East and North Hertfordshire NHS Trust

Quality Account

2019-20

PART 1

1.1 How we are accountable for quality

From September 2018, East and North Hertfordshire NHS Trust have created a holistic approach to align quality across our clinical and non-clinical services. The clinical strategy provides an overarching framework underpinned by five key strategic priorities; one of which is quality.

Clinical strategy (2019-24)

A five year strategy, developed through clinical, staff and public engagement during 2018 defines the organisation's vision to be *"Proud to deliver high quality, compassionate care to our community".*

The strategic priority for quality and its guiding principles are shown in the two boxes below. Details of how the strategic priority will be delivered are outlined within our Quality Strategy.

Strategic Priority: Deliver high quality care consistently across all of our services in terms of clinical quality, safety and compassion.

Therefore, guiding principles for the clinical strategy have included:

- We will deliver consistently high quality, safe, patient-centered care across all our services, 7 days a week
- Our services will be underpinned by a culture of continuous quality improvement and learning
- We will standardise clinical pathways and eliminate unwarranted clinical variation, ensuring that every patient receives the most appropriate care for their condition

The cultural commitment, agreed by the board in 2018/19, clarifies the desired leadership behaviours to support the delivery of the clinical strategy.

Cultural commitment
Quality and compassion are at the centre of how we behave and act
Staff are proud of the care they deliver
Our roles and purpose are clear
Feedback to staff and services is a continuous process
Our Trust and leadership values are visible through our choices, actions & behaviours
Staff are empowered to deliver and improve performance in all areas
The development of staff is the responsibility of us all as we work to nurture talent
Challenge and speaking up are welcomed in a safe and supportive climate

Quality Strategy (2019-2024)

The quality strategy aims to improve our quality management systems by approaching quality with a more holistic view that includes: quality planning, quality assurance and quality improvement.

This strategy guides our staff to work safely, by giving them the skills and authority to make changes that drive continuous improvement for our patients. The strategy supports our Trust 'pivot' values by:

- Putting **p**atients first, through patient co-design and innovation of quality improvements plans
- Striving for continuous **i**mprovement and continually learning that becomes integral in everything we do
- **V**aluing everybody through providing robust governance and improvement frameworks that celebrate excellence
- Being **o**pen and honest with candid, supportive skills that ensure fair balance of accountability and kindness
- Recognising the importance of **t**eamwork is the core fundamental ingredient to any efforts of improving quality of what we do

Key objectives of the Quality Strategy include:

To understand where variation exists and uses data to proactively drive improvement by reducing the 'unwarranted variation'. Aiming to enable staff to develop anlaytical capabilites, and access to real-time data from ward to board.

To foster a culture where staff can generate ideas, lead improvement efforts, feel valued and confident to influence the care they deliver. Continuously striving to understand the experiences, wisdom, ideas and creativity of others.

To enable our people with skills and knowledge that strengthens their craftsmanship and expertise to execute their work well; supporting the practical application of quality improvement theory.

To prioritise and understand what matters to staff, patients and carers who experience our organisation. Supporting staff to move the focus with patients and carers from 'what is the matter' towards understanding 'what matters to you'?

Four key quality pillars have been identified to provide a structure in which to focus our efforts of continuous improvement. These are:

1. Valuing the basics
2. Patient & carer experience
3. Keeping our patients safe
4. Quality governance

Each pillar has an annual quality measurement plan against which to measure ourselves.

Quality Pillars	
Pillar	**Workstream**
Valuing the basics	• Harm Free Care Collaborative – falls, tissue viability (pressure ulcers), medication errors, hospital acquired infections, hospital associated thrombosis, urinary tract infections • Infection prevention and control • Safeguarding our most vulnerable patients • Medical devices and use of equipment

Quality Pillars	
Pillar	**Workstream**
Quality governance and risks	• Strengthen systems to support audit and effectiveness • Triangulate learning from patient feedback, claims and incidents • Imbed robust Serious Incident Review panels • Improve how we disseminate learning from safety incidents • Improve how we routinely learn from things that go well • Ensure quality is given agenda space at meetings at all levels of the organisation • Risk management processes that support the identification, management and tracking of identified risk from ward to board
Keeping our patients safe	• Reliable clinical harm reviews • Improving staff experience, especially during safety incidents • Reduce unwanted variation – safer invasive procedures, Getting it right first time (GIRFT), documentation standards • Deteriorating patients (SHMI) • Sepsis • Learning from deaths • Maternity and our new-borns
Patient & carer experience	• Responsiveness to complaints • Patient feedback locally • Reliability to deliver our 'Carers pathway' • Promote volunteers as fully integrated team members • End of Life care

1.2 Statement from the Chief Executive

2019/20 has been a year of building upon the foundations established by the development of the Clinical and Quality Strategies. Aligning the quality strategy with the priorities set within the quality account has provided a coordinated framework for delivering our intentions for continuous quality improvement.

A key priority is quality improvement "where it matters" to staff and our patients. I am delighted by the appointment of a dedicated quality improvement (QI) team and the development of a QI programme to coach staff in delivering improvements in their wards and departments. Examples of the QI work are given within the report.

The components of quality in healthcare are safety, effectiveness and experiences. We are seeing continuous improvements in these components to varying degrees. Whilst we are achieving our intentions in some areas such as reducing medication errors, improving mortality and maintaining standards around patient satisfaction there are other areas where further improvements are required. These include earlier interventions around sepsis care, provision of seven day service standards and greater involvement of patients and families in our service developments. We will continue to monitor progress through the quality account monitoring process. The year has seen strong developments in information management. Data is more easily visible on the trust-wide intranet and improvements in knowledge and techniques on how to gather and record data is enabling improved monitoring of quality initiatives so we can better track the effectiveness of our improvement initiatives.

Our most recent Care Quality Commission (CQC) inspection report published in December 2019 showed improvement in most areas. The trust retained its Good rating for caring, and

improved its rating for effectiveness from Requires Improvement to Good. The CQC report recognises the ongoing improvement work; further details are described within this report.

Towards the end of 2019/20 the effects of the COVID-19 pandemic began to affect all of our services. Staff were involved in redesigning services and taking on new roles to facilitate the safe management of patients with and without the virus. I cannot emphasise enough how proud I am of our staff who worked tirelessly, compassionately, and as one united team to care for our patients. Staff demonstrated incredible resilience, flexibility, and innovation. During this time some of the quality initiatives were put on hold; but this was important to focus efforts on managing the situation we faced to maximise staff safety and patient care.

In 2020/21 and beyond we recognise that hospital services will be different. We will continue to work with our staff and partners to develop different ways of working – so we can be flexible to deliver planned services as well as meet the needs of those requiring emergency care. The uncertainty of COVID-19 requires this flexibility. New ways of working offers an opportunity to improve quality by re-designing services in ways that deliver what matters most to staff and patients.

