Quality Account
2014-15

To be amongst the best
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If members of the public would like to provide feedback on this Quality Account or suggest items for inclusion in next year's report they can email qualityaccount.enh-tr@nhs.net or contact the Board Secretary on 01438 314333
Part 1

1a Statement on quality from the Chief Executive

1b About us

1a Statement on quality from the Chief Executive

In line with our ambition and vision ‘to be amongst the best’ at East and North Hertfordshire NHS Trust (ENHT) we aim to deliver high quality, patient-centred care. This means providing services that are safe and deliver the best clinical outcomes and patient satisfaction.

Last year at ENHT we cared for 124,836 patients in the emergency department, 89,523 patients as inpatients and day cases and delivered 5441 babies. Almost 494,000 people visited our out-patient clinics. Whilst achieving that we have consolidated acute services onto the Lister Hospital site, finalising what has been a significant period of change over the last few years.

Throughout these changes we have remained relentless in striving to achieve upper quartile performance in everything that we do, ensuring that this reflects our five organisational values.

We have achieved some excellent results this year, particularly in areas such as heart attack and trauma care. The number of patients who would recommend us is higher than the national average. These successes are down to the commitment of our staff and their work ethic in line with the Trust values.

However, there are areas where we have not performed as well as planned despite continued improvement, for example in falls prevention and readmission rates. The unprecedented demand for care and treatment, as in other organisations across England, together with staffing instability associated with our service changes has caused significant challenges. As we near the end of the year our permanent staffing levels are recovering and our measures are showing signs of improvement.

We know how we are performing – what we are doing well and where improvements are required. We know how we are performing compared to other organisations in a number of areas. We also know what our patients think of us – that is, whilst we are providing good care, we need to improve our administrative systems. We will continue to use this rich information to drive further improvements, working in partnership with our community and embracing technological and innovative solutions.

I am very proud of what our staff have achieved this year. This Quality Account provides a snapshot of some of these achievements. To the best of my knowledge the information in this document is accurate.

Nick Carver
Chief Executive
1b About us

A year of change
It is important at this point in the report to recognise the extent and consequent impact of the organisational changes that occurred during 2014/15. ‘Our Changing Hospitals’ is a programme of work to bring together general in-patient services onto the Lister Hospital site; development of a range of improved services and infrastructure and finally the relocation of out-patient services to a new Queen Elizabeth II Hospital. The changes have taken place over a number of years with the first stages of the projects being completed in 2011. Section 3c summarises the changes that have been made overall but in particular focuses on the changes during 2014/15.

Hospitals cannot close for building work to be undertaken. Enabling building work to carry on whilst continuing to deliver health care has meant that we have shuffled services, using different or temporary locations. Staff and patients have consequently delivered and received care in areas less than ideal at times – amongst temporary signs, the sound of drills etc. During these times we have endeavoured to maintain the quality of care but recognise from feedback that we have not always got it right.

2014/15 has been the most significant in terms of the impact upon staff. As services were centralised the number of staff required to run the services was reduced and the location of some services was changed. Therefore the Trust launched 38 consultations involving over 3,100 members of staff. Some roles would no longer exist whilst other roles would be affected to a lesser extent. This change process was very carefully managed to avoid job losses and a strong support system was put in place for people affected. As services were relocated new teams were brought together but it takes a while before new teams can start to work together effectively, particularly when they are in a new location. This was a difficult time for staff, some of whom chose to work elsewhere both before and after the main changes.

Clinical teams and the Trust Board carefully scrutinised the impact of changes – monitoring for example the number of falls, the vacancy rates and use of temporary staff. This report shows that some of the improvements in quality were not achieved to the extent planned, although given the challenges presented this year of change has resulted in many successes.

Amongst the best
The Trust aspires ‘to be amongst the best’ performing NHS trusts in the country. This vision is underpinned by:

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

- a set of five PIVOT values which are integral to the way our staff undertake their work.
A strategy for quality

The Quality and Risk Management Strategy (2015) outlines how quality is incorporated into the everyday business of the organisation. This strategy is supported by the Patient Safety Strategy, the Patients and Carers Experience Strategy, the Nursing and Midwifery Strategy and the Improving Patient Outcomes plans which aim to:

- Reduce harm and avoidable deaths
- Reduce variability of care
- Promote a culture where safety is an integral part of what we do
- Design services, pathways and systems which protect patients from harm and maximise clinical outcomes
- Improve the physical and emotional experiences of patients, their families and carers.

Measuring for quality improvement

We have well established ways of measuring our performance through routine data reporting, collection of feedback or special reviews. Examples of this are given throughout the report.

For each item we measure, known as an indicator, we have an aim (also referred to as a target) – something that we strive for and a specific timeframe. The actual result is known as an outcome.

For example:

Indicator: Number of portions of fruit and vegetables eaten

Aim: 7
Timeframe: per day
Outcome: 4

In this example we’ve only eaten 4 out of the 7 we aimed for so need to increase the number the next day, and afterwards, to meet our aim.

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.

The NHS uses hundreds of indicators – some set nationally so that performance across the NHS can be measured, known as benchmarking. Others are set by us to monitor local initiatives.

Listening to you

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

- Surveys
- 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
There are examples of comments and learning from feedback given throughout the report.

**Monitoring for quality improvement**

Monitoring performance allows us to demonstrate how efficient the Trust is in using its resources and how effective it is in achieving the best outcomes. Performance information is used in the following ways:

- 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

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

**Committee structure**

The Trust Board has overall responsibility for the monitoring and delivery of services. This includes all aspects relating to quality. At each meeting of the Trust Board a range of quality indicators are reviewed and reports are scrutinised. The meetings are held in public with the papers available via the Trust website. 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 the Director of Nursing)
- Patient Safety Committee (Chaired by the Associate Medical Director for Patient Safety).

These each receive scheduled reports from departments, committees or individuals tasked with quality improvement, for monitoring and assurance purposes. A process of escalation enables any concerns or significant achievements to be shared with the parent committee.
Management structure
Each Clinical Division and Specialty is led by a dedicated medical, nursing and management team. Together they are responsible for quality within their own areas and are held accountable for this through the organisational hierarchy structure.

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

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

Each Specialty meeting records minutes of the discussion and presentations. RHD ‘learning points’ are prepared centrally and are circulated prior to the meetings for discussion. These highlight recent matters of concern or interest for sharing.

“bluebell ward staff were amazing
friday 13th feb ,what a day my 11 yr old son with hospital phobia needs emergency operation,i know my son better than anyone and i didnt even think it were possible to get him to the hospital let alone in theatre. nurse clinic G ,talks him through it all and find him a bed in the kids ward such a nice lady, then another nurse takes over on bluebell ward gets him up to theatre [dont know how she did this] but it was amazing really calming nature such a nice lady put me and him at ease, and stayed with him at all times, when the theatre was ready for him we all made our way up stairs and he was introducecc to the dr and the anesthistes and her team they were just amazing they told him the whole truth what would happen ,showed him around and even let him walk into the room as he didnt want to get on the bed, she was so careful he didnt even feel the drip go into his hand.
the most precious thing in my life was now in their hands and they did an amazing job and brought him back safe and sound to me and for this iam truly greatful, when he came round in recovery he was smiling from ear to ear and a nurse from bluebell ward was waiting at his bed side with presents and a bravery certificate she was so nice ,she got him back on the ward and comfortable and so i can only say one more thing these ladies really are our angles luv 1 happy mum and 1 very very greatful little boy brooklyn xx god bless u all x”

Anonymous, 15 February 2015, NHS Choices
Part 2

Priority for improvement:

2a | Priorities for 2015/16
   | A review of 2014/15 priorities
2b | Statements of assurance from the Board
2c | Performance against national core indicators

2a Priorities for improvement

Priorities for 2015/16

In order to seek views about priorities for 2015/16 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
  - Involvement Committee for all priorities
  - Clinical Governance Strategy Committee for priorities about clinical outcomes
- Review of complaints and PALS concerns
- Review of feedback from NHS Choices
- Staff involved in developing their plans for improving outcomes contributed their ideas
- Focus groups with patients / carers identified what is important to them as part of the developing Patient and Carer Experience Strategy
- Review of forthcoming strategic plans
- Regional and national documentation was consulted to identify likely initiatives
- 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
- Alignment with CQUIN and operating plan aims

Following this review it has been agreed to continue with the same priorities as last year. There are further improvements to make. The priorities and their individual indicators are shown in the tables on the next few pages together with how they will be monitored and who the lead directors are.
### PRIORITY 1: SAFETY

<table>
<thead>
<tr>
<th>No</th>
<th>Indicator</th>
<th>Why this is important</th>
<th>How this will be measured</th>
<th>Where this will be monitored and Lead Director</th>
</tr>
</thead>
</table>
| 1  | Improve safety thermometer scores             | The Trust has seen significant reductions in harms over the past few years, although latterly not at the rate desired. We wish to move towards a zero tolerance for harms relating to falls and pressure ulcers. | • Safety thermometer score for falls, pressure ulcers, UTI and VTE  
• Number of falls  
• Number of falls resulting in serious harm  
• Number of pressure ulcers (hospital acquired) | Bi-monthly report to the Risk and Quality Committee  
Monthly ‘Floodlight’ report to the Board  
Lead: Director of Nursing and Patient Experience |
| 2  | Improve medication management                 | Incident reporting and audits show medication errors are still occurring. We wish to ensure that patients receive the correct medicines on time and are empowered to take ownership of their treatment. | • Survey results (medication purpose & side effects)  
• Incident reporting remedication  
• Medication omission audit  
• Implement Medicines Optimisation Strategy objectives for year  
• Results of medication thermometer | Bi-monthly report to the Risk and Quality Committee  
Monthly ‘Floodlight’ report to the Board  
Leads: Medical Director & Director of Nursing and Patient Experience |

### PRIORITY 2: EFFECTIVENESS

<table>
<thead>
<tr>
<th>No</th>
<th>Indicator</th>
<th>Why this is important</th>
<th>How this will be measured</th>
<th>Where this will be monitored and Lead Director</th>
</tr>
</thead>
</table>
| 3  | Continue to reduce mortality                 | The Trust has made significant progress in reducing mortality and in 2014/15 introduced a mortality review process. The Trust wishes to see further reductions. | • HSMR  
• SHMI  
• SHMI data adjusted for palliative care  
• Unexpected admissions to ICU audit  
• Cardiac arrest calls  
• Observation Compliance  
• Mortality review | Monthly ‘Floodlight’ report  
Bi-monthly report to the Risk and Quality Committee & Board (via Medical Director report)  
Quarterly thematic reviews of mortality at Clinical Governance Strategy Committee  
Lead: Medical Director |
4. **Continue to improve stroke standards**

   Improvements have been seen through improved working with the community but there are still challenges around the treatment and care of patients, particularly at the rehabilitation stage.

   - 3 hr thrombolysis
   - 4 hrs to stroke unit
   - 90% time on stroke unit
   - 60 minute to scan

   Monthly ‘Floodlight’ report (and exception reporting where necessary) to the Board

   **Lead:**
   Director of Operations

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**PRIORITY 3: EXPERIENCES**

<table>
<thead>
<tr>
<th>No</th>
<th>Indicator</th>
<th>Why this is important</th>
<th>How this will be measured</th>
<th>Where this will be monitored and Lead Director</th>
</tr>
</thead>
</table>
| 5  | Improve communication | Communication remains one of the most common subjects in complaints and PALS concerns. There has been a large investment in customer care training and awareness but further scrutiny and improvement is required. | • Improvement in survey results (involved in decisions, consistent info, providing understandable answers, name of contact)  
• Monitoring ward staffing levels  
• Reduction in complaints & PALS concerns (rate)  
• GP Survey | **Patient Experience Committee**  
**Risk & Quality Committee**  

**Leads:**
Director of Nursing & Patient Experience; Director of Operations |
| 6  | Reduce delays | Delays feature as common subjects in complaints and PALS concerns; and are also raised as a concern by stakeholders particularly in outpatients and the contact centre | • Reduction in complaints & PALS concerns (rate)  
• Improvements in survey results (waiting list, waiting for bed, OPD waiting time) | **Bi-monthly report to the Risk and Quality Committee**  
**Patient Experience Committee**  

**Monthly floodlight to the Trust Board**  

**Leads:**
Director of Operations; Director of Nursing & Patient Experience |
A review of 2014/15 priorities

In the 2013/14 quality account a list of priorities for delivery during 2014/15 was given. Progress against each of these priorities is given in the sections below.

PRIORIT Y 1 – IMPROVING SAFETY

Comparison table and achievement in-year

<table>
<thead>
<tr>
<th>Priority</th>
<th>Description</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>Aim for 14/15</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1a</td>
<td>Safety thermometer score for falls, pressure ulcers, UTI and VTE (no of harms)</td>
<td>N/A</td>
<td>N/A</td>
<td>Collected</td>
<td>Collect</td>
<td>✓</td>
</tr>
<tr>
<td>1.1b</td>
<td>Number of inpatient falls</td>
<td>1244</td>
<td>988</td>
<td>919</td>
<td>&lt;888</td>
<td>x</td>
</tr>
<tr>
<td>1.1c</td>
<td>Reduce number of in-patient falls resulting in serious harm</td>
<td>14</td>
<td>16</td>
<td>14</td>
<td>&lt;=24</td>
<td>✓</td>
</tr>
<tr>
<td>1.1d</td>
<td>Reduce number of preventable hospital acquired pressure ulcers</td>
<td>113</td>
<td>45</td>
<td>54</td>
<td>&lt;=96</td>
<td>✓</td>
</tr>
<tr>
<td>2.1</td>
<td>Survey results: - medication purpose - side effects</td>
<td>8.4</td>
<td>8.2</td>
<td>8.4</td>
<td>4.8</td>
<td>Improve ✓</td>
</tr>
<tr>
<td>2.2</td>
<td>Medication incidents - rate per 100 discharges - % leading to harm</td>
<td>1175</td>
<td>987*</td>
<td>799</td>
<td>N/A</td>
<td>N/A x</td>
</tr>
<tr>
<td>2.3</td>
<td>Undertake medication omission audit</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2.4</td>
<td>Implement Medicines Optimisation Strategy objectives for year</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2.5</td>
<td>Results of medication thermometer (if decision made to implement)</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

* Number revised in 14/15 to include controlled drug incidents

Monthly progress in 2014/15

<table>
<thead>
<tr>
<th>No</th>
<th>Indicator</th>
<th>Plan for 2014/15</th>
<th>Freq of reporting</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Safety thermometer (number of harms)</td>
<td>&lt;=31</td>
<td>M</td>
<td>36</td>
<td>18</td>
<td>26</td>
<td>29</td>
<td>24</td>
<td>33</td>
<td>33</td>
<td>27</td>
<td>32</td>
<td>24</td>
<td>96</td>
<td>26</td>
</tr>
<tr>
<td>1.3</td>
<td>No. of falls</td>
<td>&lt;=74</td>
<td>M</td>
<td>79</td>
<td>69</td>
<td>70</td>
<td>71</td>
<td>94</td>
<td>59</td>
<td>60</td>
<td>73</td>
<td>31</td>
<td>44</td>
<td>75</td>
<td>60</td>
</tr>
<tr>
<td>1.4</td>
<td>No. of HAIPUs</td>
<td>&lt;=2</td>
<td>M</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>2.1</td>
<td>Survey - medication purpose</td>
<td>N/A</td>
<td>D</td>
<td>62</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2.2</td>
<td>Survey - medication side effects</td>
<td>N/A</td>
<td>D</td>
<td>63</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>Medication incidents - rate per 100 discharges</td>
<td>&gt;=1.24</td>
<td>Q</td>
<td>1.1</td>
<td>0.9</td>
<td>0.91</td>
<td>0.75</td>
<td></td>
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</tr>
<tr>
<td>2.3</td>
<td>Medication incidents - % leading to harm</td>
<td>&lt;=11.96%</td>
<td>D</td>
<td>9.93%</td>
<td>11.11%</td>
<td>9.99%</td>
<td>15.25%</td>
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<tr>
<td>2.3</td>
<td>Medication omission audit</td>
<td>A</td>
<td>Audit completed in May 2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2.4</td>
<td>Medicine optimisation strategy objectives</td>
<td>A</td>
<td>Approved in July</td>
<td></td>
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<tr>
<td>2.5</td>
<td>Medication thermometer</td>
<td>A</td>
<td>Pilot completed Nov 14</td>
<td></td>
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</tbody>
</table>

1.1a Safety thermometer

The NHS Safety Thermometer provides a ‘temperature check’ on harm. It is a method of measuring, on a certain day, the proportion of patients that are ‘harm-free’. Staff undertake an audit each month by looking at the health records of all patients to identify whether a patient
has had a fall, has a pressure ulcer, has been assessed for a blood clot (also known as a venous thromboembolus – VTE) or has a urinary infection (UT)) if they have a catheter. It identifies the proportion of patients who are free from harm on a particular day. The information is uploaded onto a dedicated website from where benchmarking information can be extracted.

The funnel plots below highlight the Trust position in relation to harms per 1000 bed days (for all four harm areas) as recorded on the national patient safety thermometer. The Trust is shown as a blue or red dot. The funnel plots for falls and pressure ulcers show the Trusts performance is amongst the best in the NHS (below the pink line) whilst catheter related infections are in line with national averages and VTE incidence is worse than the national average. For further information on VTE please refer to section 2c, point 6.

![Funnel plot for falls with harm](image1)
![Funnel plot for pressure ulcer prevalence](image2)
![Funnel plot for catheters with UTI](image3)
![Funnel plot for VTE incidence](image4)

1.1b Falls

919 inpatient falls have been reported in 2014/15. This represents a 7% reduction compared with the number of falls in 2013/14 and is slightly short (31 falls) of our 10% reduction target. The charts below demonstrate the:

a) number of falls per month in 2014/15 and
b) reduction in the overall number of falls on an annual basis since 2011.

![Falls data - all Trust](image5)

![ENHT, Falls and seasonality 2011-2014](image6)
In 2014/15 the numbers of falls reduced steadily in the first half of the year. Since October however, the numbers have increased. This can be linked with staff and team changes following the Trust centralisation programme and unprecedented demand for acute hospital services. During the spring the number of falls has continued to reduce per month and in March the ‘falls per 1000 bed days’ was the lowest on record for the Trust.

Since October 2012 the number of people attending the emergency department following a fall in the community has increased by 16.58%; and those requiring admission has increased by 20.85%. Patients who are admitted to hospital following a fall in the community are 2-3 times more likely to fall during their admission.

A review of national incident data (April – Sept 2014) shows that 19% of Trust incidents result from a ‘patient accident’ which includes falls. This compares with an average of 19.7% across all acute (non-specialist) trusts.

1.1c Falls resulting in serious harm

During 2014/15, there have been 12 severe harm falls recorded in the Trust along with two incidents in which a patient’s deaths were directly attributed to head injuries sustained as a result of an inpatient fall. These incidents have been fully investigated using root cause analysis techniques and where problems were identified this has led to changes in practice.

The two pie charts below demonstrate the number of falls broken down by level of harm for 2013/14 and 2014/15.

During 2014/15 the following changes compared to the previous year are seen:

- 35% decrease in the number of falls leading to low harm
- 61% decrease in moderate harm falls
- Decrease in falls leading to severe harm or death.

