Results from the NHS Staff Survey in 2014 showed that the trust performed similar to other trust in 18 questions and was in the bottom 20% of trusts for the remaining 13 questions. There were no areas of the survey that showed significant improvement from 2013.

The trust had developed a strategy to lead their approach to care delivery from 2015 to 2020. This was not yet well embedded and knowledge amongst staff was limited. There was no detailed cancer strategy in place to support the development of services at MVCC. The trust had a well-developed set of values (called PIVOT) that was recognised by most staff.

We found that there were governance systems in place to escalate issues and risks to the trust board. However the effectiveness of these processes varied between divisions.

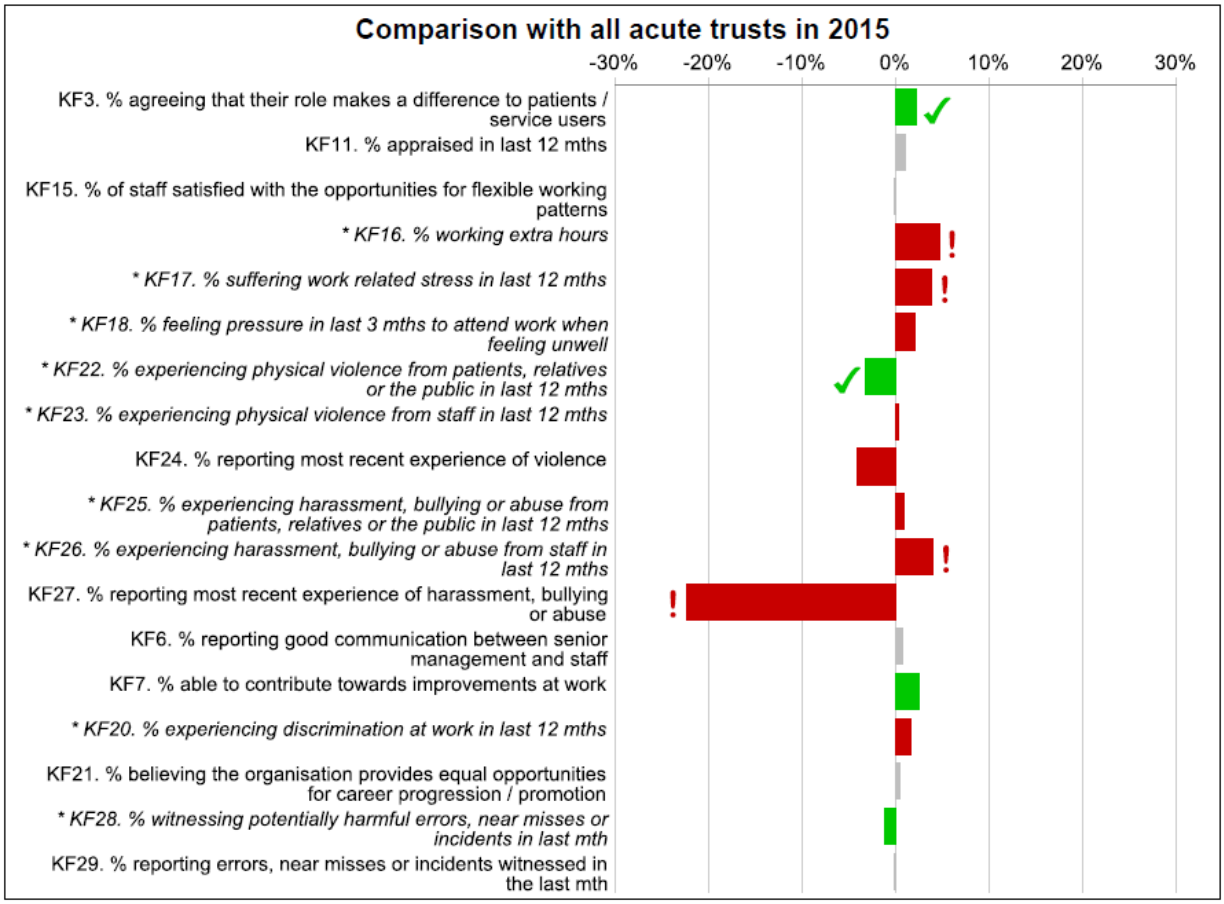
We found risks within paediatric services had not been addressed or managed with pace.