I would like thank all of our staff for their continued hard work, commitment and professionalism whilst caring for our community. Their dedication to continued high-quality, compassionate care has been outstanding.

This report describes just some of their achievements. To the best of my knowledge the information in this document is accurate.

Nick Carver, Chief Executive

PART 2

2.1 Priorities for improvement

Priority One: Build ENHT Quality Improvement Capability & Capacity

Reason: Adoption of quality improvement to become an integral part of everything we do requires an infrastructure that supports all staff.

Monitoring: Quality & Safety Committee

Reporting: Scheduled update to Quality & Safety Committee

Responsible Directors: Director of Nursing and Patient Experience

Theme	Measure	18/19	19/20	20/21
1.1 Clinical and Non-Clinical staff are offered opportunities to gain knowledge on Quality Improvement theory.	Quality Improvement for all Theory & Practitioner level	N/A	Ascertain organisational readiness and set trajectory	QI introductory session for all staff on induction to the trust. Adopt patient and carer experience information to focus 'what matters to you' design to training.
	Quality Improvement for Leaders	Approx. 60	Ascertain organisational spread and set trajectory.	Align continuous quality improvement leadership through: • Patient safety • Patient Experience • Clinical Leadership Programme priorities
	Organisational wide quality learning events	N/A	Minimum one summer and one winter event.	Deploy 'virtual' summer celebration with assistance of Organisation Development (OD) and communications teams
	Measurement masterclass sessions	N/A	Deliver approx. 1 per quarter	Offer 1 virtual masterclass
1.2 Staff are supported to practically apply Quality Improvement knowledge through QI coaching.	Establish 'quality clinics' that will empower all staff to discuss quality, scope new ideas and think how they could work differently.	N/A	Deliver approx. 1 per month	Offer a virtual clinic every week with a QI coach to explore a QI idea
	Agree and	N/A	Ascertain	Train all of band 7's and

Theme	Measure	18/19	19/20	20/21
	deliver curriculum for Quality Improvement coaches		organisational readiness and set trajectory	8's from the patient experience team to this level exploring the use of virtual training and coaching them while they run a project
	Recruit to Quality Improvement Team	N/A	AIM: 4 WTE posts dedicated to QI capability building	N/A Action complete
1.3 Deliver organisational wide structured Quality Improvement continuous learning programme	Adopt 'Patient Safety Breakthrough Series Collaborative'	N/A	Successfully recruit approx. 10-15 improvement teams who contributing over 18 month programme.	Look at lessons learned from SIM teaching and COVID response and offer a virtual breakthrough series to build on this.
1.4 Clinical Excellence Framework	Design and imbed ENHT Exemplar ward programme	N/A	Following published accreditation criteria, all adult in patient areas shall have undertaken accreditation assessment.	Scale and spread quality improvement plans to drive continuous improvement across pathway pillars
1.5 Adopt a framework that reflects and values patient co-design	Patient co-design faculty shall be established	N/A	N/A	Following a 'what matters to you' model ENH QI & Engagement team shall continue to build new ways of working that promote meaningful patient involvement though continuous quality improvement plans

From September 2019 the Quality Improvement (QI) team have successfully been recruited and started. This consists of:

- Head of Quality Improvement: Tracey van Wyk
- Quality Improvement Coach: Ruth Bradford
- Quality Improvement Coach: Bianca Viegas
- Quality Improvement data analyst (supported through HEE): Karan Jhajj
- Quality Improvement coordinator: Claire Batchelor

The team objectives are to help ascertain organisational readiness for system wide quality improvement, which will include working with wider ENHT key stakeholders (Education & Organisation Development teams, Patient Safety team, Clinical Audit team, Divisional Quality teams, Information team, Business & strategy teams, Human Resources Business Partners, Project Management teams) as well as engage clinical and non-clinical workforce groups.

1.1 Clinical and Non-Clinical staff are offered opportunities to gain knowledge on Quality Improvement theory

Early information gathering has been undertaken by the QI team to understand how to enable clinical and non-clinical staff with the right skills, at the right time, to help drive continuous quality improvement.

Aligning with the wider Trust education review, the objective is to seek an understanding of how QI thinking and methodology is incorporated into existing education approaches. The aim is to establish an organisation-wide approach whereby elements of QI are embedded into all training.

Historically there has been structured QI training delivered to staff by the Patient Safety and Organisational Development leadership team. This has also incorporated project management tools and skills.

A recent analysis has been undertaken to review the effectiveness of this QI training. Staff who attended the last 3 cohorts of training have been contacted and asked some key questions:

Question	Answer
To rate the 2 day QI training between 1-10 (least to very effective)	Scored between 8-9 mostly
How useful was the training?	Inspiring, useful, too long, unclear about day 2, would be useful to have more skills in *how* to run the project

Have you applied the skills in practice i.e. started a QI Project	37% said 'Yes' 63% said 'No' For those who said no, time/resources constraints or unable to engage stakeholders were cited as the most common reason
How far have you come along with the project?	For those who said yes it is unclear and details were lacking of how skills had been applied successfully
Did you get any help after attending the course or how could we help further?	All said 'No' Request for adhoc and ongoing support and feedback were made from 50% of respondents.

General awareness-raising of adopting a quality improvement approach has been started through Trust quality huddles, Friday @ 8, visiting wards, visiting key stakeholders, joining existing team and committee meetings. Current plans include:

- Ongoing collaborative working between the OD and QI teams to review training plans and appropriate 'QI offer'. This work takes account of what is offered by the project management office, human factors training and leadership training and considers a tiered approach to all, depending upon an individual's role in the organisation. This will result in a new suite of training packages and ongoing support in the form of clinics or a hub for staff to access. It was intended that the training packages were developed by April 2020. Given the Covid-19 pandemic these training packages are likely to be designed and tested in June 2020

- Designing a Quality Improvement Science in depth session for key leaders of Quality across the trust. These targeted sessions will help to build theory and QI coaching capability as a priority with key stakeholders such as quality managers, senior nurses, and medical clinical leads involved in current quality improvement work.

- Supporting the design of our 'ENH Improvement Task & Finish group', which is now exploring what key principles and skills are needed for sustainable models of improvement, across the wider health care systems.

- A quality and safety learning event was held over a day in June 2019 where staff presented the achievements of their teams. The event was attended by 258 members of staff.