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 facilitated by the Falls Prevention Nurse along with a ward manager and ward matron. Findings from the RCA investigations are shared amongst relevant members of the multi-disciplinary team to ensure that interim risk mitigation measures are in place. All falls-related serious incidents are discussed during the bi-monthly Falls, Fragility and Bones Group where any trust-wide changes to practice or the Falls Prevention Strategy are agreed.

1.1c Pressure ulcers

The Trust aimed to reduce by 25% against a defined baseline\(^1\) the number of patients recorded as having a category 2-4 pressure ulcer as measured using the NHS Safety

\(^1\) Baseline = median of 6 consecutive data points to 31 March 2014 constructed from 5 consecutive monthly data points up to 31 March 2015 all lower than the baseline median value.
Thermometer tool. On one day each month the audit is undertaken. The results are shown in the graph below.

A member of the Tissue Viability Team has been seconded to work with Hertfordshire Community Trust for six months to assist with achieving this aim. Analysis of the data shows that most patients with existing pressure ulcers have been cared for in their own homes or residential homes prior to coming into hospital. An educational programme with residential homes is planned to reduce pressure ulcer development.

During 2014/15, there were 54 grade 2-3 avoidable hospital acquired pressure ulcers. This is the first time since 2011 that there has been an increase in avoidable (those that could have been prevented) pressure ulcers. The main themes from all the RCA investigations conducted by the Tissue Viability Team are lack of consistent documentation of the care given to the patient especially in the area of skin inspection. The causes are probably multifactorial and may be influenced by the recent increased use of temporary staff.

During World Stop the Pressure month in November the Tissue Viability Team visited the wards with a stand which highlighted the need to protect heels. This event was followed by a Link Nurse Study day focusing on heel management.

The chart below shows the number of hospital acquired pressure ulcers (avoidable and unavoidable) graded 2–4 since April 2010. Since April 2012 Tissue Viability Nurses have prospectively validated all pressure ulcers and subsequent data reports avoidable pressure ulcers only. There have been no grade 4 hospital acquired pressure ulcers since 2011.
2.1 Medication - feedback

We wanted to measure two important aspects of medicines:

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Explained purpose</td>
<td>8.2</td>
<td>8.4</td>
<td>7.3 - 9.7</td>
<td>8.2</td>
<td>9.14</td>
</tr>
<tr>
<td>Side effects</td>
<td>4.4</td>
<td>4.8</td>
<td>3.7 - 7.6</td>
<td>5.3</td>
<td>7.71</td>
</tr>
</tbody>
</table>

The results above show the outcomes for the same questions from the national survey, postal survey and a snapshot audit of 48 patients. The postal survey was undertaken for quarter 1 (April – June 2014) only.

Results of the national survey 2014 show slightly improved scores compared with the previous year and are average compared to the national results.

It would appear that local findings indicate a better outcome than the national survey findings.

2.2 Medication incidents

The number of medication-related incidents recorded, such as prescribing or administration errors, has appeared to fall in the last few years from 1175 in 2012/13 to 799 in 2014/15. However, this apparent reduction does not necessarily mean an improvement as it does not account for fluctuating numbers of patients.

This year we have focused upon rates of incidents – that is the number of incidents per 100 discharged patients – which is a better indication. We aimed to increase the reporting rate while reducing the rate of harm. A high reporting organisation is encouraged and seen to be a positive characteristic demonstrating the willingness to report and learn from incidents. The Trust has historically been a high reporting organisation. 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 falling during the year. This could be due to a fall in reporting behaviour or a fall in incident numbers. Compared to other organisations the latest national data (April-Sept 2014) shows that 12.8% of our reported incidents relate to medication. This compares with an average of 11% across all acute (non-specialist) trusts. So despite a falling reporting pattern the Trust is reporting a slightly larger percentage of medication errors than other trusts on average.
- the level of harm resulting from medication incidents averages at 11.76 during the year which is a slight improvement against the baseline figure in 2013 of 11.96%. The figures below show the quarterly results.

<table>
<thead>
<tr>
<th>% of medication incidents:</th>
<th>Baseline</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>- per 100 discharges</td>
<td>1.24</td>
<td>1.25</td>
<td>1.27</td>
<td>1.29</td>
<td>1.30</td>
</tr>
<tr>
<td>Actual</td>
<td>1.10</td>
<td>0.9</td>
<td>0.91</td>
<td>0.76</td>
<td></td>
</tr>
<tr>
<td>- resulting in harm</td>
<td>11.96%</td>
<td>11.5%</td>
<td>11.0%</td>
<td>10.5%</td>
<td>10%</td>
</tr>
<tr>
<td>Actual</td>
<td>8.93%</td>
<td>14.14%</td>
<td>9.66%</td>
<td>15.25%</td>
<td></td>
</tr>
</tbody>
</table>
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 one given more than 2 hours late. An audit undertaken in May 2014 showed that 23% of 1432 doses were delayed or omitted. The actual types of medications omitted are given in the pie chart below together with the reasons why the medications were not given.

As a result of this audit the following actions were taken:

- Communication to staff about results
- Emphasis on using the SBAR\(^2\) communication tool when requesting the insertion of a cannula (needle in the vein) to give intravenous medication – this will alert the doctor of the urgency to replace the cannula
- Revision of medication chart to facilitate reporting of reasons

A re-audit undertaken in January 2015 has shown significant improvement as shown in the table below.

<table>
<thead>
<tr>
<th></th>
<th>May 2014</th>
<th>January 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total no. of critical drug doses</td>
<td>1432</td>
<td>2547</td>
</tr>
<tr>
<td>No. of doses of critical drugs given</td>
<td>76.75%</td>
<td>89.16% ↑</td>
</tr>
<tr>
<td>No. of doses of critical drugs omitted</td>
<td>23.25%</td>
<td>10.33% ↑</td>
</tr>
</tbody>
</table>

2.4 Implement Medicines Optimisation Strategy
Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. This is a patient focused approach that aims to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety.

The Trust Medicines Optimisation Strategy has been developed using the NHS Trust Development Authority (NTDA) Medicines Optimisation and Pharmaceutical Services Framework and the Royal Pharmaceutical Society’s ‘Principles for medicines optimisation.’

The Trust undertook a baseline assessment of medicines optimisation against a national framework in December 2013 and scored 115 out of 144. A more recent assessment shows performance has improved to 120 due to the following achievements:

- Updating the New Drugs and Formulary committee terms of reference to ensure greater integration with primary care
- Completion of audits on the introduction of new drugs and on unlicensed medicines

\(^2\) SBAR – Situation, Background, Assessment, Recommendation. This is a specific order of information to provide and receive concise accurate information
• Appointment of a Medication Safety Officer
• Updating the non medical prescribing policy
• Consolidation of the acute pharmacy services at the Lister site

The Trust has also established a pharmacy subsidiary company for the dispensing of outpatient prescriptions at the Lister Hospital and Mount Vernon Cancer Centre. This is an exciting achievement which will be extended to the new QEII Hospital when it opens.

2.5 The Medication Safety Thermometer
The Medication Safety Thermometer is a measurement tool for improvement that focuses on medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines.

The survey is undertaken at a point in time and follows a three step process in order to identify harm occurring from medication error. Data are collected on one day each month and enable wards, teams and organisations to understand the burden of medication error and harm, to measure improvement over time and to connect frontline teams to the issues of medication error and harm, enabling immediate improvements to patient care.

The medication safety thermometer was piloted in November in six wards across the Trust. The results demonstrated the need for shared learning at ward level between medical, nursing and pharmacy staff. Routine use of the tool will be introduced in a phased approach across the Trust from April 2015.

PRIORITY 2 – IMPROVING CLINICAL OUTCOMES

Comparison table and achievement in-year

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>Aim for 14/15</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>HSMR (3 month arrears)</td>
<td>97</td>
<td>88.96</td>
<td>92.31</td>
<td>&lt;=93</td>
<td>✓</td>
</tr>
<tr>
<td>3.2</td>
<td>SHMI</td>
<td>111.39</td>
<td>111.76</td>
<td>112.9</td>
<td>&lt;=105</td>
<td>×</td>
</tr>
<tr>
<td>3.3</td>
<td>SHMI (adj palliative care)</td>
<td>102.04</td>
<td>100.43</td>
<td>100.51</td>
<td>&lt;=95</td>
<td>×</td>
</tr>
<tr>
<td>3.4</td>
<td>Unexpected admissions to critical care</td>
<td>N/A</td>
<td>Audit completed</td>
<td>Completed</td>
<td>Complete audit</td>
<td>✓</td>
</tr>
<tr>
<td>3.5</td>
<td>Cardiac Arrests</td>
<td>219</td>
<td>174</td>
<td>203</td>
<td>&lt;174</td>
<td>×</td>
</tr>
<tr>
<td>3.6</td>
<td>Observations*</td>
<td>96.02</td>
<td>95.88</td>
<td>95.49</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>3.7</td>
<td>PPCI (%)</td>
<td>88.46</td>
<td>100</td>
<td>99.6</td>
<td>&gt;=80</td>
<td>✓</td>
</tr>
<tr>
<td>4.1</td>
<td>3 hour thrombolysis for stroke</td>
<td>8.1%</td>
<td>10.08%</td>
<td>7.36</td>
<td>&gt;=12%</td>
<td>×</td>
</tr>
<tr>
<td>4.2</td>
<td>Admission to stroke unit within 4 hours of arrival</td>
<td>46.5%</td>
<td>66.25%</td>
<td>51.89</td>
<td>&gt;=90%</td>
<td>×</td>
</tr>
<tr>
<td>4.3</td>
<td>90% time in dedicated stroke unit</td>
<td>79.8%</td>
<td>72.71%</td>
<td>73.87</td>
<td>&gt;=80%</td>
<td>×</td>
</tr>
</tbody>
</table>

* Commenced October 2012
Monthly progress in 2014/15

<table>
<thead>
<tr>
<th>No</th>
<th>Indicator</th>
<th>Plan for 2014/15</th>
<th>Freq of repeating</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>30-day mortality (month average)</td>
<td>&lt;=65</td>
<td>M</td>
<td>100</td>
<td>100</td>
<td>85</td>
<td>82</td>
<td>98</td>
<td>96</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>99</td>
<td>92</td>
</tr>
<tr>
<td>3.2</td>
<td>30-day mortality (7-9 month average)</td>
<td>&lt;=105</td>
<td>Q</td>
<td>112</td>
<td>97</td>
<td>72</td>
<td>85</td>
<td>93</td>
<td>98</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>3.3</td>
<td>SPIRI - adjusted for palliative care</td>
<td>&lt;=86</td>
<td>G</td>
<td>100</td>
<td>51</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td>Unexpected admission to Critical Care Audit</td>
<td>N/A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>Cardiac arrest calls</td>
<td>N/A</td>
<td>M</td>
<td>14</td>
<td>10</td>
<td>7</td>
<td>7</td>
<td>11</td>
<td>6</td>
<td>20</td>
<td>19</td>
<td>22</td>
<td>30</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>3.6</td>
<td>Observation compliance (EDWS)</td>
<td>N/A</td>
<td>M</td>
<td>96</td>
<td>96</td>
<td>96</td>
<td>93</td>
<td>95</td>
<td>93</td>
<td>95</td>
<td>95</td>
<td>96</td>
<td>95</td>
<td>94</td>
<td>94</td>
</tr>
<tr>
<td>3.7</td>
<td>Access to PPHU</td>
<td>&lt;=85%</td>
<td>M</td>
<td>100</td>
<td>98</td>
<td>97</td>
<td>96</td>
<td>96</td>
<td>96</td>
<td>96</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>4.1</td>
<td>3 hour threshold analysis</td>
<td>&lt;=12%</td>
<td>M</td>
<td>19.44</td>
<td>6.61</td>
<td>11.36</td>
<td>14.72</td>
<td>2.49</td>
<td>15.15</td>
<td>13.63</td>
<td>6.67</td>
<td>2.04</td>
<td>2.56</td>
<td>2.56</td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>4 hours to stroke unit</td>
<td>&gt;=50%</td>
<td>M</td>
<td>83.53</td>
<td>71.43</td>
<td>58.00</td>
<td>83.50</td>
<td>80.68</td>
<td>46.62</td>
<td>48.72</td>
<td>61.64</td>
<td>29.68</td>
<td>44.72</td>
<td>50.00</td>
<td>55.50</td>
</tr>
<tr>
<td>4.3</td>
<td>90% time on stroke unit (%)</td>
<td>&gt;=80%</td>
<td>M</td>
<td>74.42</td>
<td>90.95</td>
<td>70</td>
<td>66.7</td>
<td>71.8</td>
<td>67.3</td>
<td>66.67</td>
<td>63.33</td>
<td>79.26</td>
<td>84.91</td>
<td>78.4</td>
<td>66.9</td>
</tr>
</tbody>
</table>

3.1 – 3.3
Please refer to section 2c for more details on the indicators relating to mortality.

3.4 - 3.6
This suite of indicators represents how staff identify and deal with a patient whose condition is deteriorating. To effectively identify and manage deteriorating patients it requires strict adherence to undertaking timely and complete observations eg. blood pressure; prompt escalation to senior staff to instigate actions and prompt decision making regarding ongoing management. Staff have available to them 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. If deterioration is not acted upon quickly the patient’s survival may be compromised leading to a cardiac arrest or the requirement for a transfer to critical care.

Using this information we can measure how effectively we identify and manage the deteriorating patient in a number of ways:

- Recording of observations
- Unexpected cardiac arrest calls
- Unexpected transfers to critical care

If observations are not recorded thoroughly then any deterioration may not be identified quickly. Audits of observation compliance indicates that on average 95% are completed properly. The graph below shows the monthly results since April 2014. These results are reported to ward leaders to make improvements.

The renal team has piloted an electronic observations recording system. This enables concerns to be identified quickly and for medical staff to be automatically alerted to these concerns. Staff can access the information from any computer within the hospital and therefore instigate actions quickly. The success of the pilot and a bid for funding from the national nursing technology fund means that this electronic system will be rolled out across the organisation in 2015/16.

The graph below shows a comparison of actual cardiac arrests at the Lister and QEII Hospitals since 2012/13. The dotted line shows the averages and it can be seen that
significant improvements were made in 2013/14 and even further improvements in the early half of 2014/15. A rise in arrests post October 2014, coinciding with the Trust consolidation, has raised the annual average slightly.

In January 2014 an audit of unexpected admissions to critical care was conducted. It was found that: staff needed greater clarity around when to increase the frequency of observations; not all observations had been recorded; not all concerns were escalated; a reliance upon consultant opinion may have delayed an action and DNACPR orders (instructions to ‘do not attempt cardiopulmonary resuscitation) could be improved.

This audit looked at admissions prior to the use of the National Early Warning Score (NEWS) observation chart. Many of the findings of the audit would have been addressed by using the new chart but we have since made it clearer that:

- advice from the consultant is sought during working hours when the patient demonstrates some mild concerns so that a plan can be developed if the patient should deteriorate further
- the consultant must be involved where an admission to critical care seems likely
- consideration is given to an 8pm call with senior doctors to provide updates and consider plans for the sickest patients during the night

A re-audit of 32 unexpected admissions to critical care between February and June 2015 was undertaken. This audit reveals improvements compared to the 2013/14 audit in a number of areas including the following:

- consultant review within 24 hours of admission (95% vs 75%)
- compliance with NEWS observations recording on admission and thereafter at least 12 hourly (100% vs 91%)

However, this re-audit uncovers several of same issues highlighted in the previous audit and include:

- deteriorating patients were not escalated to the nurse (51% vs 50%)
- When an increase in frequency of monitoring was requested by the team as a result of patient deterioration, it was only achieved in 61% of cases (50% previously)
- documentation was not always thorough eg.
At the time of publishing the Quality Account the audit analysis was just being finalised. An action plan will be developed with oversight of the Clinical Governance Strategy Committee.

### 3.7 PPCI

Primary Percutaneous Coronary Intervention (PPCI) is a procedure for treating a heart attack. It involves putting a wire, via the wrist, into the heart vessels and opening the blocked vessels.

On 28th April 2014 the PPCI service commenced a 24 hour a day, seven days a week service. There are two cardiac catheterisation laboratories and a full team of dedicated staff with support from other teams such as anaesthetics. The Acute Cardiac Unit was opened in July 2014 with 16 Coronary Care Unit beds and 16 step down beds. It is co-located with the emergency department, PPCI ambulance drop off point, cardiology department and catheter laboratories.

An external review of the service in October indicated it is compliant with the national service specification and that outcomes are within expected limits.

#### “Excellent Care”

I was admitted in February for a combined angiogram/angioplasty procedure and can say with absolute certainty the care I received was first class. I was treated with respect and consideration by all of the staff despite it been a very busy day and the difficulties caused by one lab being out of commission.”

David, 6th March 2015, NHS Choices

#### “Coronary Angiogram”

Consultant, Doctors and Nurses were brilliant. They were very attentive, explained the procedure to me, found my vein and artery with little fuss and no problems. The diagnostic test was conducted efficiently and was over before I knew it. The Consultant gave me the results straight away and was very reassuring. The nurses checked to see if I was experiencing any discomfort and offered me food and drink as soon as I was able to take it.”

Brenda, 2015, NHS Choices

### 4.1 - 4.3 Stroke

A variety of improvements have taken place in Stroke care to improve outcomes for patients. These include:

- Recruitment of 3rd consultant which allows for 5 day consultant review of patients on the hyper acute stroke unit and 5 day cover for thrombolysis by our own consultants
- Participation in a regional telemedicine service to support out of hours thrombolysis
- Specialist nurse cover 12 hours per day, 7 days per week
- Senior nurse presence on the stroke ward 24/7
- Increase in the number of stroke beds
- Dedicated daily radiology slots for stroke patients
• Early supported discharge allowing patients to be discharged with support earlier than normal which supports both the 4 hour admission to ward and 90% stay on a stroke unit metrics
• Detailed stroke specific mortality review

In addition a stroke early supported discharge service for Hertfordshire was launched by Hertfordshire County Council in October. The scheme allows people to go home sooner by supporting them at home to receive an intensive rehabilitation package for up to six weeks.

Despite these changes we are still struggling to admit stroke patients to the ward within four hours, achieving this for less than 50% of patients. The reasons for this are complex and are related largely to increases in emergency demand and the consequent pressures this has placed on bed capacity. In addition, a temporary closure of the stroke ward due to infection has had an impact.

The Trust has enhanced its action plan with the Clinical Commissioning Group (CCG) to improve stroke performance and has commissioned an external review of thrombolysis rates as although internal reviews confirmed that all eligible patients had received thrombolysis the numbers are low compared to other acute trusts. The results of the clinical audit of the stroke pathway are also due in the summer and will be reviewed to identify any required improvements.

Death resulting from stroke is showing an improving picture when measuring using the HSMR indicator. The most recent data (July 2013 – June 2014) shows a mortality rate better than the national average at 85. The chart below shows the HSMR trend for Stroke over the past two years.