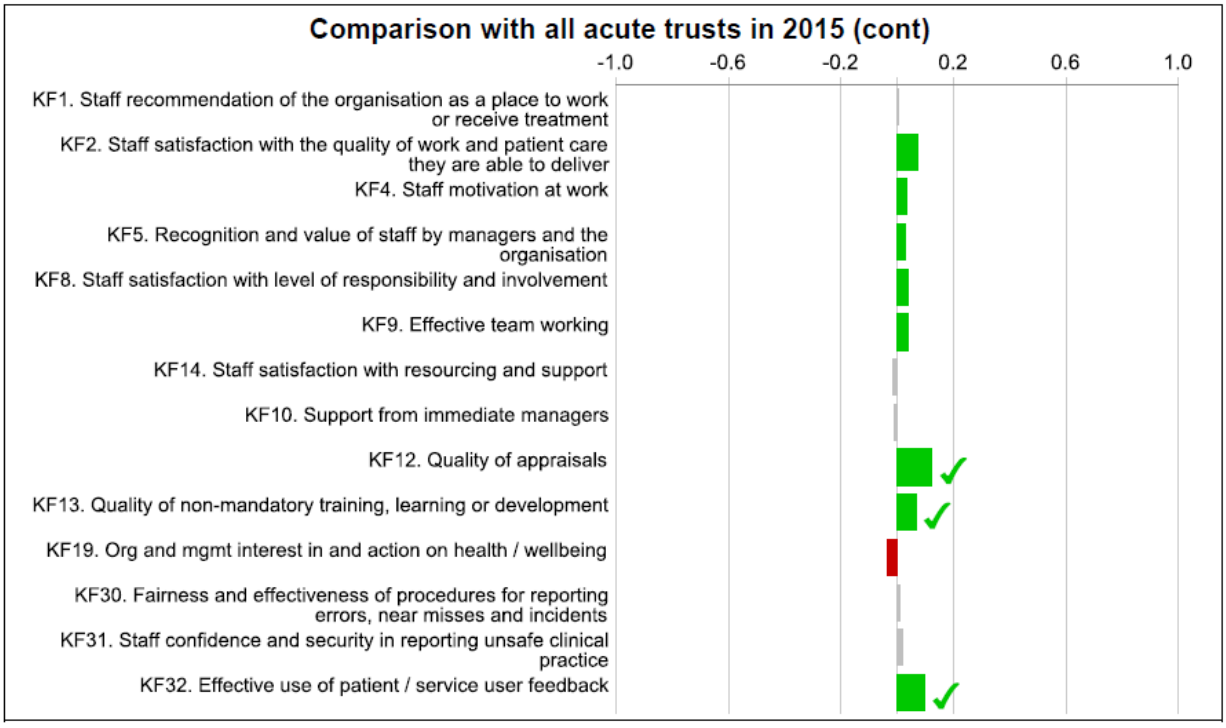
We found standard of the divisional risk registers to be variable and we were not assured that there was always effective divisional ownership and scrutiny or corporate oversight of this.

Overall the trust board were a stable team and the CEO particularly was seen by staff as highly visible and approachable. Visibility amongst the rest of the board was reported as variable.

The trust was very proactive in engaging with the local community and had exceptional engagement with young people.

Appendix 3 - National Staff Survey 2015





KEY

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

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

Grey = Average.

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

Annexes

Annex 1 Statements from stakeholders

Annex 2 Statement from auditors

Annex 3 Statement by the Directors