Topics throughout the day included:

Enjoying work…..Quality improvement for all
Patient safety incident reporting
'Proud to improve our environment'
Improving quality through human factors in health care
Quality & safety dashboard
Equality and diversity
Clinical audit to quality improvement
Safer medication
Learning form deaths & introduction of the Medical Examiner
Litigation overview and duty of candour
National safety standard for invasive procedures (NatSSIP) – what is the ask?
Celebrating excellence – ENHT Framework

The Trust was honoured to welcome Dr Suzette Woodward, Senior Advisor for the Department of Health and Social Care, who gave the keynote address entitled 'working safely…what do we mean?' This address focused on civility and respect.

- The Measurement masterclass will be completed in 2020 using a virtual platform, in combination with the digital team, to improve the capability of our staff to understand data from improvement.

1.2 Staff are supported to practically apply Quality Improvement knowledge through QI coaching

Current steps to support staff to practically apply Quality Improvement knowledge are applied through the 'QI coaching' model. In essence this means:

- Staff engagement starts with a 'what matters to you' conversation and helping staff look at variation in their data
- Agreeing consensus that QI approach is appropriate and progress to set up a coaching contract with identified project leads
- Assessing the team's likelihood of success for QI or the project leads self-assessment of their current QI abilities
- Setting ground rules and check in to build team cohesion, ensuring multidisciplinary team (MDT) approach
- Helping teams understand their aim, measures and tests of change they plan to carry out. Helping them track their progress over time through a validated QI project scoring tool.

Identified enablers:

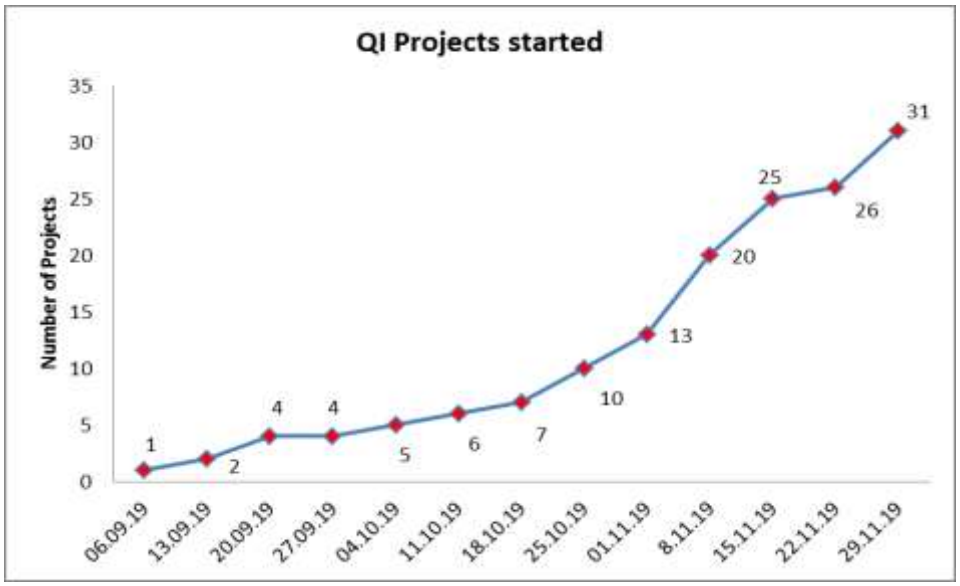
- Good sources of data to help understand problems
- Enthusiastic and motivated leads who are keen to see change

Identified barriers:

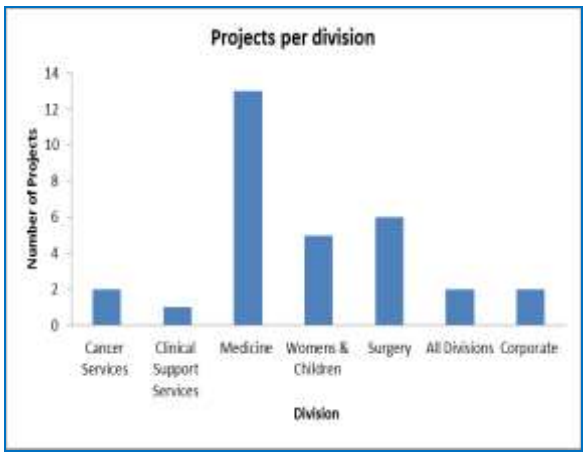
- Staff finding time/ capacity a challenge
- Cultural norms of 'uni-disciplinary' thinking rather than MDT involvement, therefore missing engagement with the right people
- Teams often focus on the problems with process. However the issues often appear to be human factors and the 'non-technical' skills required to deliver high quality care.

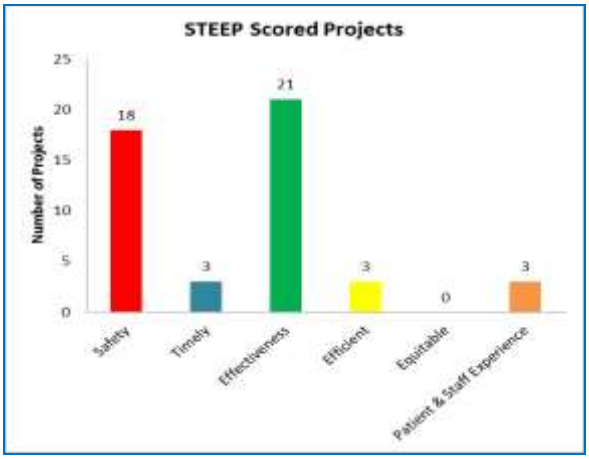
- Establish 'quality clinics' that will empower all staff to discuss quality, scope new ideas and think how they could work differently. These will restart virtually in June 2020. The projects will be triaged and support offered depending on the level of support already available within their divisions. All participants will be signposted to the next steps to encourage a culture of continuous learning.

- Agree and deliver curriculum for Quality Improvement coaches and a timescale for starting a virtual coaching programme. The number of supported QI projects are given in the chart below, showing a rise since the recruitment of the QI team.