![HSMR Trend Chart](chart.png)

As a result of joint working with the CCG in the Mortality Review Group the Trust has concluded a Stroke Mortality Review on 50 patients, a proportion of whom died in the community after discharge. The results of this audit show that:

• 96% of patients had a Stroke Management Plan in place with plan compliance at 94%
• 96% of patients suffered with an additional condition which was not well controlled in 44% of these patients
• 66% of patients had their assessment by the Stroke Team delayed by more than 30 minutes
• The swallowing of 24% of patients was not checked
• 75% of patients with a secondary complication developed pneumonia

Clearly further improvements are possible, particularly in relation to assessments and the management of additional conditions. This work will progress during 2015/16.
PRIORITY 3 – IMPROVING PATIENT EXPERIENCES

<table>
<thead>
<tr>
<th></th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>Aim for 14/15</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Improvement in postal &amp; national surveys (involved in decisions, consistent info, providing understandable answers, name of contact)</td>
<td>See results below</td>
<td>N/A</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Further increase customer care training (cumulative)</td>
<td>650</td>
<td>2336</td>
<td>2664 ↑</td>
<td>✓</td>
</tr>
<tr>
<td>5.3</td>
<td>Monitoring ward staffing levels</td>
<td>N/A</td>
<td>N/A</td>
<td>Introduce</td>
<td>✓</td>
</tr>
<tr>
<td>5.4</td>
<td>Communication - reduction in complaints &amp; PALS concerns (rate)</td>
<td>See results below</td>
<td>Reduce</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>GP Survey</td>
<td>N/A</td>
<td>N/A</td>
<td>Undertake</td>
<td>✓</td>
</tr>
<tr>
<td>6.1</td>
<td>Conclude design of pathways for services from New QEII, inc rapid assessment</td>
<td>N/A</td>
<td></td>
<td>Complete</td>
<td>✓</td>
</tr>
<tr>
<td>6.2</td>
<td>Delays - reduction in complaints &amp; PALS concerns (rate)</td>
<td>See results below</td>
<td>N/A</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Improvements in postal &amp; national surveys (waiting list, waiting for bed, OPD waiting time)</td>
<td>See results below</td>
<td>N/A</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

5.1 Survey scores - communication
We wanted to measure the results of five important questions about communication. Results for these questions from national surveys since 2012, the postal survey conducted in April – June 2014 and the ongoing electronic (Meridian) surveys are given below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you involved as much as you wanted to be in decisions about your care and treatment</td>
<td>6.9</td>
<td>6.8</td>
<td>7.3</td>
<td>Same</td>
<td>71</td>
<td>84.29</td>
</tr>
<tr>
<td>Did a member of staff say one thing and another say something different</td>
<td>7.9</td>
<td>7.7</td>
<td>7.7</td>
<td>Same</td>
<td>81</td>
<td>N/A</td>
</tr>
<tr>
<td>When you had important questions to ask a doctor, did you get answers that you could understand</td>
<td>7.9</td>
<td>7.8</td>
<td>7.8</td>
<td>Same</td>
<td>81</td>
<td>85.53</td>
</tr>
<tr>
<td>When you had important questions to ask a nurse, did you get answers that you could understand</td>
<td>8.1</td>
<td>7.8</td>
<td>8.3</td>
<td>Same</td>
<td>80</td>
<td>91.78</td>
</tr>
<tr>
<td>Did hospital staff tell you</td>
<td>7.9</td>
<td>7.6</td>
<td>7.8</td>
<td>Same</td>
<td>75</td>
<td>N/A</td>
</tr>
</tbody>
</table>
who to contact if you were worried about your condition or treatment after you left hospital

The national results for 2014 are either the same (2 questions) or better (3 questions) than in 2013. This is encouraging given the organisational changes. These results are in line with national averages and the Trust will endeavour to improve further in 2015/16.

5.2 Customer care training
The customer care training programme was launched in 2012/13 and ran until June 2014. Approximately half of the Trust staff have received customer care training as shown in the table below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/2013</td>
<td>650</td>
</tr>
<tr>
<td>2013/2014</td>
<td>1686</td>
</tr>
<tr>
<td>2014/2015 (to June)</td>
<td>328</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2664</strong></td>
</tr>
</tbody>
</table>

At present the programme is changing as we’re developing a customer care/culture change strategy whereby customer care training will form part of a wider staff engagement programme and be delivered in a way that best suits the needs of our staff and our services. Juice Learning, who delivered the original customer care training programme, has developed a legacy training package for use by Trust staff. The first ‘train the trainer’ event took place at the end February 2015 for roll-out later in the year.

5.3 Monitoring ward staffing levels
The Trust is committed to ensuring that levels of nursing staff match the dependency needs of patients. This includes an appropriate number and mix of skills of nursing staff to provide safe and effective care.

Staff availability, also known as fill rates, can be influenced by vacancy rates, sickness, reduced bank or agency staff availability for example in school holidays. It can also be influenced by an increase in demand for staff, for example when more beds are opened so more staff are required to care for the additional patients.

Safe staffing levels are monitored and managed daily. At the 08.45am bed meeting, the Director of Nursing/Deputy Director of Nursing supported by the Trust Liaison Coordinator for NHS Professionals (the organisation who coordinate providing our ‘bank and agency nurses), in conjunction with the Nursing Services Managers and Matrons, are provided with an overall view of all wards for the next 3 days by shift, registered and unregistered workforce numbers and ratios. Actions are agreed to ensure that all areas are made safe. In the event of shortfalls of staff or unexpected increases in patient acuity and dependency requirements, the agreed staffing levels are reviewed on a shift by shift basis.

- Green shifts = safe levels
- Amber shifts = minimum safe level and the matron will be alerted. Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any changes to the acuity and dependency of patients
- Red shifts = unsafe level. The matron will be 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.

Data of shifts triggering ‘red’ has been collected since July. The figure tends to be around 6% but peaked in December when demand was very high.
Details of staffing levels are published on the NHS Choices website and are shown on the status boards on the entrance to all wards.

Recent approval of a business case to upgrade the nursing rota system will enable more informed real-time data collection on patient need and staffing numbers. The system will be implemented on a rolling programme across the organisation in 2015/16.

5.4 and 6.2 Reduction in complaints & PALS concerns
The graph below shows the categories accounting for the greatest number of complaint concerns for 2014/15.

**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.

**Table: Rate of complaints or PALS concerns by finished consultant episode.**

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td>Complaints</td>
<td>0.15%</td>
<td>0.16%</td>
<td>0.15%</td>
</tr>
<tr>
<td>PALS</td>
<td>0.22%</td>
<td>0.28%</td>
<td>0.50%</td>
</tr>
</tbody>
</table>
It was expected that with consolidation coming to an end and wards / staff being in the right place that the rate of concerns / complaints would reduce. This has not been the case fully. Consolidation resulted in more turbulence than expected with staffing levels dropping, bank and agency numbers increasing, high turnover and the requirement for new teams to work together. Consequently this had an impact upon communication. Towards the end of the year the trend appears to be improving.

Communication accounted for 10% of complaints in February. This compares with 27% in October 2014 and 38% overall during 2013/14. This improvement may be attributed to the Customer Care training programme that is in place for all staff and should be sustained and improved upon further through other more recent initiatives being introduced by the workforce team such as ‘SPEAK’ (explained in section 3c).

**Delays**
The rate of formal complaints or concerns reported to the PALS regarding ‘delays’ is given below.

Similar to complaints about communication above it was expected that with consolidation coming to an end and wards / staff being in the right place that the rate of concerns / complaints would reduce. This has again not been the case. The graph above in section 5.4 shows that delays have been the main cause of complaints with half of the ‘delays’ relating to appointments.

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td><strong>Complaints</strong></td>
<td>0.3%</td>
<td>0.25%</td>
<td>0.25%</td>
</tr>
<tr>
<td><strong>PALS</strong></td>
<td>0.82%</td>
<td>0.66%</td>
<td>0.96%</td>
</tr>
</tbody>
</table>

**5.5 GP Survey**
The Trust’s annual GP survey, which has been conducted since 2010, is a formal mechanism to seek the opinions and perceptions of those working in primary care. 46 people, primarily GPs, responded to the survey.

Discharge letters are tremendously important as the main clinical communication tool between the Trust and GPs, hence the need for timeliness, clarity and level of detailed information required by GPs. Poorly written and unclear discharge summaries produce extra work, both for the GP and the Trust, as calls are made into the Trust to try to clarify information. The following responses demonstrate a varied picture with improvements in the provision of discharge summaries and details regarding medication; but improvements are required in timeliness and quality of discharge summaries together with reasons for changes in care or treatment.
There are also reported quality issues with the provision and timeliness of clinic letters, with no noticeable improvement in the last six months. This is despite the move towards sending clinic letters electronically by some specialties. Improvements are required to ensure that letters are sent within a reasonable time after the clinical appointment.

The Trust continues to work towards improvement as identified in the Service Development Improvement Plan 15/16 monitored by the CCG.

6.1 Conclude design of pathways for services from New QEII
With the changing function of the QEII Hospital it has been necessary to redesign the processes for caring for specific groups of patients.

One example is given below involving the urgent care services (please note that this is a copy of the pathway and consequently the medical terminology is shown). Although the Urgent Care Centre is open 24 hours per day it does not offer full emergency services or 24 hour support services such as radiology. Therefore pathways indicate how, and by whom, treatment for minor injury and illness is given. This aims to streamline care and offer consistency of care.
A Day patient at the Endoscopy unit Lister Hospital

On February 25th I was a day patient at the Endoscopy unit. From the time I got booked in to the time that my wife picked me up I was made to feel like someone very special everything was explained what would happen and why, the nurses and doctors who attended to me were just great I cannot thank them enough.

Graham, 26 February 2015, NHS Choices

"no reflection on doctors & nurses but organisation appaling

When I initially attended my pre op appointment call not a good start considering I was in their waiting room! I was booked in for a day procedure for which I received no confirmation of time or place and had to call them myself the day before. On arriving at the time and department there were no staff there, after waiting over half an hour a nurse informed me I had been told to attend the incorrect department and they didn't have my notes and I needed to go to another department that did have them. When I arrived at the other place (with 2 other patients) they didn't know that we were booked in for that day but thankfully a surgeon was available to carry out the procedure. I was called into a waiting area where I sat for another 30 minutes only to be told that they couldn't find my notes! After about another 30 minutes they found them at the original department I'd been waiting at. A complete shambles that added stress to what was already a stressful time. When I spoke to the surgeon she informed me that she had been told that we would be at the day surgery centre so had no idea where we actually were! Once I was booked in I was taken back to the day surgery centre for my procedure which thankfully went very well and quickly thanks to the staff that were looking after me, in fact the nurses, sister, surgeon and anaesthetist were brilliant and I have no complaints about them at all quite the opposite they were fantastic and really looked after me."

Anonymous, 22 October 2014, NHS Choices
6.3 Survey scores – waiting times

We wanted to measure the results of four questions relating to waiting times. Results for these questions from national surveys since 2012, the postal survey conducted in April – June 2014 and the ongoing electronic (Meridian) surveys are given below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you feel about the length of time you were on the waiting list</td>
<td>7.7</td>
<td>7.8</td>
<td>7.5</td>
<td>Same</td>
<td>85</td>
<td>N/A</td>
</tr>
<tr>
<td>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</td>
<td>6.9</td>
<td>6.9</td>
<td>6.9</td>
<td>Same</td>
<td>76</td>
<td>N/A</td>
</tr>
<tr>
<td>How long after the stated appointment time did the appointment start</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>69.02 (3194 responses)</td>
</tr>
<tr>
<td>On arrival were you told how long you would have to wait</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>44.33 (3194 responses)</td>
</tr>
</tbody>
</table>

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.

Clearly further work is required to improve waiting times and possibly to improve the way we communicate both expectations of waiting times but also to be clear with our patients that assessment units are wards.

Within outpatients almost half of the patients were seen on time or within 5 minutes of the stated time; but almost half of the patients were not informed how long they would have to wait. The responses are shown in the charts below.
The Trust is determined to improve this and has set up a range of improvement projects collectively known as the Transforming Outpatients Management Programme (TOMP).

The programme has been underway for approximately a year and has delivered a number of improvements and benefits including increases in slot utilisation and reducing ‘do not attend’ rates. However, we are not yet in the upper quartile performance for outpatients and feedback from our stakeholders clearly shows improvements are required.
2b Statement of assurances from the Board

Review of services

During 2014/15, 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 2014/15 represents 100% of the total income generated from the provision of NHS services by the ENHT for 2014/15.

Participation in clinical audits

The Trust has an extensive clinical audit programme. Each year all clinical teams produce a ‘forward plan’ of audits to be undertaken throughout that year. An overview of the audit plan for the year, summarising the 631 audits, is given in the table below.

<table>
<thead>
<tr>
<th>Division</th>
<th>National &amp; regional priority</th>
<th>Trust priority</th>
<th>Local priority</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>15</td>
<td>10</td>
<td>54</td>
<td>79</td>
</tr>
<tr>
<td>Clinical Support</td>
<td>9</td>
<td>8</td>
<td>40</td>
<td>57</td>
</tr>
<tr>
<td>Medicine</td>
<td>44</td>
<td>57</td>
<td>76</td>
<td>177</td>
</tr>
<tr>
<td>Surgery</td>
<td>36</td>
<td>42</td>
<td>111</td>
<td>189</td>
</tr>
<tr>
<td>Women’s &amp; Children’s</td>
<td>14</td>
<td>40</td>
<td>69</td>
<td>123</td>
</tr>
<tr>
<td>Trust</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>119</td>
<td>159</td>
<td>353</td>
<td>631</td>
</tr>
</tbody>
</table>

Fifty seven National Clinical Audits covering services provided by ENHT were scheduled to take place during 2014/15. Eleven of these did not take place either because they were withdrawn nationally or because the data collection stage was postponed (BTS audits Non-Invasive Ventilation, Adult Bronchiectasis and Paediatric Pneumonia, National Diabetes Inpatient Audit (NADIA), Patient Experience of Diabetes Care, Patient Recorded Experience Measures (PREMs), Management of Familial Hypercholesterolemia, National Audit of Dementia, National Parkinson’s Disease audit, Breast Care Cancer Audit and the Ophthalmology Audit for which the contract was never awarded). This left a total of 46 audits in which the Trust was eligible to participate. Of these, the Trust took part in 45 (98%).

The Trust took part in all 5 National Confidential Enquiries in which it was eligible to participate.

The two tables below show:

- The National Clinical Audits and National Confidential Enquiries in which ENHT was eligible to participate during 2014/15.
- The National Clinical Audits and National Confidential Enquiries in which ENHT did not participate during 2014/15.
- The percentage submission rates for those eligible studies in which the Trust participated during 2014/15.

<table>
<thead>
<tr>
<th>Eligible topics – National Confidential Enquiries</th>
<th>Trust Participation</th>
<th>% Cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD Gastrointestinal haemorrhage</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Eligible topics – National Audits</td>
<td>Trust Participation</td>
<td>% Cases submitted</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>AAA Repair (National Vascular Registry)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing</td>
<td>×¹</td>
<td>NA</td>
</tr>
<tr>
<td>Audit of transfusion in children and adults with Sickle Cell Disease (NHSBT)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Breast Care Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BTS Acute Community Acquired Pneumonia (01/12/14-31/01/15)</td>
<td>✓</td>
<td>IP²</td>
</tr>
<tr>
<td>BTS Adult Bronchiectasis (01/10/2014-30/11/2014)</td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td>BTS Non-Invasive Ventilation - Adults (01/02/15-31/03/15)</td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td>BTS Paediatric Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BTS Pleurals Procedures (01/06/2014-31/07/2014)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Carotid Endarterectomy (National Vascular Registry)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Angioplasty (BCIS)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes Core Audit NDA</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Elective Surgery (National PROMs programme)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Epilepsy 12</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Falls &amp; Fragility Fractures Audit Programme FFFAP inc NHFD</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Fitting child (care in emergency departments)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Head and Neck Oncology National Audit 2014 - 2015 (DAHNO)</td>
<td>✓</td>
<td>continuous</td>
</tr>
<tr>
<td>IBD National Audit</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>ICNARC Case Mix programme 2014 - 2015</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Lower Limb Amputation (National Vascular Registry)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Lower Limb Angioplasty/Stenting (National Vascular Registry)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Lower Limb Bypass (National Vascular Registry)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Management of Familial Hypercholesterolemia</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Mental Health (care in emergency departments)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>×³</td>
<td>NA</td>
</tr>
<tr>
<td>National Audit of Diabetes Foot Care Audit</td>
<td>✓</td>
<td>IP⁴</td>
</tr>
<tr>
<td>National audit Rheumatoid and Early Inflammatory Arthritis 2013-14</td>
<td>✓</td>
<td>IP⁵</td>
</tr>
<tr>
<td>National Bowel Cancer Audit Programme General Surgery Lead (NBOCAP)</td>
<td>✓</td>
<td>continuous</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National COPD audit</td>
<td>✓⁶</td>
<td>70%</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit (NADIA) Withdrawn</td>
<td>✓</td>
<td>NA</td>
</tr>
</tbody>
</table>

A list of patients was sent out as required at this stage. Questionnaires will be sent out in 2015/16.
### Eligible topics – National Audits

<table>
<thead>
<tr>
<th>Eligible topic</th>
<th>Trust Participation</th>
<th>% Cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Emergency Laparotomy Audit [NELA] 2013-14</td>
<td>✓</td>
<td>IP/</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Joint Registry [NJR]</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Lung Cancer Audit [NCLA]</td>
<td>✓</td>
<td>continuous</td>
</tr>
<tr>
<td>National Neonatal Audit Programme [NNAP]</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Oesophagogastric cancer audit (NOGCA)</td>
<td>✓</td>
<td>continuous</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit (NPDA) Core Audit (14th April 2014-14 July 2014)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>National Parkinson's Disease</td>
<td>No data collection in 2014/15</td>
<td>NA</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes (NPID)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Older People (care in emergency departments)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Ophthalmology Audit</td>
<td>No data collection in 2014/15</td>
<td>NA</td>
</tr>
<tr>
<td>Patient Experience of Diabetes Care (PEDS)</td>
<td>No data collection in 2014/15</td>
<td>NA</td>
</tr>
<tr>
<td>Patient Recorded Experience Measures (PREMs) Diabetes</td>
<td>No data collection in 2014/15</td>
<td>NA</td>
</tr>
<tr>
<td>Prostate Cancer National Audit</td>
<td>✓</td>
<td>continuous</td>
</tr>
<tr>
<td>Renal Replacement Therapy (Renal Registry)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>✓</td>
<td>100%</td>
</tr>
<tr>
<td>TARN (Severe Trauma audit and research network)</td>
<td>✗</td>
<td>83.9%</td>
</tr>
</tbody>
</table>

1. We have not participated in this audit as it was not directly relevant to the services we provide.
2. Data collection finished on the 31/01/2015. The data entry period finishes at the end of May 2015.
3. This national audit has been piloted this year. The ENHT did not take part in the pilot as only 10 hospitals in the country were selected for this stage. The main audit begins in 2016.
4. The deadline for data submission is July 2015.
5. This audit is in progress and will run for 2 more years.
6. 70% of eligible cases submitted due to problems with acquiring patients’ notes on time.
7. This audit will run until the end of December 2015. We are awaiting summary report for the first year round. According to the historical hospital episode statistics (HES) data we have entered around 90% of eligible cases. Historical HES, however, are to be used as a predictive tool only not a definite target.
8. According to the historical hospital episode statistics we have submitted 83.9% of the cases. That is only, however, based on the estimated figure.