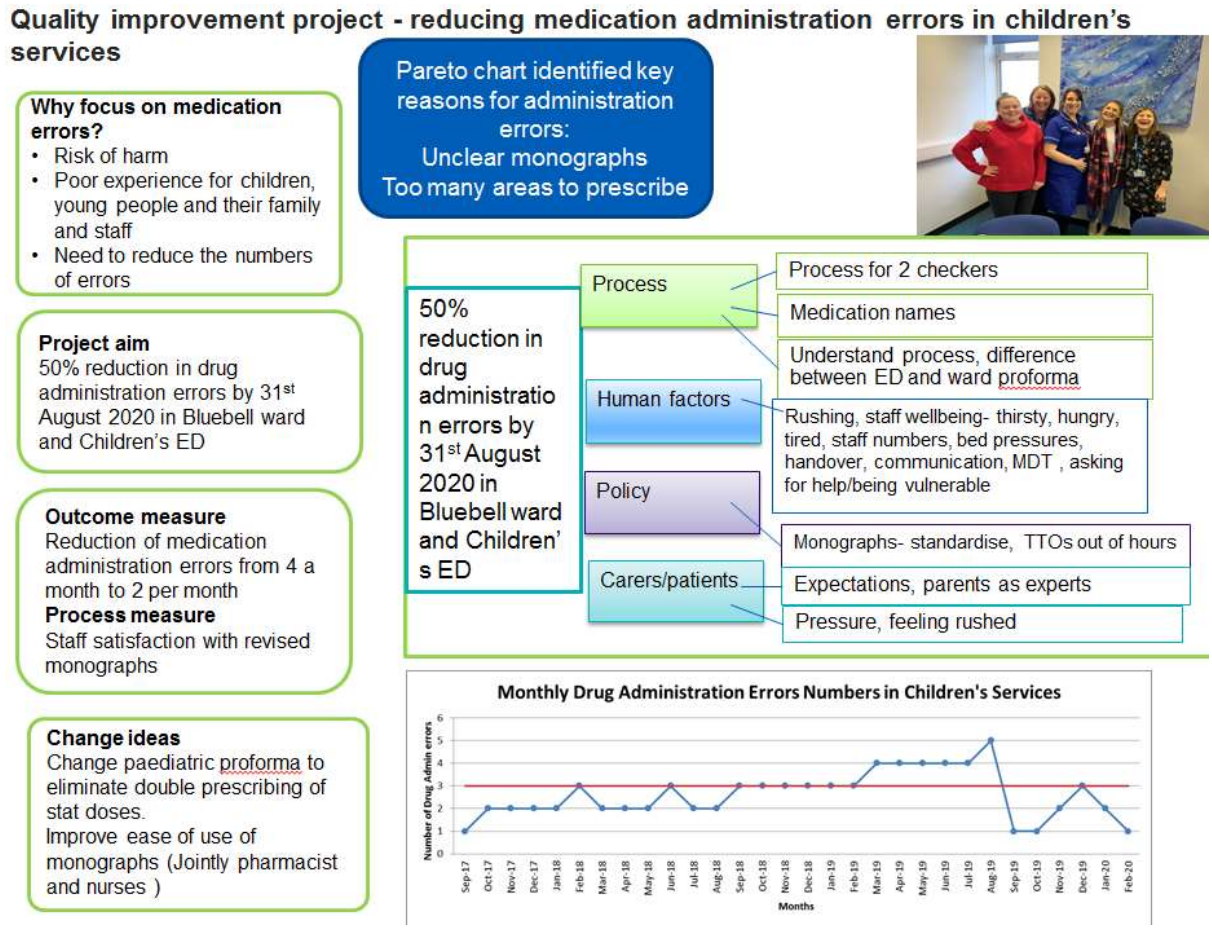


The number of projects per division is given below, together with details of the number of projects aligned with STEEP.





STEEP represents safety, timely, effectiveness, efficient, equitable and patient / staff experience. Such an approach provides a method of indicating how the components of quality ie safety, effectiveness and experiences are reflected within the projects.

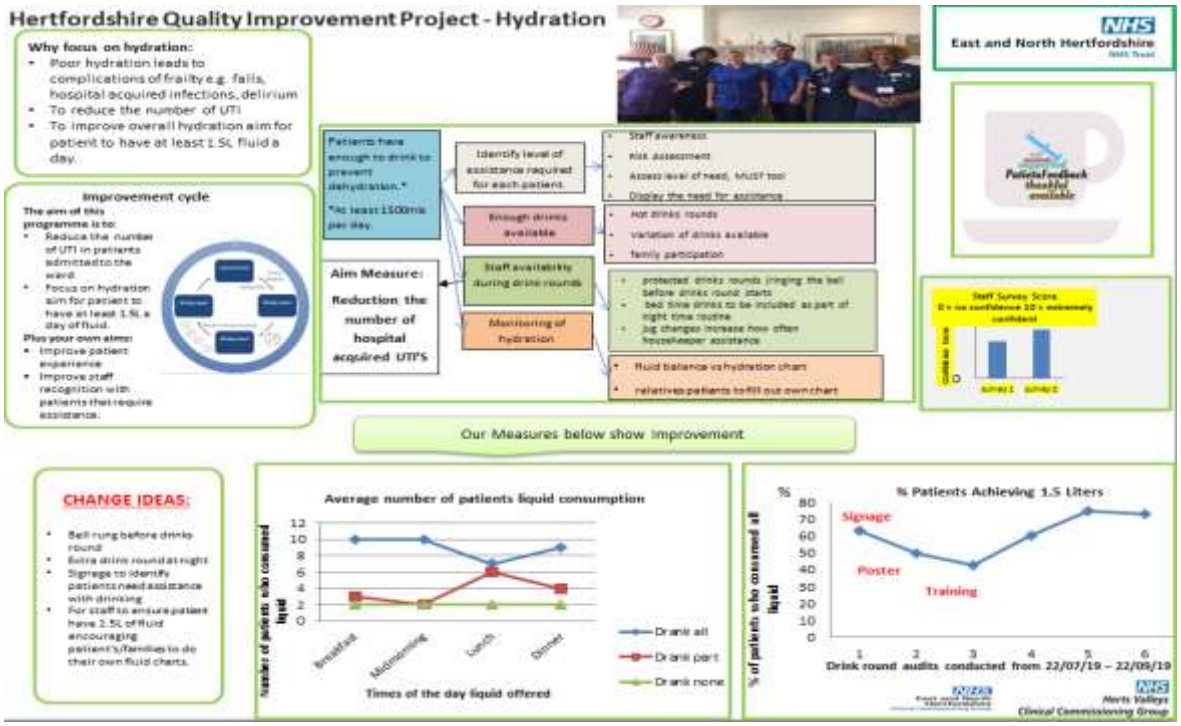


NHS Improvement

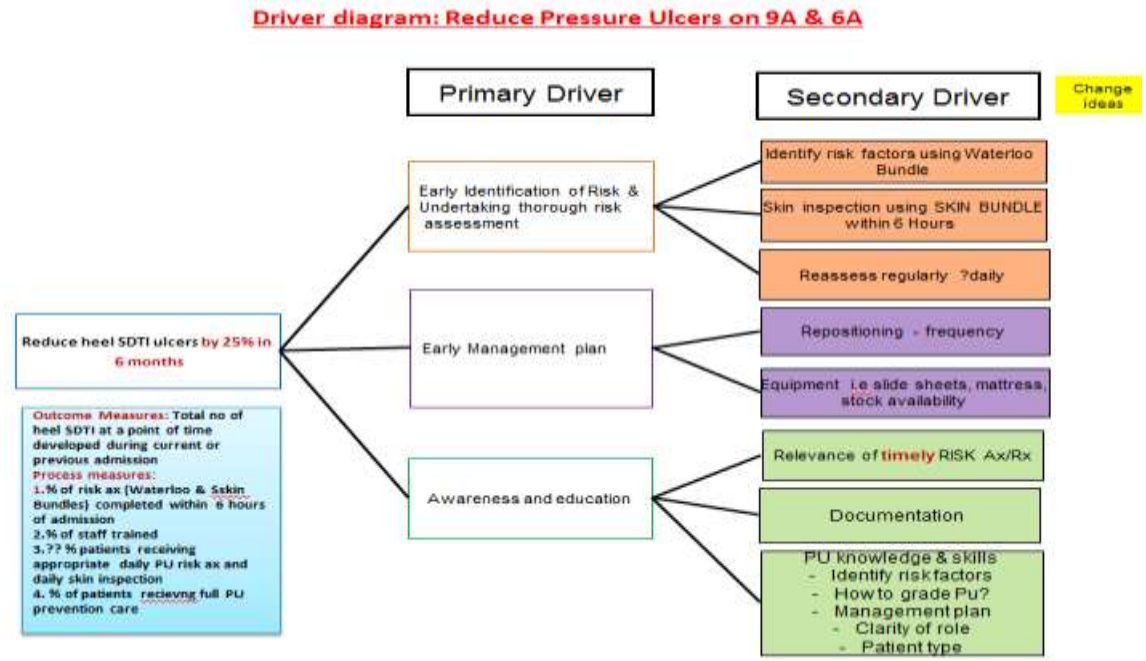
Some clinical teams are participating in a national improvement collaborative. These teams are supported locally through quality improvement coaching on a weekly basis.

Examples of the projects are given below which include the projects to improve hydration and reduce pressure ulcers.

Hertfordshire QI hydration project



National pressure ulcer quality improvement collaborative



1.3 Deliver organisational wide structured Quality Improvement continuous learning programme

- Plans have been agreed with Executives and Divisional leads to embark on a trust Deteriorating Patient Breakthrough series collaborative. This is an 18 month structured programme to improve the recognition and management of deteriorating patients. This

programme enables multiple clinical teams with the skills, knowledge and supported ward based coaching to drive continuous improvements. The first learning event was arranged but had to be postponed until 20/21 due to changing circumstances resulting from the Covid-19 pandemic. It is possible that a shortened version of the programme will be offered in the future.

- In August 2019 the trust partnered with the Royal College of Nursing to deliver a 12 month Clinical Leadership Programme to support our first cohort of 20 ward leaders develop leadership and quality improvement skills through delivery of a QI project over the 12 month period.

The aims of the programme are to:

- Develop an individual's clinical leadership skills through coaching and leading change.
- Manage the process of change in the clinical environment impacting on patient safety, practice, compassion or care.
- Ensure the clinical leader is seen as working within a team, in an organisation, influenced by and influencing local and national policy.

There are 6 in-depth classroom sessions throughout the 12 months with a focus on patient experience, capturing data, theories of leadership, financial value to quality, staff experience, compassionate leadership, understanding team and individual behaviours.

The ward leaders are also supported through structured group 'action learning sets' and practical 'QI coaching' in the clinical areas.

Group	Ward	GROUP Facilitators	Quality Improvement coach
1	7B Surgical AMU Green 6B Renal medical 9B Care of Elderly OPD MVCC Dacre Ward Antenatal 8B Surgical	Steve Andrews & Fiona Culley	Tracey Van Wyk
2	Children's Day services LMCC (Cancer Care) 10B Diabetes and Endocrine Gloucester Ward Ashwell Medical 5B Surgical Emergency Dept	Carrie Kirby & Connie Chambers	Ruth Bradford
3	10/11 MVCC (Cancer Care) Swift Surgical Surgical Assessment Unit 10A Gynaecology 5A Surgical Ambulatory Care Centre	Margaret Mary Devaney & Tracey Van Wyk	Bianca Viegas

Due to Covid-19 the project was placed on hold and it is presently unclear when this will resume as the original configuration of wards, divisions and leadership has changed in response to pandemic planning. Topics may need to be reviewed when the work restarts.

Safer Invasive Procedures Launch (October 2019)

In October 2019 over 30 people, covering 15 specialties, attended the trust launch of the Safer Invasive Procedures programme.

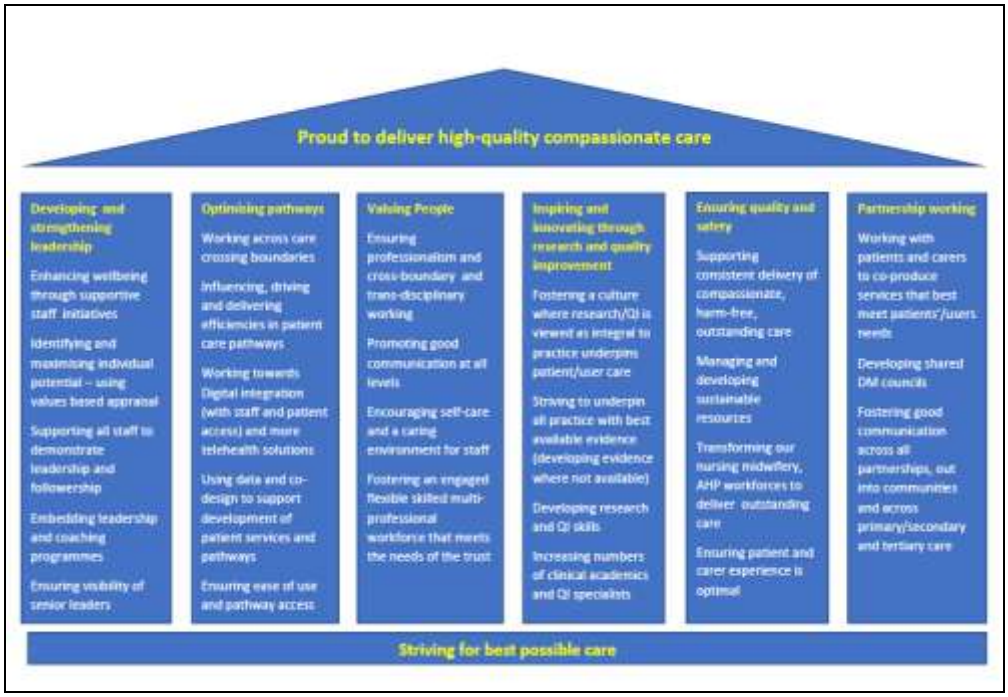
At the event staff:

- Shared data and learning from national and local never events
- Heard an inspirational story from a consutant involved in a never event
- Explored how quality improvements tools enable changes
- Heard how human factors, such as situaiton awareness and teamwork, are key to working safely
- Were introduced to a draft audit tool and explored adopting data for improvement

The event was attended by many specialities such as theatres, cardiology, respiratory, plastics, dermatology, endoscopy, radiology, critical care and renal services. Work will continue throughout 2020/21.