### National audits not relevant to the Trust

<table>
<thead>
<tr>
<th>National audits not relevant to the Trust</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing Observatory for Mental Health</td>
<td>Service not provided by Trust</td>
</tr>
<tr>
<td>Adult cardiac surgery audit</td>
<td></td>
</tr>
<tr>
<td>Chronic kidney disease in primary care</td>
<td></td>
</tr>
<tr>
<td>Congenital heart disease (Paediatric cardiac surgery)</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>National Confidential Enquiry into Deaths and Homicides</td>
<td>Relevant to Mental Health Trust only</td>
</tr>
</tbody>
</table>

### NICE Endorsement of Gap Analysis/Action Plan (GAAP) Tool

The Trust’s Clinical Effectiveness lead has produced a Gap Analysis/Action Plan tool for the review of NICE, and other, best-practice guidance. This has been submitted to NICE as a shared learning example, and has now been quality assured and published on the NICE website alongside SG1 Safe Staffing guidance for acute inpatient wards.
The GAAP tool SG1 example has been entered for consideration in NICE's 2015 Shared Learning Awards which, if successful, will be presented at the NICE conference to be held in October. The SG1 example has also been considered to have merit within NICE for their new Endorsement Programme and is currently being reviewed for accreditation of the GAAP as a product to assist providers with implementation of the NICE guideline.

Compliance with the following national audits, confidential enquiries and NICE guidance has been assessed using the GAAP tool.

National Audits
The reports of 30 national clinical audits were reviewed by the provider in 2014/15 and the ENHT has taken the following actions to improve the quality of healthcare provided. Some examples are given below.

Epilepsy12, Royal College of Paediatrics and Child Health
The Trust’s epilepsy service for children and young people was rated as the best performing in the East of England, following a detailed National clinical audit: ‘Epilepsy12’, carried out in 2014. The Trust has continually improved its services based on the audit’s findings, and has scored highly in all 12 areas, achieving a 100% rating in the following important areas:

- Input from a consultant paediatrician with expertise in epilepsy;
- Input from an epilepsy specialist nurse;
- Appropriate first paediatric clinical assessment;
- Seizure and Epilepsy classification and accuracy of diagnosis;
- Patient experience in terms of the provision of the service, as well as information provided to the families of children with epilepsy.

National Vascular Registry (NVR) UK: Carotid Endarterectomy Audit Round 5 (Report 2013)
The NVR requires all staff involved in carotid intervention to examine their data and assess their performance against NICE standards (NICE clinical guideline CG68). The findings from the reports are taken fully into account and service improvements planned against recommendations. These have included close collaboration between stroke physicians and vascular surgeons to implement full compliance with the recommendations and key indicators:

- Documented patient care pathway, from attendance through stroke unit to surgery to wards
- Referral protocols to minimise delays in the pathway
- Many referrals consultant to consultant enabling maximal responsiveness and high level discussion
- Patients requiring carotid endarterectomy are allocated to the next available operating list, within 3 days of referral (100% compliant)
- Carotid intervention is prioritised as urgent/emergency in all symptomatic cases
- The stroke service, working with ophthalmology leads, has developed a rapid access referral service for amaurosis to TIA clinic to avoid delays in the pathway

Falls and Fragility Fracture Audit Programme (FFFAP) Report 2013
The FFFAP audit criteria reflects the recommendations and standards within the NICE CG124 Management of hip fracture in adults, and NICE QS10 Quality standard for hip fracture. The Trust has made continuous improvement against the recommendations and quality standards since their publication, to develop a Hip Fracture service model, including an enhanced orthogeriatric service linking with community services.

The 2013 audit showed the Hip Fracture services to be highly compliant with the NICE guidance, meeting the audit criteria, and exceeding the national average performance in many cases, in the following key areas:
- 96.7% patients were reviewed by a Senior geriatrician within 72 hours of admission
- 98% patients received surgery, meeting the requirement of <5% non-operative rate recommended by the audit report
- 98% of people with hip fracture were offered a multifactorial risk assessment to identify and address future falls risk, and offered individualised intervention if appropriate
- 99.3% received an abbreviated mental test to look for cognitive impairment when patients first present, to minimise the patients risk and maximise their independence
- 81% patients received surgery within 48 hrs within working hours
- 99.5% people with hip fracture were offered a bone health assessment to identify future fracture risk and treatment at discharge. The Trust has reviewed the bone health assessment and pathway in line with the recommendations

The Hip Fracture service has been relocated as part of the reconfiguration of all services to the Lister Hospital. There is an action plan in place to improve any areas affected by the move. These include: reducing the mean length of stay from 19.8 days (equivalent to national mean length of stay); time to orthopaedic ward; surgery on the day of, or day after, admission and discharge pathway.

**National Parkinson’s Audit 2012 (Report July 2014)**
The criteria for this national clinical audit, run by Parkinson’s UK, are based on best-practice recommendations and standards from the NICE clinical guideline CG35 Parkinson’s Disease and the National Service Framework for Long Term Neurological Conditions.

The action plan created from the findings of the 2011 audit included the recruitment of a Parkinson’s Disease Nurse Specialist (PDNS) who joined the Trust in October 2014. Since joining, the PDNS has been implementing the actions identified previously to improve the service, including:

Integration of services needed by people living with Parkinson’s:
- Attending Neurology network to improve multi-disciplinary team (MDT) communication and service development involvement
- Providing feedback from Parkinson’s UK to MDT on commissioning and identifying local barriers to an integrated service delivery approach

Improvement of clinical processes carried out, or planned:
- Referral pathway to PDNS from elderly care and neurology specialties implemented
- Access to regular review and follow up with PDNS, implementing cross-site clinics
- Parkinson’s Disease Patient Information leaflets are in progress, and education provided to the Pharmacy team regarding information and advice to patients about their medication
- Clinical checklist being developed to document, and audit, key discussion points, eg prescribing for impulse control disorders, daytime sleepiness, impact on driving, DVLA assessment, self-management in the community
- Development of a standard assessment tool to support the provision of a full range of care and services for people with Parkinson’s disease.

**National Lung Cancer Audit 2013 (Report 2014)**
The Multi-disciplinary team for Lung Cancer is highly compliant with the measures for the process of care defined in the audit, and has continued to improve since implementing the action plan from the 2012 audit.
Examples of service improvement where we exceed the East of England average are:

- patients discussed at an MDT remains above 95%
- histological confirmation rate, up by 8% to 80.3%
- patients seen by a Lung Cancer nurse specialist are up by 2% to 81%.

Areas where actions are being taken to further improve the service include: proportion of patients receiving CT scan prior to bronchoscopy, which should exceed 95% (currently 93.6%); Lung Cancer Specialist Nurse presence at the time of diagnosis, currently at 63%, is subject to a staff review to allocate extra nursing support alongside lung cancer clinics.

**National Neonatal Audit Programme (NNAP) 2013 (Report 2014)**
The Neonatal team are fully compliant on all NNAP standards, having conducted a Gap Analysis of the service against the audit criteria following the 2011 audit, and creating an action plan which has been implemented and updated following the findings of the subsequent 2012 and 2013 audits. Service improvements implemented have included:

- First hour of care is fully embedded in practice, for example 100% babies meeting criteria having temperature taken within an hour after birth
- Improvements were made in 2013 to ensure the required environmental temperature in the delivery suite, with the addition of temperature checks to the neonatal admission proforma, and monitoring in theatre and delivery rooms
- 85% standard met for women meeting criteria receiving antenatal steroids
- 89% babies meeting criteria screened at birth for Retinopathy of Prematurity
- A new benchmark standard for the proportion of babies receiving any mother’s milk at discharge showed 49% in 2011, rising to 66% in 2013. The Trust has implemented parent and staff education to raise the proportion, and in 2013 dedicated staff hours were introduced to support infant feeding/breast feeding mothers
- The service is fully compliant with the standard for a consultation with parents by a senior member of the neonatal team within 24 hrs of admission
- The service is fully compliant for identification of early intervention requirements by Consultant and clinics for Bayley’s examination

**NCEPOD report: ‘On the right trach? A review of the care received by patients who underwent a tracheostomy.’**
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) carried out this enquiry in 2013-14 and published the report in June 2014. A dedicated Tracheostomy Group reviewed the findings of the report against the current service and found the Trust to be fully compliant with the majority of recommendations for Tracheostomy organisation and care delivery including:

- Formal MDT meetings each week, including Critical Care clinicians and nursing staff, and key members such as physiotherapists, dieticians and speech and language therapists
- Training provision, including simulation, developed and commenced in Autumn 2014 for nurses and doctors
- Ward nursing and critical care nursing competencies used for the care of tracheostomy patients
- Tracheostomy Care Bundle and guideline revised to include recommendations.

**NICE QS25 Asthma: diagnosis and treatment of asthma in adults, young people and children quality standard.**
The Quality Standard for Asthma was published in February 2013, and the Respiratory consultant lead for asthma carried out a gap analysis against the statements, taking into account the results from the British Thoracic Society National Asthma in adults audit held in 2012.
At that time the service met the quality standard in the following areas:

- Patients receive a structured review, at least annually
- Patients receive the Asthma Control test
- Written personal action plans given out to inpatients and at clinics
- There is an existing service for people with difficult asthma

An action plan was created to improve the services where it was found to be partially compliant. In June 2014 the following actions had been implemented and now meet or exceed the quality statements:

- Diagnosis in line with BTS/SIGN guidance, and recording in notes
- Implementation of a substantive Acute Chest Team
- All patients are now assessed for inhaler technique by specialist respiratory nurses and the Acute Chest Team
- Treatment for acute exacerbation of asthma introduced into new Emergency Department Integrated Care Pathway
- Follow up with all inpatients within 48 hrs has been implemented within acute chest services
- The Trust is moving towards a 7-day service with specialist nurse support – estimated completion September 2015

**NICE SG1 Safe staffing for nursing in adult inpatient wards in acute hospitals guideline**
The Trust nominated a Safe Staffing lead to implement this guidance, working with the Director of Nursing. The gap analysis/action plan showed that:

- The Trust is fully compliant in focussing on patient care, ensuring patients receive the care they need, through bed management reviews to allocate patients where their clinical needs can best be met
- Staff establishment reviews have taken place in April and October 2014 for inpatient areas, using the NICE accredited Safer Nursing Care tool
- A project plan has been agreed in consultation with clinical and business management in Divisions to implement changes based on the findings
- There is an established process in place for planned uplift, and adjustment for unplanned variation, including a specialising policy for vulnerable patients requiring additional care
- Daily staffing meetings are held using a RAG (red, amber, green) rated staffing matrix for each clinical inpatient area, for action and to mitigate risk, with an escalation process in place 24 hrs per day.

**NICE PH48 Smoking cessation in secondary care: acute, maternity and mental health services guideline.**
This public health guideline applies to the Trust acute and maternity services, all staff, patients and public, and the hospital buildings and grounds. A Smoke Free Hospital Group was set up in October 2014, together with cross-Trust Stop Smoking Champions appointed, with the aim to be totally smoke free by January 2016:

- Posters and displays have been introduced, to supplement the existing No Smoking signage, into areas and hospital foyers
- A Trust policy has been written to implement and enforce the guidance
- The pathway was already in place for referral to Hertfordshire Stop Smoking (HSS) service
- The existing booking process for maternity recorded their smoking status, this to be extended across all areas
• The Making Every Contact Count intervention has included smoking status for outpatients.

Actions for improvement taken or planned include:

• The addition of information on the no smoking policy in eg appointment letters
• Offering inpatient smokers 24 hr nicotine patches; or 16 hr patches for pregnant women, and referral for self and partners to HSS
• Training and education for staff in, and provision of, behavioural change support.

**NICE CG174 Intravenous fluid therapy (adults) clinical guideline**

The Trust formed a Trust Fluid Committee following the publication of this NICE guideline, to oversee the implementation of its recommendations. In May 2014 an audit was undertaken on a sample of medical and surgical patients to establish where we met, or fell short of, the guidance.

Results showed that the prescription on the drug chart was well done, with 93% matching the NICE criteria. For patients requiring resuscitation, 73% had a cause of the fluid deficit documented.

An action plan to implement improvements have included:

• Amendments to the fluid prescribing chart
• Adopting the NICE fluid prescription algorithms
• Assessment of patients using the ABCDE approach, and educating clinical staff in its use
• A Trust Guideline has been written, in line with the NICE guidance.

**Local audits**

The reports of 353 local clinical audits were reviewed by the provider in 2014/15 and the following are just some of the actions ENHT intends to take to improve the quality of healthcare provided. (Details taken from the Outcomes Forms/Action Plans that Audit Leads are required to complete once an audit has been undertaken and presented.)

<table>
<thead>
<tr>
<th>Local clinical audit</th>
<th>Actions taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group B strep maternal notification audit</td>
<td>• Ensure the letter to be sent to the mother regarding the positive result is available centrally from the Knowledge Centre (intranet) and ensure there is a system in place for provision of the information leaflet and sticker from the GBS support charity&lt;br&gt;• Discuss with Triage workgroup how to avoid duplication of results notification whilst paper system still in place&lt;br&gt;• Communicate that in the case of GBS positive women who have an elective C/S the baby still needs to have 12hrs of observation. Additionally the Neonatal team needs to be informed of all babies born from a mother who has a GBS positive result in the pregnancy irrespective of whether the mother had IV antibiotic cover in labour.</td>
</tr>
<tr>
<td>Reasons for referral to Obstetric US Scan</td>
<td>• There needs to be training in the use of the GROW charts&lt;br&gt;• A business case needs to be considered for increased ultrasound capacity to allow department to meet the Royal College screening and monitoring standards.</td>
</tr>
<tr>
<td>Midwifery Led Unit Service</td>
<td>• Consider workshops to explore practices that could impact on delay in the 2nd stage of labour&lt;br&gt;• Set up a process to gather information on transfers of babies to</td>
</tr>
</tbody>
</table>
the Neonatal Unit from the Midwife Led Unit

A re-audit of the Special Educational Needs (SEN) assessment statutory time scales achieved on completion of statutory medical assessments by Paediatricians

- Electronic database needs to change from an excel spreadsheet to a system that can flag up advice in danger of breaching the statutory time limit
- SEN medicals to continue to be coordinated by a dedicated SEN administrator
- Doctors to complete SEN medicals in a timely manner

Melatonin prescribing in Chronic Fatigue Syndrome (CFS) patients

- Identify Lead Consultant to monitor melatonin use in CFS patients
- Evidence of sleep disorder requiring melatonin should be recorded in notes
- Evidence of regular reviews of sleep and melatonin to be recorded in notes
- Record of melatonin- unlicensed medication should be in the notes

Smoking Cessation

- Communicate the need to offer and document CO2 monitoring for all women
- Communicate the availability of the NRT patches for inpatients

Cholestasis

- Develop cholestasis of pregnancy proforma
- Order and use cholestasis of pregnancy information leaflets
- Add to audit forward plan 2015

Obesity

- Discuss with Antenatal clinic co-ordinator the results of the audit showing the need to complete the manual handling and tissue viability assessment documentation in addition to weight at 36wks for specific groups of women with raised body mass index

MDM Decision Making and Outcome

- Disseminate results at audit/directorate meetings to improve awareness and educate on need to improve practice
- Implement documentation stickers

Research and development

The number of patients receiving NHS services, provided or sub-contracted by the ENHT in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 1573.

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients Recruited to Portfolio Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>2011</td>
</tr>
<tr>
<td>2012/13</td>
<td>1988</td>
</tr>
<tr>
<td>2013/14</td>
<td>1651</td>
</tr>
<tr>
<td>2014/15</td>
<td>1573</td>
</tr>
</tbody>
</table>
Dr Nathan, a consultant at the Mount Vernon Cancer Centre, received an award through the National Institute for Health Research (NIHR). The award was given by Dame Sally Davies and the NIHR to principal investigators who had made a significant contribution to bringing and leading commercial studies to the NIHR clinical trials portfolio.

**Research project HEALeD**

‘Hospital Experiences of Adults with Learning Disabilities’ is a research project involving the Trust, Addenbrookes Hospitals and the University of Cambridge. The research aims to see how effective recent initiatives designed to improve the experiences of patients with learning disabilities in acute hospitals are. The project started in October and is due to finish in April 2017.

**Goals agreed with commissioners**

A proportion of the ENHT’s income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between the ENHT and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at [www.enht-tr.nhs.uk](http://www.enht-tr.nhs.uk)

**Commissioning for Quality and Innovation (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. The total value of the CQUIN payment in 2014/15 amounts to approximately £7 million of which some £6.0 million was received from the Trust’s commissioners. The Trust main CQUINs for 2014/15 are set out in the table below, together with their full monetary value and details of whether or not these quality improvements were met.

<table>
<thead>
<tr>
<th>CQUIN</th>
<th>Weighting</th>
<th>Value awarded (£000s approx)</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Friends and family Test – phased expansion</td>
<td>10%</td>
<td>636</td>
<td>91%</td>
</tr>
<tr>
<td>2  Safety Thermometer*</td>
<td>5%</td>
<td>209*</td>
<td>60%*</td>
</tr>
<tr>
<td>3  Dementia – diagnosis and care</td>
<td>5%</td>
<td>349</td>
<td>100%</td>
</tr>
<tr>
<td>4  Diabetes care</td>
<td>12.5%</td>
<td>666</td>
<td>94%</td>
</tr>
<tr>
<td>5  7 day working in Stroke Care</td>
<td>15%</td>
<td>565</td>
<td>66%</td>
</tr>
<tr>
<td>6  Unscheduled Care</td>
<td>10%</td>
<td>449</td>
<td>79%</td>
</tr>
<tr>
<td>7  Implementation of individual care for patients at the end of life</td>
<td>10%</td>
<td>568</td>
<td>100%</td>
</tr>
<tr>
<td>8  To implement an Acute Chest Team in respiratory care</td>
<td>20%</td>
<td>938</td>
<td>83%</td>
</tr>
<tr>
<td>9  To support ENHT implementation of the “Right People ....” Guidance</td>
<td>12.5%</td>
<td>710</td>
<td>100%</td>
</tr>
<tr>
<td>Other schemes with specialist commissioning</td>
<td></td>
<td>860</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>5,950</td>
<td>90%</td>
</tr>
</tbody>
</table>

* At the time of publication the final monetary value had not been agreed so it is possible these figures will change, hence affecting the overall achievement.
Statements from the Care Quality Commission

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is *registered with no conditions*. The CQC has not taken enforcement action against the ENHT during 2014/15.

The ENHT has not received a special review or investigation by the CQC during 2014/15.

We continue to monitor our compliance against all the CQC requirements and have an established programme of quality and safety audits to support embedding the standards and continuous improvement.

**Intelligence monitoring**

The CQC produce quarterly reports based upon an assessment of over 150 indicators derived from surveys and performance information. The overall assessment helps the CQC to determine where to undertake its inspection activity. Trusts are placed into a band based on the likelihood that people may not be receiving safe, effective, high quality care. The highest risk band is 1, the lowest risk band is 6. The Trust is currently at band 5 and an overall risk score of 5 out of 184.

**Data quality**

The ENHT submitted records during 2014/15 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:

<table>
<thead>
<tr>
<th></th>
<th>Included valid NHS Number</th>
<th>Included valid General Medical Practice Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted patient care</td>
<td>99.7%</td>
<td>99.7%</td>
</tr>
<tr>
<td>Out patient care</td>
<td>99.9%</td>
<td>99.9%</td>
</tr>
<tr>
<td>Accident &amp; Emergency care</td>
<td>98.8%</td>
<td>98.4%</td>
</tr>
</tbody>
</table>

**Information Governance**

The ENHT’s Information Governance Assessment Report overall score for 2014/15 was 85% and was graded ‘satisfactory’ *(green)*.

**Clinical coding error rate**

The ENHT was subject to the Payment and Tariff Assurance Framework (previously *Payment by Results* clinical coding audit) during the reporting period by 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:

<table>
<thead>
<tr>
<th></th>
<th>Monitor (April 2015)</th>
<th>Information Governance Clinical Coding Audit (Feb 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnoses</td>
<td>20%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Secondary diagnoses</td>
<td>9.6%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Primary procedures</td>
<td>7%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Secondary procedures</td>
<td>31.5%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>
The findings of the Information Governance Clinical coding Audit have been reviewed and as a result the ENHT will be taking the following actions to improve data quality:

- Improving sequencing in the coding process, i.e. selecting the correct diagnosis as the main condition treated (no primary diagnoses were actually omitted)
- Improving capture of co-morbidities as 2% were omitted (the accuracy rate in this area has improved)
- Ensuring coding standards are followed correctly around coding ‘geriatric falls’
- Ensuring secondary procedure codes are included by reviewing the entire operation sheet, not just the header, as well as the main documentation around the surgery.
2c Performance against national core indicators

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

This benchmarked data is the latest published via the Health and Social Care Information Centre (HSCIC) website. Where possible, latest Trust data is also shown.

1. Mortality

There are 3 main types of mortality indicator.

**Crude mortality**
This is the percentage of patients who died against the number of admissions to hospital. At the Trust this figure has been 2.02% during the first 10 months of 2014/5 (April ‘14 to January ‘15).

**Hospital standardised mortality ratio (HSMR)**
The HSMR 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 average England figures. It is adjusted to take account of the characteristics (eg. age, other conditions) of the patients treated and also accounts for patients receiving palliative (end of life) care who are therefore expected to die.

The England average is always 100 and the Trust’s position for the full year of 2013/14 was 95.2, which is better than average. HSMR is 3 months in arrears and current data (Jan – Dec 2014) shows the Trust figure is 95.75 (against the 2013/14 data benchmark).

Improvements in crude mortality and HSMR since 2012/13 are shown in the graphs below.

**Summary Hospital-level Mortality Indicator (SHMI)**
This is similar to the HSMR but it covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge. The death does not have to be related to the diagnosis on admission. SHMI data is 7-9 months in arrears and importantly it does not make an adjustment for palliative care.

This means that trusts that have palliative care facilities such as hospices will be at a greater chance of having a higher SHMI than the England average. The Trust has a hospice at
Michael Sobell House, part of the Mount Vernon Cancer Centre. At the Trust we therefore also look at the SHMI adjusted for palliative care.

The current SHMI is 1.129 (also referred to as 112.9) which is above the England average and slightly ‘above the expected range’. During the time period over which this was measured (July 2013-June 2014), the crude mortality was 1.97%. Although there was an increase in the number of deaths in hospital at that time there was a much greater increase in the number of deaths in the community after discharge which are included in Trust figures as they happened within 30 days of discharge.

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a Summary hospital-level mortality indicator (“SHMI”) value</td>
<td>1.11</td>
<td>1.129</td>
<td>1</td>
<td>0.541</td>
<td>1.198</td>
</tr>
<tr>
<td>SHMI banding*</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>b Percentage of patient deaths with palliative care coded at diagnosis or specialty level</td>
<td>47.6%</td>
<td>48.2%</td>
<td>0</td>
<td>49%</td>
<td></td>
</tr>
</tbody>
</table>

* Band 1 - mortality rate is ‘higher than expected’
  Band 2 - mortality rate is ‘as expected’
  Band 3 - mortality rate is ‘lower than expected’

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

- The Trust manages a hospice
- There is raised mortality associated with respiratory conditions such as chronic obstructive pulmonary disease, urinary tract infections and acute cerebrovascular disease

The ENHT has taken a number of actions to improve this rate, and so the quality of its services. These are detailed in part 2a (stroke) and below for respiratory conditions and urinary tract infections.

**Respiratory**

Mortality associated with respiratory conditions, in particular Chronic Obstructive Pulmonary Disease (COPD), is closely monitored. The mortality data for three respiratory conditions with elevated SHMI are shown in the table below.

<table>
<thead>
<tr>
<th>Condition</th>
<th>HSMR</th>
<th>Crude mortality</th>
<th>HSMR</th>
<th>SHMI</th>
<th>Crude mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>88.3</td>
<td>19.3%</td>
<td>95.3</td>
<td>108.6</td>
<td>19.5%</td>
</tr>
<tr>
<td>Acute bronchitis</td>
<td>106.1</td>
<td>8.1%</td>
<td>103.1</td>
<td>139.8</td>
<td>6.3%</td>
</tr>
<tr>
<td>COPD &amp; Bronchiectasis</td>
<td>83.5</td>
<td>5.6%</td>
<td>119.7</td>
<td>150</td>
<td>7%</td>
</tr>
</tbody>
</table>

All respiratory in-patient services and non-invasive ventilation (ventilation not requiring critical care) have been centralised at the Lister Hospital this year and junior medical cover out of hours has increased. Despite this the mortality rate is not improving.
A review of a sample of patients who died from COPD showed their care and treatment to be appropriate and may indicate a lack of community support for this patient group. Also the Respiratory Department has too few consultants for the population base resulting in lack of specialist input.

The Trust is phasing the implementation of an Acute Chest Team progressing towards a 7-day service in 2015/16. Two new Consultants have been recruited and a business case approved to provide 7-day services which includes Consultant support to a planned Community Respiratory service being commissioned by the CCG.

**Urinary Tract Infection (UTI)**

Last year it was reported that over 30% of the deaths due to UTI up to 30 days after discharge occurred in the community and that the Clinical Commissioning Group had initiated an audit of hospital and community care to understand the reasons. As a result the following actions were put into place:

- Improved discharge communication to include a care plan and catheter details eg type, change date
- Proactive UTI prevention protocols and pathways in primary care and care homes
- Training of staff in primary care and care homes on prevention and management of UTI

UTI mortality has fallen significantly with SHMI now 103.3 (in-hospital SHMI 95.2) although it is likely this is the result of earlier actions implemented in 2012-2014. It is therefore expected that mortality associated with UTI will reduce further.

**Mortality Review Process**

A process was established in 2014 to review the notes of patients who died in our hospitals to identify if there were any opportunities for learning and improvement.

A small team of experienced medical staff review the notes and using internationally renowned assessment tools identify if there were any matters of concern which indicate whether the death was potentially avoidable. The results are centrally collated and concerns discussed at the specialty rolling half day meetings and scrutinised by the Clinical Governance Strategy Committee.

The process may trigger a range of options from doing nothing (no concerns identified) to sharing of learning (from minor concerns) or to initiating a Serious Incident investigation if care was deemed deficient.

Themes of these reviews have shown for example that timeliness of antibiotic administration needs to be improved.

**2. Patient Reported Outcome Measure**

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr 13 – Mar 14</td>
<td>Apr 14-Sept 14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Groin hernia surgery</td>
<td>0.1</td>
<td></td>
<td>0.081</td>
<td>0.125</td>
<td>0.009</td>
</tr>
<tr>
<td>b Varicose vein surgery</td>
<td>Number too low for analysis</td>
<td>Number too low for analysis</td>
<td>0.1</td>
<td>0.142</td>
<td>0.054</td>
</tr>
<tr>
<td>c Hip replacement surgery</td>
<td>0.448</td>
<td></td>
<td>0.442</td>
<td>0.501</td>
<td>0.35</td>
</tr>
<tr>
<td>d Knee replacement surgery</td>
<td>0.31</td>
<td></td>
<td>0.328</td>
<td>0.394</td>
<td>0.249</td>
</tr>
</tbody>
</table>
The ENHT considers that this provisional data is as described for the following reasons. Until September 2013 these planned procedures were undertaken by an independent surgicentre. Although the Trust now manages this planned surgery centre (Lister Treatment Centre) there is a time lag associated with the collection of data, and the denominator figure used in the methodology at present does not allow for separation of Trust and surgicentre patients. As such there is limited information available and inadequate numbers of responses from which to make an assessment at this point.

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

- Ensuring that questionnaires are given to patients prior to the relevant surgery so that when the methodology allows just Trust data to be captured we have the information available to make the assessment
- Working with the PROMS representative to ensure data extraction information is correct.

As reported in the Quality Account 2013/14 meaningful data is not expected until late 2015.

3. Readmissions

Data from September 2013 – August 2014 shows the Trust as having the highest readmission rate in the East of England and the second highest nationally. The 28 day emergency readmission rate is 9.89% compared with 7.71% nationally.

Data from the NHS Information Centre is given below.

<table>
<thead>
<tr>
<th>Readmissions</th>
<th>ENHT Previous Period</th>
<th>ENHT Current Period</th>
<th>National Current Period</th>
<th>National Best Performance (Large Acute)</th>
<th>National Worst Performance (Large Acute)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Percentage of patients aged 0 to 15 readmitted within 28 days of discharge</td>
<td>13.52</td>
<td>13.65</td>
<td>10.23 (Large acute)</td>
<td>6.4</td>
<td>14.94</td>
</tr>
<tr>
<td>b Percentage of patients aged 16 and over readmitted within 28 days of discharge</td>
<td>10.56</td>
<td>11.11</td>
<td>11.45 (England)</td>
<td>9.34</td>
<td>13.8</td>
</tr>
</tbody>
</table>

The ENHT considers that this data is as described for the following reasons. It is not clear yet whether there is a link between higher readmissions and the Trusts low length of stay; or whether coding has a significant effect. For example, further investigation has identified some concerns regarding the coding of the second admissions which were not related to the first admission and therefore should not have been coded as a readmission. Examples include healthy babies returning with jaundice or chemotherapy coded as a day case when it should have been coded as an outpatient visit.

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

- Instigating a more in depth and regular review of the coding quality
- Monitoring length of stay improvements as this may have a negative effect on readmission rate
• Working towards 7 day working where more senior presence will assist with decision making regarding discharge
• Continuing to work with community partners to enhance community services post-discharge.

More recent Trust data is given below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency readmissions to hospital within 28 days of discharge</td>
<td>11%</td>
<td>10.52%</td>
<td>10%</td>
</tr>
</tbody>
</table>

4. Responsiveness to Personal Needs

It is noted that this indicator was not measured by trusts in 2014/15. However information relating to the latest national data is required to be reported here.

This is the average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (score out of 100).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012/13</td>
<td>2013/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Respondsiveness to the personal needs of patients</td>
<td>66.3</td>
<td><strong>64.9</strong></td>
<td>68.7</td>
<td>84.2</td>
<td>54.4</td>
</tr>
</tbody>
</table>

The ENHT considers that this data is as described for the following reasons. 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. Survey results relating to these questions are reported elsewhere within the report.

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

5. Recommending the Trust (Staff)

<table>
<thead>
<tr>
<th>Recommending the Trust</th>
<th>ENHT Previous Period</th>
<th>ENHT Current Period</th>
<th>National Current Period</th>
<th>National Best Performance</th>
<th>National Worst Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Percentage of staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends</td>
<td>2013</td>
<td>2014</td>
<td>66%</td>
<td>67%</td>
<td>66%</td>
</tr>
</tbody>
</table>

The ENHT considers that this data is as described for the following reasons. The Trust promotes working according to Trust values and recruits staff in line with these values. It has a
strong staff development programme and the ARC programme (see section 3b) aims to ensure staff are informed and engaged. 2014/15 has, however, been a very challenging year for the Trust and it is expected that the results will improve next year with greater stability across the organisation.

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

- Continuing with the staff engagement programme
- Promoting and further developing its reward and recognition processes

Further information on initiatives to support staff is given in section 3b.

6. Venous Thromboembolism

<table>
<thead>
<tr>
<th>Venous Thromboembolism (VTE)</th>
<th>ENHT Previous Period</th>
<th>ENHT Current Period</th>
<th>National Current Period</th>
<th>National Best Performance</th>
<th>National Worst Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients who were admitted to hospital and who were risk assessed for VTE</td>
<td>July-Sept 2014</td>
<td>Oct-Dec 2014</td>
<td>97.8%</td>
<td>98%</td>
<td>96%</td>
</tr>
</tbody>
</table>

The ENHT considers that this data is as described for the following reasons. The Trust has achieved good performance in undertaking VTE assessments over the last few years.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of admitted patients risk-assessed for VTE</td>
<td>99.2%</td>
<td>98.41%</td>
<td>97.22%</td>
</tr>
</tbody>
</table>

This trend has continued through the relentless efforts as described below to ensure assessments and necessary treatment is undertaken.

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

- Providing instruction / training on VTE for new and training grade doctors during induction
- Championing VTE assessments by the Associate Medical Director for Patient Safety during safety walkabouts
- 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.

7. Clostridium Difficile

<table>
<thead>
<tr>
<th>Clostridium Difficile</th>
<th>ENHT Previous Period</th>
<th>ENHT Current Period</th>
<th>National Current Period</th>
<th>National Best Performance</th>
<th>National Worst Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of admitted patients risk-assessed for VTE</td>
<td>2012/13</td>
<td>2013/14</td>
<td>5.7</td>
<td>6.2</td>
<td>14.7</td>
</tr>
</tbody>
</table>
The ENHT considers that this data is as described for the following reasons. The Trust has had 12 cases of C. difficile in the year. 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 of each case to identify causes and use this information for learning and sharing across the organisation
- Reviewing the cleaning contract and raising the standards
- Undertaking spot checks of infection control practices

Comparative data with other trusts in the region, collated by Public Health England, show the Trust to have the second lowest incidence of C. difficile infection.

8. Number of Patient Safety Incidents

<table>
<thead>
<tr>
<th>Number of Patient Safety Incidents</th>
<th>ENHT Previous Period</th>
<th>ENHT Current Period</th>
<th>National Current Period</th>
<th>National Lowest Performance</th>
<th>National Highest Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 13-Mar 14</td>
<td>Apr 14 – Sept 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a The number of patient safety incidents reported within the Trust</td>
<td>2901</td>
<td>2527</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
| b The rate of patient safety incidents reported within the Trust:  
  - Per 100 admissions  
  - per 1000 bed-days | 7.26  
17.26 | 25.8 | 24.41 | National data not given | N/A | N/A |
| c Number of severe harm or death (Acute Trust – non specialist) | 24 | 15 | 2851 | 0 | 97 |
| d Percentage of severe harm or death (Acute Trust – non specialist) | 0.9% | 0.6% | 0.5% | 0 | 3.1% |
The ENHT considers that this data is as described for the following reasons. The Trust has historically been a high reporter of incidents. Since the introduction of electronic incident reporting there has been greater scrutiny of reports and better management of duplicate reporting. Therefore the number of reports uploaded has reduced. It is also possible that the increased use of temporary staff during the hospital changes may have resulted in reduced reporting.

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

- Continued support to staff regarding the reporting of incidents as an opportunity for learning and improvement
- Production of Safety Matters briefing providing feedback about using Datix and details of any recent trends
- Monitoring of this data by the Patient Safety Committee and the consequent sharing of learning, trends and good practices
- Performance monitoring of incidents not signed off by department managers within the required timescales

The national staff survey (2014) shows the Trust as performing at national average levels for staff reporting incidents.

**KEY FINDING 13. Percentage of staff reporting errors, near misses or incidents witnessed in the last month**

*The higher the score the better*

<table>
<thead>
<tr>
<th>Percentage score</th>
<th>0</th>
<th>25</th>
<th>50</th>
<th>75</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>Trust score 2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>89%</td>
</tr>
<tr>
<td>National 2014 average for acute trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>Best 2014 score for acute trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99%</td>
</tr>
</tbody>
</table>

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

**9. 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 FFT.

This year, NHS England has simplified the way that the result is reported and this is shown in the example below.

**Would recommend** = % of ‘extremely likely’ and ‘likely’ responses

**Would not recommend** = % of ‘unlikely’ and ‘extremely unlikely’ responses

<table>
<thead>
<tr>
<th>Response option</th>
<th>No of responses (%)</th>
<th>Would / Would not recommend (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely likely</td>
<td>48</td>
<td><strong>72% would recommend</strong></td>
</tr>
<tr>
<td>Likely</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Neither likely nor unlikely</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>
### Family and Friends Test

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a Friends &amp; family test—score of inpatient</td>
<td></td>
<td>Jan 2015</td>
<td>Feb 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b Friends &amp; family test—score of patients discharged from the accident &amp; emergency department</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>ENHT</th>
<th>National</th>
<th>ENHT</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Friends &amp; family test—score of inpatient</td>
<td>97%</td>
<td>95%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>b Friends &amp; family test—score of patients discharged from the accident &amp; emergency department</td>
<td>81%</td>
<td>85%</td>
<td>88%</td>
<td>98%</td>
</tr>
</tbody>
</table>

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

The ENHT has taken the following actions to improve this percentage, and so the quality of its services, by working with clinical teams to plan and implement actions to further meet the needs of patients through a range of activities.

FFT results are collected from in-patients, emergency department patients, out-patients, day-case patients and maternity patients. The results are used within the Trust to identify where improvements can be made, and are reported nationally so that comparisons can be made with other organisations. Results for some of the areas since November are given below.
The percentage of adult inpatients who would recommend the Trust is the same as the national average. Staff are currently working towards increasing the response rates where possible. FFT scores are shown on ward boards for patients and the public to see. In February 2,847 patients responded to the Outpatient FFT. Of those, 94.06% would and 1.79% would not recommend the service.

**You said...**  
Refreshments should be provided to patients whilst attending dialysis appointments.

**We did...**  
A pilot offering refreshments has recently taken place and has been well received by patients. Plans are now underway to implement this service across all five dialysis units by April 2015. The Trust’s Way Finding project is addressing this by renewing signage and letters to make finding your way easier.

**Signage/directions isn’t clear enough**

**Wayfinding**  
To help people find their way around the Lister site new signage has been developed with input from staff and patient focus groups. Changes include:

- Numbered ‘gates’ to use the right road entrance
- Colour coding the hospital into zones
- Revising patient letters advising patients of the colour zones where their attendance is expected.
Part 3

3a Review of quality performance in 2014/15

“The most precious thing in my life was now in their hands and they did an amazing job and brought him back safe and sound to me and for this I am truly grateful”

Anonymous, NHS Choice, Feb 2015

NHS Choices displays an overview of the hospitals (except Mount Vernon Cancer Centre) demonstrating a small set of quality indicators. The information for the Lister Hospital is shown below. Further information relating to these indicators is given throughout the report.

### Patient safety

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

- Reduce harm and avoidable deaths
- Promote a culture whereby safety is an integral part of what we do
- Design services, pathways and systems to protect patients from harm

In 2014/15 the strategy was supplemented by a set of annual objectives. These are summarised in the table below together with an indication as to whether, or not, they were met.

---

<table>
<thead>
<tr>
<th>NHS Choices users rating</th>
<th>Care Quality Commission Inspection Ratings</th>
<th>Recommended by staff</th>
<th>Open and honest reporting</th>
<th>Infection control and cleanliness</th>
<th>Mortality rate</th>
<th>Food: Choice and Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lister Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue patient safety walkabout programme</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policies / guidelines – populate central location with all Trust-wide policies &amp; guidelines</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further progress Sepsis workstream</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure handover template is established on EPR &amp; transfer checklist is revised</td>
<td>≗</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue Eastern Academic Health Science Network projects</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalise Apps implementation process linked with IT mobile devices policy &amp; library processes</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human factors – review latest research &amp; consider application in one or more areas</td>
<td>✗</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalise process for Health IT Systems Clinical Safety Process</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further progress Consent workstream</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Safety walkabouts**

A series of ‘core service’ walkabouts, each lasting approximately one day, commenced replicating the methodology used in CQC inspections. Walkabouts have been undertaken in critical care, surgery, medicine, emergency care, out-patients and childrens services. The review team have found staff to be caring. Findings have, on the whole, been positive but with some concerns around record keeping and administrative processes. The findings are reported back to the teams involved who are required to act upon them.