1.4 Clinical Excellence Accreditation Framework

The Trust's Clinical Excellence Accreditation Framework (CEAF) brings together key measures of nursing and clinical care to enable a comprehensive assessment of the quality of patient safety and patient experience at ward/unit level. The CEAF supports delivery of the Trust's Nursing, Midwifery and Allied Health Professionals Strategy 2019-24 and focuses on 6 pillars:



Teams are supported by our Quality Improvement Matrons to undertake a comprehensive self-assessment and are then reviewed by a core assessment team comprising senior leaders. Teams strive for improvement through four levels of accreditation – bronze, silver, gold and platinum.

The CEAF supports a culture which develops and strengthens leadership, recognises and rewards success and strives for continuous improvement. Staff engagement is critical to the success of the CEAF, including investment in shared decision making councils.

Progress with CEAF:	
June 2019	Development of Trust guidelines for ENHT Clinical Excellence Accreditation Framework
June/July 2019	Development and testing of CEAF metrics
July 2019	Presentation to Quality and Safety Committee with ward managers
July 2019	Development of self-assessment reporting template
August/September 2019	Cohort 1 (Swift Ward, 6B, 8B, 10B) undertake self-assessment
October 2019	Review of Cohort 1 wards by core assessment team
October/November 2019	'Time to Shine' leadership discussions for Cohort 1 followed by final review and decision by credentialing panel.
October 2019	Cohort 2 (AMU Green, 5B, Gloucester, NICU) to commence self-assessment
October 2019	Develop plan for Trust-wide roll-out
Feb 2020	Scoring matrix established linked with levels of accreditation
Feb 2020	Cohort 3 (5A, 8A, Bluebell, 9A, Ashwell, 11A) undertaking self-assessments

Priority two: Keeping our patients safe

Reason: These are quality goals within the Quality Strategy (2019-2024).

Monitoring: Medication Forum, Harm Free Care Group, Deteriorating Patient Group, Safer Surgery Collaborative, Patient Safety Committee and Safeguarding Board.

Reporting: Scheduled updates to the Quality & Safety Committee

Responsible Directors: Director of Nursing & Medical Director

	Theme	Measure	19/20	20/21
2.1	Medication management	Omissions of critical medications	<5%	<4%
		Medicines optimisation framework score (max 168)	135	135
		Antimicrobial stewardship	>90%	>90%
		Electronic prescribing / administration	-	Launch
2.2	Sepsis pathway compliance	Screening for sepsis in ED	>97%	>97%
		Neutropenic sepsis door to needle time	>80%	>80%
		Antibiotics in ED within an hour	>90%	>90%
		Antibiotics on the ward within an hour	>90%	>90%
2.3	Safer Invasive Procedure Standards	Phased approach to developing and imbedding Local Standards for Invasive Procedures	>95%	LocSSIPS for 80% of invasive procedures
2.4	Deteriorating patient	Reduce rate of cardiac arrests	<0.8%	<0.8%
		Audit of compliance with timely observations	> 95% reliability all observations	Variable
		Launch escalation module and develop a means of monitoring the escalations	Launch	Launch
2.5	Safeguarding adults and children	Ensuring reduction of harm of patients with known learning disability	Ascertain baseline data and set trajectory	Triangulate incidents, complaints & mortality data
2.6	VTE risk assessment	Improved compliance with VTE risk assessment part 1 and part 2	>95%	>95%

*Baseline will be the 2018/19 data once measurement ability becomes available

2.1 Medication management

	Aim	Achieved
Omissions of critical medications	<5%	<5%
Medicines optimisation framework score (max 168)	135	123
Antimicrobial stewardship	>90%	91.5%

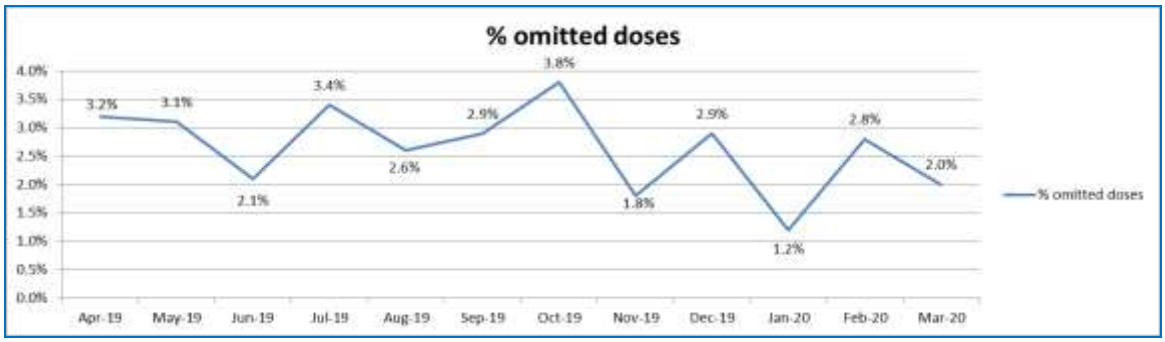
The data below are captured through monthly observation audits by the pharmacy team. There is a monthly audit of 10 patients' charts on every ward.

Omissions of critical medications

The critical medication omission numerator is the number of doses of critical medicines that have been delayed (>2h) or omitted in the previous 24h.

The denominator is the total number of doses of critical medications prescribed in the previous 24h.

The aim for the trust is to achieve < 5% omissions of critical medications that should not be missed or given late.



The aim was achieved throughout the year so in 2020/21 a more challenging aim has been set. Reducing the incidences of critical medication delays remains a priority for continuous improvement.

The Trust's Medicines Optimisation Strategy for 2019 – 2022 has been developed using the NHS Improvement, Hospital Pharmacy and Medicines Optimisation Assessment Framework.

The purpose of the Medicines Optimisation Framework is to help NHS Trusts review their approach to medicines optimisation and pharmaceutical services. In addition, the outcome will be used by NHS Improvement to provide an assessment of the extent and quality of services provided by NHS Trusts as a focus for developmental support.

The framework establishes a baseline assessment of current approach and practices; identifies areas of existing good practice but also areas for development and provides assurance on medicines optimisation and pharmaceutical services. The core domains and criteria used in the framework draw on a wide variety of sources. These include standards and guidance published by the Department of Health and Social Care, National Patient Safety Agency (now part of NHS Improvement), Care Quality Commission, NHS Litigation Authority, the Audit commission and the Royal Pharmaceutical Society (RPS).