Further walkabouts will continue in 2015/16 focusing upon other inpatient services and services offered in satellite units.

The 15 steps challenge has been introduced with staff members, non-executive directors and public representatives carrying out assessments of wards. This initiative arose from a comment by a mother who said “I can tell what kind of care my daughter is going to get within 15 steps of walking on a ward”. The challenge assesses whether the ward is welcoming, safe, well organised and caring. The assessments began in March with results being fed back to ward managers.

**Policies & guidelines**

900 policies and guidelines have been centralised on the intranet and a new system introduced to manage documents nearing expiry.

**Medication errors**

The Medication Forum reviews incidents, alerts and audit findings relating to medicines and coordinates initiatives for improvement.

**Sepsis**

The Sepsis Group reviews mortality, audit results, antibiotic usage, etc to inform further requirements relating to sepsis management. Actions are now underway to fully implement national recommended standards about ‘red flag’ sepsis.

**Handover**

The Electronic Patient Record team has been working to launch electronic records within the Emergency Department. This is due for launch in spring 2015 and incorporates improved handover records. In addition, following incidents relating to information being missed on transfer between teams a new adult transfer checklist has been produced. This uses the
SBAR methodology to communicate and document specified information during the transfer. At the time of writing the report the form is being piloted within the acute unit and elderly care.

‘Board rounds’ are now routine whereby the status of patients is reviewed by the multi-disciplinary team (around the board) to expedite decisions and actions so that people can be treated more effectively and quickly. Equally attendance of nursing staff at ward rounds is becoming routine to help improve communication.

**Eastern Academic Health Science Network**
This year has seen a hold on new projects during the development and launch of the Patient Safety Collaborative. However, projects from the previous year have continued with the Trust participating in the piloting of an intravenous connector and an intubation tube.

The Trust has joined the national Sign up to Safety Campaign which aims to deliver a single vision for the whole NHS to become the safest healthcare system in the world.

Trusts are required to identify improvement initiatives to be implemented over three years and to work with and learn from other trusts where initiatives are similar.

**Apps and electronic health systems**
A process has been agreed to approve the use of clinical Apps ensuring governance arrangements are robust. With IT systems playing a greater role in healthcare a process has been agreed to ensure that new health related IT software is quality checked for safety prior to implementation. A policy agreed between risk management, the IT Department and procurement ensure only systems deemed clinically approved are purchased and implemented.

**Human factors**
This work has not yet commenced but is a key feature of the draft Improving Patient Outcomes Strategy for 2015-18.

**Consent**
Feedback from the National in-patient Survey 2014 indicated that consenting practices were not as good as expected. It was thought that this was related to the management arrangement for emergency and planned surgery during the time of the survey as the majority of planned surgery was undertaken by the independent Surgicentre, leaving Trust patients to be surveyed on emergency procedures. Actions were undertaken to update training and to increase the use of procedure specific consent forms. All 107 Trust ratified forms have been uploaded to a central place on the intranet. The 2015 survey results show an improving picture.

**Safety indicator set**
The following indicator set gives an overview of some of our safety indicators. The results since 2012/13 are shown together with this years achievements and whether or not the aims were met.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>Aim for 14/15</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never events</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>✗</td>
</tr>
<tr>
<td>MRSA Elective Screening (all elective inpatient admissions)</td>
<td>99.9%</td>
<td>99.86%</td>
<td>Change in methodology</td>
<td>&gt;=95%</td>
<td>-</td>
</tr>
<tr>
<td>MRSA Bacteraemia</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>✗</td>
</tr>
</tbody>
</table>
**Serious incidents**
116 serious incidents were declared in the calendar year 2014. However 34 of these were downgraded as they were not considered to fulfil the definition of a serious incident. Therefore there were 82 serious incidents reported compared to 67 in the previous year.

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

<table>
<thead>
<tr>
<th>Serious Incidents</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Infection Control</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td>16</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>34</td>
</tr>
</tbody>
</table>

‘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.

- 1 'never event' was reported in the category of ‘wrong site surgery’

  Across England 271 incidents were reported as never events between 1\(^{st}\) April 2014 and 28\(^{th}\) February 2015. Of these 114 related to wrong site surgery.

  A never event is an incident that should never happen if the correct procedures are in place. The Trust incident resulted from a grommet being inserted into the wrong ear. The incident was investigated fully revealing that a number of factors were involved such as a late addition to the operating list; inadequate documentation and communication. As a result of this incident changes in practice have been made including a review of the process for making additions to the operating list at short notice.

**Duty of Candour**
The Trust aims to be open with patients / families when things go wrong. Patients / families are informed of investigations and are sent copies of investigation reports. Meetings are also held for those wanting further explanation of the reports and to discuss the events with the staff involved.

‘Knowing how we are doing’ boards are placed at ward entrances to display to staff and patients/families important details about safety on the ward such as how many falls there have been.

**MRSA**
During 2014/15 4 avoidable & 1 non-avoidable cases of MRSA were reported. Three of these resulted from blood culture contaminants and not infections.
Actions taken as a result of these infections include:

- Continuation of hand hygiene audits by the Infection Prevention and Control team
- Light box exercises to commence in any areas noted to have compliance issues – this is a test to measure the effectiveness of hand washing
- Reporting of staff non-compliance with proper hand washing as per hand hygiene policy
- Reduction of bed moves where possible
- Retraining of individuals involved in blood taking
- Development of a business case to support the provision of a dedicated team for managing central venous access devices (i.e., equipment used to gain access to the veins)

In 2014/15, the Trust had a target of 95% compliance for both Elective and Emergency MRSA screening compliance.

From January 2015, Emergency and Elective screening requirements have changed and only patients in specified categories are now required to be screened. The Information Department is reviewing processes to establish how to capture compliance.

**Safeguarding adults**
The Trust has a duty of care to vulnerable people. The Trust maintains an ‘adults at risk’ database which records all safeguarding concerns. During 2014/15 there were 146 concerns raised of which 23 were against the Trust. Also of note:

- The Clinical Commissioning Group and the Victim Support Service funded the appointment of an Independent Domestic Violence Advisor (IDVA) in January
- The Clinical Commissioning Group reviewed the Trust safeguarding practices in December and confirmed that sufficient assurance of adult safeguarding practices were in place
- Implementation of an agreed action plan to make further improvements will be monitored through the safeguarding committee
- Training data shows that 89.3% of all Trust staff are compliant with safeguarding adults training.

In 2014/15 the Trust undertook 83 urgent Deprivation of Liberty Safeguards and requests for standard authorisations. This is a significant increase compared with the previous year. These requests are made to prevent the discharge of vulnerable patients where staff believe their safety is at greater risk by going home without treatment.

**Safeguarding children**
The Trust aims to achieve 90% compliance with all levels of training. Safeguarding children training is offered at three levels with level 1 for administrative staff with no routine contact with children to level 3 where direct contact is routine. Training compliance figures at February 2015 are shown in the table.

<table>
<thead>
<tr>
<th>Level</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>89%</td>
</tr>
<tr>
<td>Level 2</td>
<td>88%</td>
</tr>
<tr>
<td>Level 3</td>
<td>69%</td>
</tr>
</tbody>
</table>

Level 3 compliance has reduced as a direct result of increased winter pressures where staff were unable to leave their departments to undertake training. A plan is in place to address this.
Child Protection – Information Sharing is a national project launched in March 2015 in Hertfordshire. It allows staff to identify children from other counties who are on a child protection plan or who are ‘Looked After’, thus ensuring communication across geographical boundaries.

Looked After Children
The Paediatrics team assist in caring for children in care. During the year they have increased the number of doctors available to undertake medical examinations and have made organisational changes so that children can be seen sooner. The quality of the medicals has been audited against national standards and it has been shown that high quality medicals are undertaken.

Learning Disability
The Learning Disability (LD) team continue to see people in the Trust and plans are underway to increase service provision as plans towards 7 day services are being developed. A presentation by the LD team was delivered at the Medical Grand Round in November about the Confidential Inquiry into deaths of people with LD and the Trust participated in a Hertfordshire LD conference in March. The Trust continues to progress the production and use of easy read outpatient appointment letters.

Seven Day Services
The Trust is working towards 7 day working and fully achieving the Keogh standards set out in the report *NHS Services, seven days a week*. A national group set up to review 5 day practices found significant variation in mortality rates, length of hospital stay, readmission rates and the patient’s experience of care for those admitted across the NHS in England at weekends.

All clinical specialties have reviewed their services to identify gaps between current provision and standards expected for 7 day working. There are ten standards, below, and the Trust is working with community partners to initially focus during 2015/16 on the five shown in bold:

1. Patient Experience
2. Time to first consultant review
3. Multi-disciplinary Team (MDT) review
4. Shift handovers
5. Diagnostics
6. Intervention / key services
7. Mental health
8. On-going review
9. Transfer to community, primary and social care
10. Quality improvement
Clinical effectiveness

Effectiveness indicator set
The following indicator set gives an overview of some of our effectiveness indicators. The results since 2012/13 are shown together with this years achievements and whether or not the aims were met.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>Aim for 14/15</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed transfers of care (%)</td>
<td>2.83</td>
<td>3.19</td>
<td>2.52</td>
<td>&lt;=3.5</td>
<td>✓</td>
</tr>
<tr>
<td>Length of stay (days)</td>
<td>4.94</td>
<td>3.91</td>
<td>3.53</td>
<td>&lt;=4.5</td>
<td>✓</td>
</tr>
<tr>
<td>Cancelled operations</td>
<td>1.44%</td>
<td>0.62%</td>
<td>1.41%</td>
<td>&lt;=0.8%</td>
<td>×</td>
</tr>
</tbody>
</table>

Mortality is a key indicator of clinical effectiveness and has been summarised in Part 2c, section 1.

Delayed transfers of care
The graph below details all the patients awaiting transfer to other agencies (red line) and expected discharges at 11:00 hours (grey bars). It can be seen that the number of patients whose transfer to home or community services is delayed is a significant proportion of those whose discharge is expected. This places severe operational challenges.

The Trust continues to work well with our community partners however the reduction in external capacity, for example norovirus in care homes, does impact on the Trusts ability to respond as quickly during surges in emergency demand. The improved position this year though can be associated with the following initiatives:

- Early identification of an expected date of discharge
- Effective multi-disciplinary team 'board rounds' – these are meetings of the nursing, medical, therapy and discharge teams whereby joint plans are agreed and any potential delays identified and dealt with
- Allocation of specific members of the discharge team to wards – this facilitates continuity and improves communication
- Appointment of a Continuing Health Care Lead to liaise with agencies and families to expedite discharge
- Improvement in ambulatory care so patients can continue some treatment without requiring an admission.
Reducing Length of Stay
Reducing the length of time people spend in hospital means that the organisation can run more efficiently by treating more patients. It also means that patients can go home more quickly. Reductions of length of stay can be seen for patients coming in as emergencies or for planned procedures as shown in the graphs below (red line).

The number of emergency and elective admissions are also shown. These improvements in length of stay have resulted from a series of workstreams such as increasing the number of senior staff to improve decision making; working towards an early agreed expected discharge date; early discharge through use of the discharge lounge and case reviews of long stay patients by the multi-disciplinary team.

![Graph 1: ENHT Emergency Admissions by ALOS - 01/04/2013 to 28/02/2015](image1)

![Graph 2: ENHT Elective Admissions by ALOS - 01/04/2013 to 28/02/2015](image2)

Cancelled operations
During the first half of the year an average 0.3% of operations were cancelled. During the time of reconfiguration the percentage increased to around 0.95% and increased further during January and February. A reduction (improvement) is now being seen. Overall during the year 1.41% of operations were cancelled.

At the time of reconfiguration and during an exceptionally busy time across England from late December and into January we saw an increase in emergency activity. This resulted in an increased demand for emergency surgery. With limited operation slots a number of planned procedures had to be cancelled.
The following actions have been taken to monitor and improve the situation:

- Establishment of dedicated emergency theatre lists so that planned surgery is not affected by an increase in emergency admissions
- Strict management of the criteria for cancellation – avoiding where possible – with weekly performance monitoring
- Priority given to patients requiring urgent cancer and non-cancer surgery

**National Trauma Peer Review Visit**
The Trust's trauma service was assessed against national standards. Feedback shows good teamwork and communication with other units, but most importantly that the Trust has:

- a robust process to deliver high standards of care to the multiply injured patient
- shown a constantly improving patient survival rate in the last few years becoming one of the best units in the region
- outstanding modern facilities

There were some minor concerns around therapy provision for patients undergoing rehabilitation and to formally agree trauma training for nurses in the Emergency Department.

**Diabetes National Peer Review Audit**
The results of a national peer review audit published recently shows that the Trust's dedicated diabetes service for children and young people is the fourth best in the country and the best in the East of England. The service scored 100% in many areas and Consultant paediatrician Dr Raffles comments

"We take great pride in providing our young patients with an innovative service that provides them with great care”.

**Diabetes award**
The Trust's adult diabetes team won the national Quality in Care award in the diabetes category for its diabetes outreach team, which has enabled seven-day working. The team supports the Lister’s emergency department to help prevent readmissions of patients, whilst also ensuring that diabetic emergencies are dealt with by specialists at the earliest opportunity.

**Telemedicine**
The renal team was awarded £140k to introduce telemedicine to support renal patients manage their own care. So far 40 patients are using modem-type devices to send information about their dialysis to medical staff at the telemedicine hub. The information helps to monitor the effectiveness of the dialysis and whether any changes are required.

Clinical Nurse Specialist for head and neck cancer Jackie Jones has introduced a teleclinic where consultations are held via Skype. Still in the early stages, patients report positively about the experiences such as not having to travel to the hospital and having the appointment at a time that suits.

**Attention Deficit Hyperactivity Disorder (ADHD)**

“The ADHD Service has developed a monthly dedicated workshop for our ADHD parents with the aim of raising awareness of the disorder and providing strategies for parents to support their children. The workshop is normally run in Stevenage library through an innovative partnership developed last year. Feedback obtained from parents indicates we're doing the right thing.”

Dr Susan Ozer
Consultant Paediatrician, ADHD lead
**Patient experiences**

Feedback from patients is gathered in many ways:

- **Surveys**
  - Using electronic devices (Meridian) in wards and departments to complete surveys
  - Via a postal survey (April – June only)
  - Participation in national surveys
- Reviewing complaints and PALS concerns (at the individual level and looking for trends)
- Focus groups
- Patient stories at the Trust Board
- Walkabouts on wards and departments by senior staff

The **Patient Experience Committee** reviews the findings of this feedback and oversees action plans to ensure that improvements are made where required. There are five members of the public on this committee.

A summary of patient experience information is produced monthly and presented on the dashboard as below. This is presented to, and discussed at, various committees including the Trust Board.

---

**Experiences indicator set**

The following indicator set gives an overview of some of our patient experiences indicators. The results since 2012/13 are shown.
### Indicator 2012/13 2013/14 2014/15 Aim for 14/15 Met

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>Aim for 14/15</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints</td>
<td>969</td>
<td>864</td>
<td>1181</td>
<td>↓</td>
<td>×</td>
</tr>
<tr>
<td>Complaints – care</td>
<td>113</td>
<td>186</td>
<td>119</td>
<td>↓</td>
<td>✓</td>
</tr>
<tr>
<td>Complaints – communication</td>
<td>385</td>
<td>149</td>
<td>166</td>
<td>↓</td>
<td>×</td>
</tr>
<tr>
<td>Complaints – response within 25 days</td>
<td>58%</td>
<td>49%</td>
<td>59%*</td>
<td>↑</td>
<td>✓</td>
</tr>
<tr>
<td>Complaints per level of activity</td>
<td>1.08%</td>
<td>0.9%</td>
<td>1.32%</td>
<td>↓</td>
<td>✓</td>
</tr>
<tr>
<td>Local resolution meetings</td>
<td>30</td>
<td>24</td>
<td>20</td>
<td>N/A</td>
<td>-</td>
</tr>
<tr>
<td>Ombudsman investigation</td>
<td>7</td>
<td>17</td>
<td>10</td>
<td>N/A</td>
<td>×</td>
</tr>
<tr>
<td>Number of PALS concerns</td>
<td>1724</td>
<td>1728</td>
<td>2306</td>
<td>N/A</td>
<td>-</td>
</tr>
</tbody>
</table>

* Response within agreed timeframe

### 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 also enable us to evaluate whether our patients would recommend our Trust (see Friends and Family Test).

Quarterly postal surveys were undertaken early in the year (April – June 2014) whereby questionnaires were sent to patients at their homes after their discharge. We no longer do these surveys for three reasons: there were new technical difficulties with completing checks to ensure we weren’t sending questionnaires to patients who had died; patient were telling us there were so many surveys and we have developed our electronic surveys to the extent that many thousands of patients contribute.

**Electronic surveys**

The number of patient experience 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

**You said…**  
**You didn’t rate highly hospital food**  
We did…  
An event in Sept 2014 sought feedback from patients about what makes an excellent food service. It was clear that patients wanted more wholesome food and to decide on the day what they wanted to eat. New patient menus are being introduced with separate ones for special diets. Trays of food are being delivered to the ward and served at ward level meaning that food is hotter and that people can choose the content and size of portion.

**You didn’t always know your named nurse**  
Ward sisters are to ensure ward boards and boards in bay areas are updated daily with details of the named nurse. The need for staff to introduce themselves upon greeting patients has been reiterated.
The following chart shows the questions and scores from the meridian in-patient survey.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Question No.</th>
<th>Question</th>
<th>Score</th>
<th>Questionnaires</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>19</td>
<td>Did you feel you were treated with respect and dignity while you were in the hospital?</td>
<td>97.08</td>
<td>5964</td>
</tr>
<tr>
<td>2</td>
<td>17</td>
<td>Do you think the hospital staff did everything they could to help control your pain?</td>
<td>92.18</td>
<td>5964</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>When you had important questions to ask a nurse, did you get answers that you could understand?</td>
<td>91.91</td>
<td>5964</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>In your opinion, how clean was the hospital room or ward that you were in?</td>
<td>91.17</td>
<td>5964</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>Did you get enough help from staff to eat your meals?</td>
<td>89.59</td>
<td>5964</td>
</tr>
<tr>
<td>6</td>
<td>9</td>
<td>Were you ever bothered by noise at night from hospital staff?</td>
<td>86.33</td>
<td>5964</td>
</tr>
<tr>
<td>7</td>
<td>15</td>
<td>Do you feel you got enough emotional support from hospital staff during your stay?</td>
<td>85.83</td>
<td>5964</td>
</tr>
<tr>
<td>8</td>
<td>11</td>
<td>When you had important questions to ask a doctor, did you get answers that you could understand?</td>
<td>85.70</td>
<td>5964</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>Were you involved as much as you wanted to be in decisions made about your care and treatment?</td>
<td>84.27</td>
<td>5964</td>
</tr>
<tr>
<td>10</td>
<td>15</td>
<td>Did you find someone on the hospital staff to talk to about your worries and fears?</td>
<td>83.17</td>
<td>5964</td>
</tr>
<tr>
<td>11</td>
<td>13</td>
<td>In your opinion, were there enough nurses on duty to care for you in hospital?</td>
<td>73.78</td>
<td>5964</td>
</tr>
<tr>
<td>12</td>
<td>18</td>
<td>After you used the call button, how long did it usually take before you got help?</td>
<td>71.35</td>
<td>5964</td>
</tr>
<tr>
<td>13</td>
<td>6</td>
<td>Were you ever bothered by noise at night from other patients?</td>
<td>70.44</td>
<td>5964</td>
</tr>
<tr>
<td>14</td>
<td>14</td>
<td>Do you know who your named nurse is?</td>
<td>69.42</td>
<td>5964</td>
</tr>
<tr>
<td>15</td>
<td>6</td>
<td>How would you rate the hospital food?</td>
<td>65.82</td>
<td>5964</td>
</tr>
</tbody>
</table>

National in-patient survey 2014
333 patients responded to the survey, with a 40% response rate (47% nationally).

<table>
<thead>
<tr>
<th>Question group</th>
<th>2013</th>
<th>Comparison to other Trusts</th>
<th>2014</th>
<th>Comparison to other Trusts</th>
<th>Highest national score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency / A&amp;E department</td>
<td>Trust 8</td>
<td>Same</td>
<td>Trust 8.1</td>
<td>Same</td>
<td>9.4</td>
</tr>
<tr>
<td>Waiting lists &amp; planned admissions</td>
<td>8.6</td>
<td>Same</td>
<td>Trust 8.6</td>
<td>Same</td>
<td>9.6</td>
</tr>
<tr>
<td>Waiting to get to a bed</td>
<td>6.9</td>
<td>Same</td>
<td>Trust 6.9</td>
<td>Same</td>
<td>9.9</td>
</tr>
<tr>
<td>Hospital &amp; ward</td>
<td>Trust 7.8</td>
<td>Same</td>
<td>Trust 7.7</td>
<td>Worse</td>
<td>9.1</td>
</tr>
<tr>
<td>Doctors</td>
<td>Trust 8.2</td>
<td>Same</td>
<td>Trust 8.1</td>
<td>Same</td>
<td>9.5</td>
</tr>
<tr>
<td>Nurses</td>
<td>Trust 8.1</td>
<td>Same</td>
<td>Trust 8.2</td>
<td>Same</td>
<td>9.3</td>
</tr>
<tr>
<td>Care &amp; treatment</td>
<td>Trust 7.2</td>
<td>Same</td>
<td>Trust 7.4</td>
<td>Same</td>
<td>8.9</td>
</tr>
<tr>
<td>Operations &amp; procedures</td>
<td>Trust 7.8</td>
<td>Worse</td>
<td>Trust 8.2</td>
<td>Same</td>
<td>9.2</td>
</tr>
<tr>
<td>Leaving hospital</td>
<td>Trust 6.9</td>
<td>Same</td>
<td>Trust 6.9</td>
<td>Same</td>
<td>8.3</td>
</tr>
<tr>
<td>Overall views &amp; experiences</td>
<td>Trust 5.1</td>
<td>Same</td>
<td>Trust 5.4</td>
<td>Same</td>
<td>7.7</td>
</tr>
</tbody>
</table>

The Trust was pleased to note improvements in five question groups but noted the decline in two areas, one of which – the hospital and ward compared unfavourably with other trusts.
Analysis of the questions indicates this is associated with noise at night; assistance at mealtimes and the quality of food.

Actions are in place to address these as highlighted elsewhere within the report. In addition, we have had the ‘red tray’ system for a while indicating that a patient requires some assistance to eat. We’ve recently introduced a ‘blue plate’ which identifies people with dementia who not only may require help to eat but to ensure they do eat.

**National emergency department survey 2014**
270 patients responded to the survey, with a 32% response rate (34% nationally). The patients had attended the emergency department between January and March 2014.

<table>
<thead>
<tr>
<th>Question</th>
<th>2012 Trust</th>
<th>Comparison to other Trusts</th>
<th>2014 Trust</th>
<th>Comparison to other Trusts</th>
<th>Highest national score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrival at A&amp;E</td>
<td>9.2</td>
<td>Same</td>
<td>7.5</td>
<td>Same</td>
<td>8.6</td>
</tr>
<tr>
<td>Waiting times</td>
<td>5.7</td>
<td>Same</td>
<td>5.4</td>
<td>Same</td>
<td>7</td>
</tr>
<tr>
<td>Doctors and nurses</td>
<td>8</td>
<td>Same</td>
<td>8</td>
<td>Same</td>
<td>8.7</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>7.9</td>
<td>Same</td>
<td>7.4</td>
<td>Same</td>
<td>8.5</td>
</tr>
<tr>
<td>Tests</td>
<td>8.2</td>
<td>Same</td>
<td>8.2</td>
<td>Same</td>
<td>8.9</td>
</tr>
<tr>
<td>Hospital environment and facilities</td>
<td>8</td>
<td>Same</td>
<td>8.1</td>
<td>Same</td>
<td>9</td>
</tr>
<tr>
<td>Leaving A&amp;E</td>
<td>6.1</td>
<td>Same</td>
<td>5.7</td>
<td>Same</td>
<td>7.1</td>
</tr>
<tr>
<td>Experience overall</td>
<td>6.8</td>
<td>Same</td>
<td>8.2</td>
<td>Same</td>
<td>9</td>
</tr>
</tbody>
</table>

Of the 35 questions patients told us about their two main concerns:

**You said…**
You were not told how long you would have to wait to be examined?

**We did…**
We aim to see and treat everyone within 4 hours. Emergency department staff where they can try to indicate how long waits are likely to be.

You were not given enough privacy when being examined or treated?

**We did…**
The survey was undertaken at a time when the department was undergoing building work. This work is now finished and facilities have improved.

A score of 96.19 (out of 100) was given from 210 patients surveyed since September.

**National Cancer Survey 2014**
153 acute hospital trusts providing cancer services took part in this national survey of inpatient or day case patients between September-October 2013. 591 patients responded to the survey, with a 62% response rate (64% nationally).

The Trust was rated the same as other trusts for 49 questions but was significantly better in one area (GP liaison) and worse in 13.
Significant improvements compared to the previous (2013) survey were made in the following areas:

- Patients received understandable answers from ward nurses to important questions all/most of the time
- All staff asked patients by what name they preferred to be called
- Always treated with respect and dignity by staff

The areas where the Trust performed worse than average related to access (being seen as soon as thought necessary); communications (providing explanations or listening); lack of information for example about free prescriptions and management of side effects. The Trust has developed an action plan which includes:

- The development of an Acute Oncology service to support medical and nursing teams
- DVD at doctors induction about communication
- Introduction of Compassion in Care programme for support workers
- Posters advising of free prescriptions

Progress in implementing the action plan is monitored by the Patient Experience Committee.

**Complaints and PALS**

The graph below shows complaints and PALS activity together with the result of the friends and family test (FFT). Complaints have been received by 1.2% of patients and PALS concerns raised by 2.6% of patients.

![Complaints, PALS & Friends & Family Test (FFT)](image)

Upon receipt of a formal complaint the complaints team aim to telephone the complainant, acknowledge the correspondence and respond within an agreed timeframe. Monitoring commenced in June with the results as below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Aim</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Call made to complainant</td>
<td>&gt;65%</td>
<td>75%</td>
<td>86%</td>
<td>90%</td>
<td>72%</td>
<td>83%</td>
<td>52%</td>
<td>72%</td>
<td>67%</td>
<td>71%</td>
</tr>
<tr>
<td>Acknowledged within 3 working days</td>
<td>&gt;60%</td>
<td>98%</td>
<td>89%</td>
<td>90%</td>
<td>91%</td>
<td>88%</td>
<td>84%</td>
<td>80%</td>
<td>91%</td>
<td>78%</td>
</tr>
<tr>
<td>Replied within agreed time frame</td>
<td>&gt;55%</td>
<td>70%</td>
<td>44%</td>
<td>72%</td>
<td>81%</td>
<td>57%</td>
<td>59%</td>
<td>56%</td>
<td>52%</td>
<td>42%</td>
</tr>
</tbody>
</table>
It can be seen that the winter pressures have had an impact upon achieving the plan, particularly as divisions struggle to conclude investigations whilst dealing with increasing numbers of admissions.

A review of the complaints service was undertaken by the internal auditors resulting in the development of an action plan. The following actions are underway:

- Introduction of timescales for dealing with complaints in relation to the grading of the complaint
- Complaint Case Handlers will agree with the complainant the appropriate route for resolution i.e. resolution at ward/department level or as a formal complaint
- Development of a satisfaction survey
- Review of structure to include some administration support

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

<table>
<thead>
<tr>
<th>You said…</th>
<th>We did…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of information given to a carer</td>
<td>Full explanation of facilities that are available for carers given. Apologies that ward staff were not aware of these.</td>
</tr>
<tr>
<td>Difficulty contacting the Treatment Centre to discuss an appointment.</td>
<td>Business plan for a new telecommunication system is being prepared</td>
</tr>
<tr>
<td>Delay for appointment.</td>
<td>Error was a training issue - training has now been arranged for staff</td>
</tr>
<tr>
<td>Concerns that patient was discharged without informing care home.</td>
<td>Transfer letter being produced to accompany patients when they are discharged to residential care.</td>
</tr>
<tr>
<td>Tongue tie missed at birth.</td>
<td>New, but limited, service has been set up whereby babies can be referred direct to oro-maxillofacial surgeons.</td>
</tr>
<tr>
<td>We performed a procedure to insert a fistula for use in renal dialysis, but the placement was not as expected leaving visible scarring on the wrist.</td>
<td>We were unable to find the health records which described the decisions made at the time so it was difficult to investigate this complaint. Explanations have been given about the options for placement and the benefits and risks of each. Whilst it is acknowledged that the clinical aspects of the surgery were sound there were elements of consent that could have been improved. The Trust has an active audit programme, training programme and regular review of consent practices. Also of concern were the delays in responding to this family. Although the investigations were carried out the results were not communicated within a reasonable time and the Trust has apologised for this.</td>
</tr>
</tbody>
</table>

The ‘Birth Afterthoughts’ initiative in Midwifery asks new mothers about their experiences in hospital and aims to address any concerns either before or soon after discharge, thus reducing complaints.
Claims
The NHS Litigation Authority extranet enables trusts to benchmark themselves against similar organisations with respect to the number of claims received. The graph below shows the number of claims reported by the Trust in comparison with other similar trusts.

More detailed review shows that:

- Claims arising from the Emergency Department are now broadly in line with other similar trusts
- Claims arising in Obstetrics are below those reported by other similar trusts
- Claims arising in General Surgery are significantly below those reported by other similar trusts.

Compliments
The Trust receives compliments from a variety of sources, including NHS Choices Feedback and Twitter. It is not possible to count and record each individual expression of gratitude although some examples of compliments received by the Chief Executive’s office are given below:

- Very happy with the service from the Breast Unit at the QEII from her referral to discharge
- Very happy with efficient and helpful staff in the Emergency Out of Hours GP Service at the Lister
- Mother of patient brought into QEII urgent care centre wishes to say how much she appreciated the care her son received following an injury incurred in a swimming race
- Congratulations to everyone on the high level of service and professionalism patient received following a heart attack last October
- Very happy with service from Ophthalmology staff on both QEII and Lister sites following a query regarding whether an eye condition would be a problem for renewal of driving licence
- Pleased with the care on Ward 8A South. Staff were wonderful, and kept them informed. Patient care was first class
- Parent very pleased with the service he received from the Lister children's A&E service. The staff were ‘fantastic’ from start to finish, professional in their approach and with helping their son
- Expectant parents took part in the Maternity Tour and were very impressed particularly with the midwife who gave a thorough and comprehensive guide of the maternity services available
Caring for Carers
The Trust recognises the contribution of carers in looking after patients both at home and sometimes during their stay in hospital and is committed to ensuring a partnership approach is adopted when working with carers supporting patients attending hospital.

Through the successful Carers Friendly Hospital pilot, the Trust has secured funding for another year to continue a carer’s lead role.

Feedback from a survey of 92 carers during 2014/15 showed that where a ‘Carers Agreement’ was in place that carers found it helpful but that generally half of the carers said they did not receive enough information about the person they look after or about support available; or feel that their skills were recognised. The updated Patient and Carer Experience Strategy 2015-18, which was produced with input from carers via a series of focus groups aims to improve the carers experiences by:

- Actively engaging with carers encouraging all feedback and demonstrating genuine learning from listening.
- Ensuring that carers are provided with the best possible experience whilst using our services.
3b Our Staff

2014/15 has been a challenging year for staff as described on page 4. The organisational changes that have been underway over the last few years largely came to an end with all in-patient services from the QEII Hospital, and some of the staff associated with them, relocating to the Lister Hospital. With change has come opportunities and these too are described in this section.

Staff indicator set

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>Aim for 14/15</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff engagement</td>
<td>3.72</td>
<td>3.76</td>
<td><strong>3.71</strong></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Appraisal completions</td>
<td>70.2%</td>
<td>45.33%</td>
<td><strong>68.33%</strong></td>
<td>&gt;=90%</td>
<td>✗</td>
</tr>
<tr>
<td>Sickness rate (annualised)</td>
<td>3.6%</td>
<td>3.41%</td>
<td><strong>3.55%</strong></td>
<td>&lt;=3.5%</td>
<td>✗</td>
</tr>
<tr>
<td>Turnover</td>
<td>9.9%</td>
<td>10.71%</td>
<td><strong>12.91%</strong></td>
<td>&lt;9.5-10.5</td>
<td>✗</td>
</tr>
<tr>
<td>Vacancy rate</td>
<td>8.6%</td>
<td>5.65%</td>
<td><strong>7.11%</strong></td>
<td>&lt;6-8</td>
<td>✓</td>
</tr>
</tbody>
</table>
In 2013/14 an appraisal process linked with mandatory training and pay progression was introduced.

Trust data above shows that the percentage of appraisals has increased.

However the National Staff Survey 2014 indicates a worsening score compared with 2013 and below average scores compared with other trusts.

Sickness rates increased around the time of consolidation. Since then the rates have remained at the higher level, although compared with national figures remain favourable.

Turnover has varied during the year with the reconfiguration changes. The level has been coming down to match that of a year ago. A more streamlined recruitment process is helping to place people more quickly into vacancies.

Staff development

The Trust launched its People Strategy 2014-19 which outlines our intentions around:

- Culture
- Performance
- Staff development
- Making a difference to our communities

The staff development programme known as ARC (accelerate, refocus, consolidate) has continued with sessions on building quality teams, preparing for a CQC inspection and staff relations.

The Trust offers numerous staff development programmes both to support managers (eg. core management skills, effective manager programme) and to enhance the skills of individuals (eg. IT skills). Clinical skills courses are available using a range of teaching techniques from classroom, simulation training and competency assessments to large scale practices such as major incident decontamination. Staff have access to local and national courses or opportunities as below.
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. 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 1.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 12/13</th>
<th>Trust 13/14</th>
<th>Trust 14/15</th>
<th>National 14/15</th>
<th>Comparison to national</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role makes a difference to patients</td>
<td>91%</td>
<td>90%</td>
<td>92%</td>
<td>91%</td>
<td>Better</td>
</tr>
<tr>
<td>Level of satisfaction with work and care</td>
<td>84%</td>
<td>81%</td>
<td>77%</td>
<td>77%</td>
<td>Same</td>
</tr>
<tr>
<td>Good communication with managers</td>
<td>26%</td>
<td>27%</td>
<td>26%</td>
<td>30%</td>
<td>Worse</td>
</tr>
<tr>
<td>Undertaking training</td>
<td>81%</td>
<td>81%</td>
<td>82%</td>
<td>81%</td>
<td>Better</td>
</tr>
<tr>
<td>Equality &amp; diversity training</td>
<td>74%</td>
<td>74%</td>
<td>72%</td>
<td>63%</td>
<td>Better</td>
</tr>
</tbody>
</table>

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.

Equality Delivery System

The Equality Delivery System (EDS) 2 is being implemented. Work is under way to collect evidence for the new EDS2 and Race Equality standards. For more details please refer to http://www.enherts-tr.nhs.uk/about-the-trust/equality-diversity

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. It can be seen that improvements have been made against the baseline (starting point two years ago). Fire and information governance training has to be completed annually, hence the difficulties in meeting compliance compared with the other competencies which are required less frequently.

At March 2015, 54.8% of staff are fully compliant with all competencies. The Trust continues to work towards a compliance of 90% or more and the current achievements and plan are given in the chart below.
Other trusts measure compliance slightly differently, reporting an overall coverage. At present the Trust stands at 86% compliant, using this measure.

The Trust was visited by the School of Anaesthesia in December 2014 & School of General Practice in January 2015. Both visits went very well and the Schools applauded the high standards of training in the Trust.

The National Staff Survey 2014 shows the Trust is:

- **above average** for delivering equality & diversity training
- **average** for health and safety training
- **above average** for having job-relevant training.

**Ward accreditation**

The new ward accreditation programme that starts in April will require full statutory and mandatory training compliance to have been achieved as part of the standard for recognition.
Aligning the national staff survey results with Trust values

**KEY FINDING 2. Percentage of staff agreeing that their role makes a difference to patients**

- Trust score 2014: 92%
- Trust score 2013: 90%
- National 2014 average for acute trusts: 91%
- Best 2014 score for acute trusts: 95%

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

- Trust score 2014: 63%
- Trust score 2013: 67%
- National 2014 average for acute trusts: 68%
- Best 2014 score for acute trusts: 78%

**KEY FINDING 29. Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department**

- Trust score 2014: 58%
- National 2014 average for acute trusts: 56%
- Best 2014 score for acute trusts: 74%

**KEY FINDING 25. Staff motivation at work**

- Trust score 2014: 3.85
- Trust score 2013: 3.89
- National 2014 average for acute trusts: 3.86
- Best 2014 score for acute trusts: 4.08

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

- Trust score 2014: 26%
- Trust score 2013: 27%
- National 2014 average for acute trusts: 30%
- Best 2014 score for acute trusts: 46%

**KEY FINDING 4. Effective team working**

- Trust score 2014: 3.68
- Trust score 2013: 3.70
- National 2014 average for acute trusts: 3.74
- Best 2014 score for acute trusts: 3.94
3c Our Hospitals

The East and North Hertfordshire NHS Trust employs approximately 4,300 staff and has an annual income of approximately £306m. It provides secondary (hospital) and limited tertiary (specialist) care services from four sites.

Hertford County Hospital

Based in Hertford the original hospital was built in the early 1800s and in 2004 a new hospital was built on the same site. The hospital provides a wide range of outpatients, ante/post natal, diagnostic and therapeutic services to the people of south-east Hertfordshire.

It is open Monday to Friday, expect on bank holidays, between 8am and 6pm and services include:

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

“Pathology department Tues 7th Oct

Thank you to really lovely, friendly staff yesterday about noon and for the short wait for blood tests. The receptionist was really good when I arrived. She acknowledged that I’d arrived and said she’d be there when she’d walked back round to the other side of reception. The nurse who took the blood (with lovely earrings) was really friendly and positive. Thank you - don't underestimate how much difference your team makes. The only thing I found embarrassing was handing over an ‘ahem’ sample! Not sure if there’s any way of making it feel less mortifying when you hand it over! Ridiculous I know and all in a day’s work for you, I’m sure bit being British and all that......Somehow giving a urine sample feels so much less embarrassing! Not a criticism at all though. Really appreciated the care you gave. Thank you.”