The outcome of the baseline assessment was an achievement score of 115 out of a maximum score of 168. The Trust strategy is to improve our score over the next three years to be comparable with the highest achieving Trusts. The Medicines Optimisation Framework was reviewed in November 2019 and the achievement score has increased from 115 to 123.

Progress has been made in the following areas:

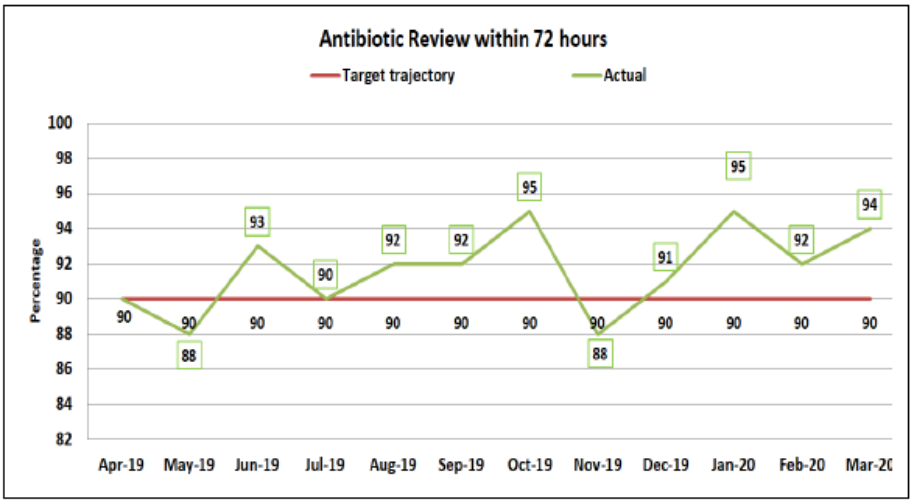
- The Hospital Pharmacy Transformation Plan (Ward Based Pharmacy) has demonstrated increases in the number of medicines reconciliation completed at ward level and the number of 'to take out' (TTO) medications prescribed by pharmacists.
- A Therapeutics Policy Committee biannual report was presented to the Clinical Effectiveness Committee in September 2019.

- A Medication Forum biannual report was presented to the Quality and Safety Committee in July 2019.
- The Medicines Optimisation key performance indicators (KPIs) on Qlikview have been presented at Divisional Accountability Review Meetings, the Nursing Quality Huddle, Medication Forum and Pharmacy Rolling Half Day.
- The Medical Director and the Director of Nursing receive a biweekly report on Medication Safety and Security from the Pharmacy and Senior Nurse Executive Walk Around.
- Pharmacy reports quarterly to Medicine and Surgery on their drug spend and top 50 drugs.
- The Trust has a register of Patient Group Directions and all the PGDs are in date.
- Electronic Prescribing and Medicines Administration system (EPMA) - the Lorenzo Investment Case (LIC) and Benefits case has been approved by NHS-Digital. A pilot of the system commenced on one ward in February, with a plan for roll-out once system feedback had been received and addressed. The plan was placed on hold as a result of the covid-19 pandemic

Antimicrobial stewardship

Antimicrobial stewardship is a coordinated program to promote the appropriate use of antimicrobials (including antibiotics) to improve patient outcomes and reduce resistance in the long term. Reviewing antibiotic usage helps to ensure they are used optimally – long enough to be effective; yet not too long to develop resistance.

The aim is to achieve >90% compliance with good governance of antibiotic stewardship. The graph below demonstrates the results of a monthly audit and shows reliability of undertaking a clinical review of medications within 72 hours. Complliance was achieved during ten months of the year.



The annual Antimicrobial Point Prevalence Audit was carried out at Lister Hospital with the aim of assessing the appropriateness of antimicrobial prescribing for inpatients according to the principles of ‘Start Smart - Then Focus’.

The audit data collection was carried in November 2019 and a total of 469 patients from all divisions were audited.

The Trust only met standard one out of the six audit standards, referring to 92% of antimicrobial prescriptions complying with the Trust's guidelines. Despite not achieving the other five standards there were improvements compared to last year:

- Stop/review date on drug chart increased by 13.2% to 53.4%
- 24-72 hours review increased by 14.6% to 80.4%
- 6.4% fewer antimicrobials were prescribed compared to last year

There two areas where performance worsened compared to the previous year:

- 'Stop/review date in medical notes' fell by 29.4% to 56.6%
- Indication in notes and drug chart fell by 4.7% and 6.4% respectively

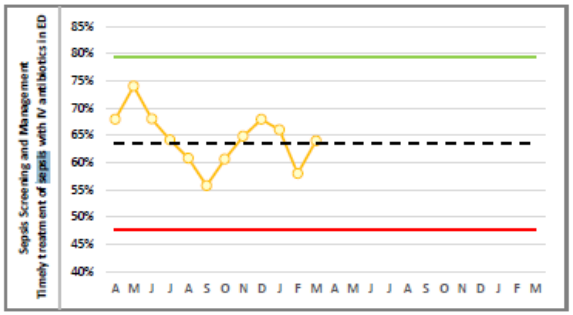
In summary, this audit has found that despite progress being made in several areas, there is room for improvement.

2.2 Sepsis pathway compliance

	Aim	Achieved
Screening for sepsis in Emergency Department (ED)	> 97%	64%
Antibiotics in ED within an hour	> 90%	76%
Antibiotics on the ward within an hour	> 90%	31%
Neutropenic sepsis door to needle time	> 80%	74%

Emergency Department Sepsis Care

Compliance figures have been variable throughout the year for screening and delivery of antibiotics within the hour. Timely screening has been achieved on average 64% of occasions.



The data in the middle row of the table below shows a varying trend of timely antibiotic administration within 1 hour of suspected diagnosis; achieving an average of 76% compliance.