Anonymous, October 2014, NHS Choices

NHS Choices collates feedback from patients, asking them to rate certain aspects of their care and treatment. An overview from three of our hospitals is given below. (Information for Mount Vernon Cancer Centre is not collated).

Feedback from NHS Choices gives the Hertford County Hospital 4.5 stars out of 5.
Mount Vernon Cancer Centre

Mount Vernon Cancer Centre is a highly specialised cancer centre based in Northwood in Middlesex. With a catchment population of almost 2 million the hospital sees over 5,000 new patients each year.

The Cancer Centre is at the forefront with the latest technology available for treatment. Many patients are offered clinical trials for both chemotherapy and radiotherapy treatments.

The chemotherapy suite treats around 150 patients a week, providing systemic anti-cancer therapy using established and cutting edge drug treatments for all cancer types. There are two inpatient wards which have in total 47 beds including 2 high dependency beds. The hospital offers 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.

Although services at the Cancer Centre are managed by the Trust the buildings are owned by Hillingdon Hospitals NHS Trust. This means that significant future developments require the involvement of both organisations. The Trust has produced a redevelopment strategy which outlines the intended provision of services in the future at the Cancer Centre.

Queen Elizabeth II Hospital

The Queen Elizabeth II (QEII) Hospital is located in Welwyn Garden City. It was the first full hospital to be built by the NHS. All inpatient and emergency services were transferred from the QEII by October 2014 to the expanded Lister Hospital in Stevenage.

Since October 2014, the QEII has continued to offer a range of general hospital services for people living and working in many parts of east and south Hertfordshire. These include a full range of outpatient, diagnostic (radiology, pathology and endoscopy), therapy and ante/post-natal services, as well as 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.

The New QEII hospital will open in Spring 2015. At this time services currently running from the current QEII will transfer over.
Lister Hospital

The Lister Hospital is a 620-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.

The Trust also provides sub-regional services based at the Lister Hospital in:

- Urology – including robotic surgery
- Renal dialysis – we are trialing home dialysis machines currently, which will give our patients more choice and flexibility.

Our Changing Hospitals

‘Our Changing Hospitals’ is a major programme of change to services at the Lister and QEII hospitals. Progress around projects in the early phases has been reported in last two quality accounts. 2014/15 has seen progress relating to the final elements of phase 4 with centralisation of services at the Lister site completed in October.

The final phase of the project is in the spring of 2015 when outpatient, urgent care and diagnostic services transfer from the old to the new QEII Hospital.
The phases are summarised in the table below.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Status</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgicentre</td>
<td>✓</td>
<td>Opened September 2011</td>
</tr>
<tr>
<td>Maternity centralisation (includes neonatal services and gynaecology)</td>
<td>✓</td>
<td>Opened October 2011</td>
</tr>
<tr>
<td>Multi-storey car park</td>
<td>✓</td>
<td>Opened September 2011</td>
</tr>
<tr>
<td>Ward 11A refurbishment</td>
<td>✓</td>
<td>Completed October 2011</td>
</tr>
<tr>
<td>Critical care expansion</td>
<td>✓</td>
<td>Completed October 2012</td>
</tr>
<tr>
<td>Mortuary refurbishment</td>
<td>✓</td>
<td>Completed October 2012</td>
</tr>
<tr>
<td>Ward 7A refurbishment</td>
<td>✓</td>
<td>Completed December 2012</td>
</tr>
<tr>
<td>Health records centralisation</td>
<td>✓</td>
<td>Completed Spring 2014</td>
</tr>
<tr>
<td>Chemotherapy expansion</td>
<td>✓</td>
<td>Opened June 2014</td>
</tr>
<tr>
<td>New ward block</td>
<td>✓</td>
<td>Opened August 2014</td>
</tr>
<tr>
<td>Theatres and endoscopy expansion</td>
<td>✓</td>
<td>Completed September 2014</td>
</tr>
<tr>
<td>Emergency Department expansion</td>
<td>✓</td>
<td>Completed October 2014</td>
</tr>
<tr>
<td>Pathology</td>
<td>In progress</td>
<td>Final stages underway</td>
</tr>
</tbody>
</table>

Since April 2014...

- The Health Records Department centralised and thousands of records have been tagged electronically to assist with tracking to ensure they can be found more easily prior to appointments or admissions.
- The Lister MacMillan Chemotherapy Unit opened providing spacious facilities for patients requiring treatment. Its design helps to improve privacy and dignity; offers dedicated space for counselling and has dedicated pharmacy arrangements for the preparation of chemotherapy.
- A reconfigured emergency department opened with increased number of cubicles and resuscitation areas; better facilities for children; an additional CT scanner and a new urgent care centre for the assessment and treatment of minor illnesses and injuries.
- A new fracture clinic, which includes radiology / digital radiology, medical photography and outpatients services was opened.
- A new ward block opened accommodating 62 in-patients – 50% in single ensuite rooms. The ground floor, co-located with the emergency department, houses the Acute Medical Unit for unwell patients referred by GPs and transferred from the emergency department. The first floor is dedicated to coronary care and is co-located with the cardiac catheterisation laboratories and the ambulance entry to the heart attack centre.
- A new theatre block opened comprising endoscopy rooms and a dedicated day surgery unit containing 2 operating theatres and recovery area.

The Trust is a partner in the Transforming Pathology Partnership – a consortia offering pathology services across the region. Many of the pathology services are now undertaken off-site supported by improved access to results by Trust and Community health organisations.

**Engagement**

We systematically capture feedback from stakeholders through a range of methods, including surveys, focus groups and utilizing methods and channels that our patients and the wider public find convenient, including Twitter and Facebook.
The Trust continues to make strong progress on delivering its Engagement Strategy through working with external stakeholders. Community engagement is now well developed. Below is a summary of some of our achievements:

- Delivered a successful AGM attended by over 400 members, partners and staff ~ ‘probably the biggest and best NHS provider AGM in the country’
- Visiting and engaging more GPs, ensuring they get the practical information they need to refer their patients to us
- Promoting our services to a wide range of CCG commissioners and clinicians
- Reaching out to communities, listening to their concerns and providing reassurance that their hospital services are continually improving
- Proactively contribute to strategic partnerships’ delivery projects that enhance our reputation and support our business development priorities
- Delivering an imaginative involvement programme to a growing and more diverse public
- Membership – the involvement of our young members is now national best practice accredited by NHS England. Two examples are given below.

Artwork produced by young people from Stevenage’s John Henry Newman Catholic School is now displayed proudly throughout the Lister’s new emergency department. Over 18 months the young people have produced quality artwork to help the Trust emphasise one of its key themes – namely being part of the local community. The Trusts Head of Engagement David Brewer comments “this project has been a great example of our award-winning approach to youth engagement that has seen young people contribute their ideas and perspectives to hospital projects.”

**SPEAK**

One of the Trust’s young public members, 15-year old Hannah Price, has launched her “SPEAK – It’s a two-way thing” campaign, which has been designed to promote effective communication between hospital staff and young patients.

Staff across the Trust, especially those in frontline clinical roles, are being asked to take a moment to think about Hannah’s message and what it means for hospital services.
## 3d Performance against national requirements

<table>
<thead>
<tr>
<th>Compliance Framework Priorities</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15 YTD</th>
<th>Plan for 14/15</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium Difficile incidence</td>
<td>13</td>
<td>14</td>
<td>12</td>
<td>&lt;=15</td>
<td>✓</td>
</tr>
<tr>
<td>MRSA Bacteraemia</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>×</td>
</tr>
<tr>
<td>31-day second or subsequent treatment (Surgery)*</td>
<td>97.6%</td>
<td>96.8%</td>
<td>94.6%</td>
<td>&gt;=94%</td>
<td>✓</td>
</tr>
<tr>
<td>31-day diagnosis to treatment for all cancers*</td>
<td>97.8%</td>
<td>97.5%</td>
<td>96.8%</td>
<td>&gt;=96%</td>
<td>✓</td>
</tr>
<tr>
<td>31-day second or subsequent treatment (Anti Cancer Drug Treatments)*</td>
<td>99.8%</td>
<td>98.8%</td>
<td>99%</td>
<td>&gt;=98%</td>
<td>✓</td>
</tr>
<tr>
<td>31-day second or subsequent treatment (Radiotherapy Treatments)*</td>
<td>98.8%</td>
<td>97.5%</td>
<td>95.9%</td>
<td>&gt;=94%</td>
<td>✓</td>
</tr>
<tr>
<td>62-day urgent referral to treatment of all cancers*</td>
<td>86%</td>
<td>85.9%</td>
<td>81.4%</td>
<td>&gt;=85%</td>
<td>×</td>
</tr>
<tr>
<td>62-day referral to treatment from screening*</td>
<td>93.2%</td>
<td>92.1%</td>
<td>93.7%</td>
<td>&gt;=90%</td>
<td>✓</td>
</tr>
<tr>
<td>18-week Referral to Treatment (RTT) target for Admitted pathways (95th percentile)*</td>
<td>92.2%</td>
<td>90.8%</td>
<td>88%</td>
<td>&gt;=90%</td>
<td>×</td>
</tr>
<tr>
<td>18-week RTT target for Non-Admitted pathways (95th percentile)</td>
<td>97.1%</td>
<td>96.6%</td>
<td>95.6%</td>
<td>&gt;=95%</td>
<td>✓</td>
</tr>
<tr>
<td>18-week RTT target for patients on incomplete pathways (95th percentile)</td>
<td>94.9%</td>
<td>94.8%</td>
<td>94.2%</td>
<td>&gt;=92%</td>
<td>✓</td>
</tr>
<tr>
<td>All cancers: two week maximum wait from GP referral to first outpatient Attendance*</td>
<td>98.5%</td>
<td>97.8%</td>
<td>97.4%</td>
<td>&gt;=93%</td>
<td>✓</td>
</tr>
<tr>
<td>2 week wait – Breast Symptoms*</td>
<td>96.3%</td>
<td>96.5%</td>
<td>94.4%</td>
<td>&gt;=93%</td>
<td>✓</td>
</tr>
<tr>
<td>Four hour maximum wait in A&amp;E</td>
<td>95.8%</td>
<td>95.7%</td>
<td>92.3%</td>
<td>&gt;=95%</td>
<td>×</td>
</tr>
</tbody>
</table>
Appendix 1 National Staff Survey 2014

Comparison with all acute trusts in 2014

KF1. % feeling satisfied with the quality of work and patient care they are able to deliver
KF2. % agreeing that their role makes a difference to patients
KF6. % receiving job-related training, learning or development in last 12 mths
KF7. % appraised in last 12 mths
KF8. % having well structured appraisals in last 12 mths
KF10. % receiving health and safety training in last 12 mths
*KF11. % suffering work-related stress in last 12 mths
*KF12. % witnessing potentially harmful errors, near misses or incidents in last mth
KF13. % reporting errors, near misses or incidents witnessed in the last mth
KF15. % agreeing that they would feel secure raising concerns about unsafe clinical practice
*KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths
*KF17. % experiencing physical violence from staff in last 12 mths
*KF19. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths
*KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths
*KF20. % feeling pressure in last 3 mths to attend work when feeling unwell
KF21. % reporting good communication between senior management and staff
KF22. % able to contribute towards improvements at work
KF26. % having equality and diversity training in last 12 mths
KF27. % believing the trust provides equal opportunities for career progression or promotion
*KF28. % experiencing discrimination at work in last 12 mths
KF29. % agreeing feedback from patients/service users is used to make informed decisions in their directorate/department

*KF3. Work pressure felt by staff
KF4. Effective team working
KF9. Support from immediate managers
KF14. Fairness and effectiveness of incident reporting procedures
KF23. Staff job satisfaction
KF24. Staff recommendation of the trust as a place to work or receive treatment
KF26. Staff motivation at work
Annexes

Annex 1 Statements from stakeholders

East and North Herts Clinical Commissioning Group’s Response to the Quality Account provided by East and North Hertfordshire Hospitals NHS Trust

East and North Herts CCG (ENHCCG) has reviewed the information provided by East and North Hertfordshire Hospitals NHS Trust (ENHT) and checked the accuracy of the data within it. We believe the information is a true reflection of the Trust’s performance during 2014/15, based on the data submitted during the year as part of the on-going quality monitoring process.

During 2014/15 ENHCCG has worked closely with ENHT, meeting regularly to review progress in relation to quality improvement initiatives.

The Trust has clearly identified within its Quality Account where progress has been made and where further improvements are still needed.

2014/15 has been a significant year for the Trust with a number of key changes as part of the ‘Our Changing Hospital’ programme including the consolidation of inpatient services at the Lister Hospital, the reconfiguration of the emergency department and the centralisation of health records. All of the changes support improved patient outcomes; however despite careful planning the changes did have an impact on both patients and staff; the CCG notes that this has since settled.

We would firstly like to acknowledge the Trust’s performance in relation to the Commissioning for Quality and Innovation (CQUIN) scheme, with the Trust achieving the majority of the 2014/15 schemes. The CCG particularly notes the achievement in relation to diabetes care and the introduction of the acute chest team service. We are pleased to see the commitment to further improve the quality of care provided through the 2015/16 CQUIN scheme.

During 2014/15 ENHT has seen mixed results in relation to achievement of their quality priorities. It is pleasing to see a reduction in falls with harm, and an overall reduction in falls of 7% compared to the previous year. However there has been a slight increase in the number of avoidable pressure ulcers, and ENHCCG would wish to see improvement in this area during 2015/16.

ENHT reported 12 cases of c-difficile during 2014/15; this is within the annual ceiling of 15 cases. 5 MRSA cases were reported, including 3 contaminants. ENHCCG is working with the Trust to improve infection prevention and control issues and expects to see improved performance over the coming year.

ENHCCG acknowledges the work undertaken by ENHT to reduce mortality levels during 2014/15. Whilst the CCG notes the decrease in both crude mortality and HSMR, progress in relation to Summary Hospital-Level Mortality Indicator (SHMI) is disappointing. Focus on action plans and clinical audits will continue through the Mortality Review Group.

ENHCCG notes the actions that have been taken to improve stroke services such as increased consultant and specialist nurse cover, and participation in the regional telemedicine service. However the Trust has failed to achieve a number of key national metrics during 2014/15 including time patients spend on the stroke unit and
access to the stroke unit within 4 hours. ENHCCG expects to see improvements in this important area during 2015/16.

The Trust has received positive feedback via the Friends and Family test during 2014/15, with the Trust consistently scoring equal or above the national average for the proportion of inpatients recommending the service. Whilst the A&E scores are just below the national average there has been a steady improvement since September.

National patient surveys published during 2014/15 include surveys regarding inpatient, emergency department and cancer services. It is positive to see improvements in a number of areas, however there also continues to be areas where the Trust performs below the national average, particularly in the cancer survey. The Trust has clearly identified where improvements are required; the CCG will be monitoring the actions closely over the coming year and will expect to see improvements in this key area of patient experience.

The Trust’s national staff survey showed variable results compared to other acute trusts. It is likely that the significant number of staff consultations has impacted on the staff during 2014/15, and it is pleasing to see that staff development and engagement is a key focus for 2015/16.

The CCG would like to acknowledge the open and transparent approach the Trust takes in all aspects of quality, including the sharing of key data at ward level with the CCG which is exemplary.

ENHCCG supports the Trust’s decision to continue with the same quality priorities as 2014/15 in order that further improvements are made. Additionally the CCG is pleased to see the clear focus regarding improved quality and timeliness of discharge summaries and clinic letters being sent to primary care.

Overall a number of improvements have been made during 2014/15; however ENHCCG wishes to see significant focus and drive to ensure on-going improvements in the quality of services delivered, particularly in relation to mortality, stroke, patient experience, and staff satisfaction during the coming year.

ENHCCG looks forward to working with and supporting ENHT in further developing and monitoring the quality of services it provides for patients. We hope the Trust finds these comments helpful and we look forward to continuous improvement in 2015/16.

Lesley Watts
Chief Executive
East & North Herts CCG
June 2015
Healthwatch Hertfordshire’s response to East and North Hertfordshire NHS Trust (ENHT) Quality Account 2015

Healthwatch Hertfordshire is pleased to submit a response to ENHT’s Quality Account. The Quality Account gives a detailed picture of what the Trust has achieved during the year with the aim to deliver high quality, patient-centred care and where the focus will be in order ‘to be amongst the best’. Healthwatch Hertfordshire fully support the priorities chosen for 2015/16.

No new priorities have been chosen this year as the Trust wants to further consolidate the work it has already undertaken in these areas to see sustained improvements. For example, despite a number of improvement initiatives last year the Trust still struggles to admit patients to the stroke unit within four hours and it is good that this will continue to be a key focus in the coming year.

Information about how improvement will be achieved and the Lead Director responsible is clearly set out in tables and we welcome the method of monitoring performance and taking in the views of patients, their families and public seriously.

Throughout the report it is evident that the Trust knows where it needs to improve. Consolidation and changing teams as well as a surge in emergency admissions has impacted on complaints, administrative processes and staff but the Trust has clearly set out how it will support staff and improve systems. We look forward to seeing this progress.

The Trust has much to be congratulated on. For example having the second lowest incidence of C. Difficile infection in the region, the Trust’s epilepsy service for young people being rated the best performing in the East of England, awards such as ‘Most caring Nurse’ (University of Hertfordshire) and the Sleep Service (Finalist 2014 Innovation Competition) to name a few.

Healthwatch Hertfordshire would also like to congratulate the Trust on a successful and well attended AGM and on the work with young people and schools in the local community.

Healthwatch Hertfordshire welcomes the ‘Our Changing Hospitals’ programme and the progress being made with the challenge it has given. The opening of the new reconfigured emergency department recently has been welcomed by the community.

Healthwatch Hertfordshire values its relationship with ENHT and looks forward to having further involvement in 2015/16 to support improvements in patient experience and to the services expansion programme.

Michael Downing, Chairman Healthwatch Hertfordshire, May 2015
Chairman
Health Scrutiny Committee

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Dear Colleague

Unfortunately, due to purdah and Health Scrutiny Committee hosting the Budget café, the committee is unable to provide the resource needed to respond to the Quality Account. Despite this, regular communication between the Health Scrutiny Committee and the Trust over the past 12 months leaves us confident of continued support for the scrutiny process. The committee anticipates working with the Trust on future Quality Accounts.

Yours sincerely

[Signature]

Seamus Quilty
Chair, Health Scrutiny Committee
Annex 2 Statement from auditors

Independent Auditor’s Limited Assurance Report to the Directors of East and North Hertfordshire NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of East and North Hertfordshire NHS Trust’s Quality Account for the year ended 31 March 2015 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- percentage of patient incidents resulting in severe harm or death on page 48
- percentage of patients risk assessed for venous thromboembolism (VTE) on page 47

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of directors and auditors
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

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

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 (“the Guidance”); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.
We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated June 2015;
- feedback from Local Healthwatch dated May 2015;
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated March 2015;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 2014;
- the latest national staff survey dated 2014;
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated 27 May 2015;
- the annual governance statement dated 27 May 2015; and

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of East and North Hertfordshire NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and East and North Hertfordshire NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.
Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East and North Hertfordshire NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton House, Melton Street, Euston, London, NW1 2EP

19 June 2015
Annex 3 Statement by the Directors

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011) and the National Health Service (Quality Accounts) Amendment Regulations 2012.

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

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

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.
By order of the Board

24 June 15 .................................................. Chair

24 May 15 .................................................. Chief Executive