Domain	Metric	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Sepsis Screening and Management	Emergency attendances with Sepsis - sample size	50	23	19	17	33	22	15	12	18	19	59	65	41
	Emergency attendances receiving IVABs within 1 hour of Red Flag	90%	100%	84%	88%	88%	86%	73%	67%	72%	79%	68%	86%	78%
	Sepsis six bundle compliance - ED	90%	tbc	tbc	tbc	48%	68%	40%	17%	22%	74%	14%	14%	29%

During 2019/20 the Trust aimed to audit 50 sets of patient records per quarter focusing on the six elements of the sepsis bundle:

- Administration of IV antibiotics
- Serum lactate measurement
- Accurate Fluid Balance chart
- Sample for blood culture
- Administration of IV fluid challenge
- Administration of 02 therapy

Compliance with all six elements of the bundles has varied from 14% per month to 73% (3rd row in the table above)

Themes identified for continuous improvement include:

- Improving recognition and awareness to clinical signs of new confusion / change in mental state through use of NEWS2 score.
- Improving urine output/fluid balance monitoring at the time of admission/deterioration. The ED team has commenced improvement sessions on these two elements
- Improving timeliness of cannulation (providing access to a vein to deliver antibiotics into the bloodstream)
- Requirement for timely blood cultures
- Early confirmation of the optimum antibiotic, taking account of allergies
- Improving practices around blood sampling as the blood gas machine does not always print out lactate results when blood samples have clotted resulting in delays in obtaining diagnostic information

In patient sepsis care

The data below shows an average compliance of 31% timely administration of IV antibiotics in in-patient settings against an aim of 90%

Domain	Metric	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Sepsis Screening and Management	Inpatients with Sepsis - sample size	50	27	21	19	10	10	6	5	4	10	12	21	9
	Inpatients receiving IVABs within 1 hour of Red Flag	90%	48%	48%	0%	40%	40%	17%	40%	50%	50%	25%	25%	33%

Themes identified for continuous improvement include:

- Time to escalation by ward team after first red flag (trigger for immediate action)
- Time to doctor review after trigger
- New antibiotics being written on the regular side of the drug chart rather than stat (single dose)
- Implementation of ePMA to facilitate more accurate measurement of doses of antibiotics and intravenous fluid therapies administered

Sepsis is a priority for improvement as part of the trust-wide Deteriorating Patient Collaborative. Targeted work continues with the acute kidney injury team and critical care outreach team on fluid balance monitoring.

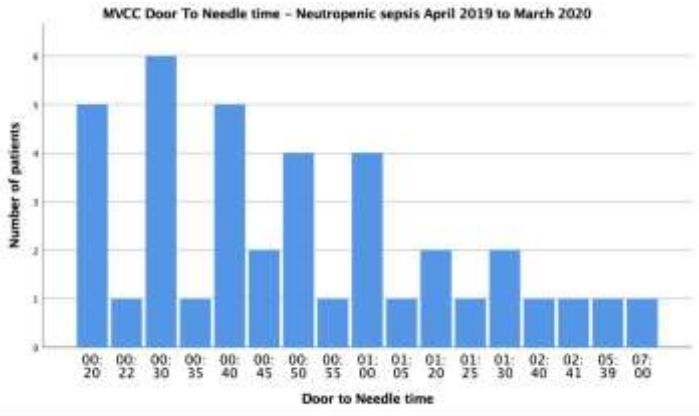
50% of the cases of sepsis are triggered by pneumonia and some readmissions relate to sepsis after treatment for pneumonia. Joint work is underway between the sepsis team and the Acute Chest Team, using quality improvement tools to improve survival from pneumonia and sepsis by:

- Improving sepsis screening & treatment (if appropriate) for patients with pneumonia
- Improving time to pneumonia treatment according to guidelines
- Giving consistent verbal and written safety netting advice to all patients before discharge

Neutropenic sepsis

A total of 39 patients presented with neutropenic sepsis between the period of April 2019 and March 2020 at Mount Vernon Cancer Centre (MVCC).

29 (74%) patients received intravenous (IV) antibiotics within an hour of arrival, known as 'door to needle time' as shown in the graph below.



6 (15%) patients had the antibiotics administered between one and two hours from arrival and the remaining 4 (10%) patients received them within seven hours.

Themes identified for continuous improvement include:

- In-depth understanding of the reasons for all delays not meeting the 'door to needle' target with consequent feedback of the learning outcomes
- Improving the management of patients where the diagnosis of neutropenic sepsis is uncertain
- Revamping training and teaching about 'patient group directions' which allow nursing staff to deliver medication, in certain circumstances, without prescription by a doctor.

2.3 Safer Invasive Procedure Standards

	Aim	Achieved
Phased approach to developing and embedding Local Standards for Invasive Procedures	>95%	Approach finalised

A procedure is invasive when a cut is made into the body. The most obvious invasive procedures are undertaken when a person has an operation which most likely requires a general anaesthetic. However other procedures such as insertion of heart stents to help treat angina, or insertion of feeding tubes through the abdomen are also invasive.

National Safety Standards for Invasive Procedures (NatSSIPs) outline a range of standards that optimise safety during an invasive procedure. Trusts are required to develop

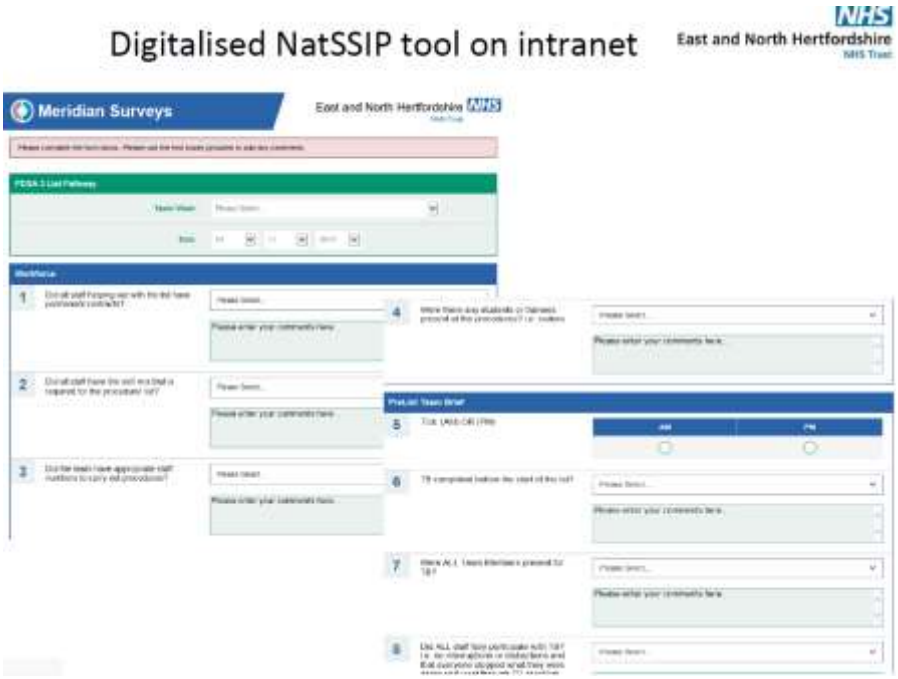
their own Local Safety Standards for Invasive Procedures (LocSSIPs) for the invasive procedures they carry out.

Whilst elements of the NatSSIPS have been commonplace within the organisation the trust did not have a range of LocSSIPs against which to audit compliance and therefore demonstrate safety.

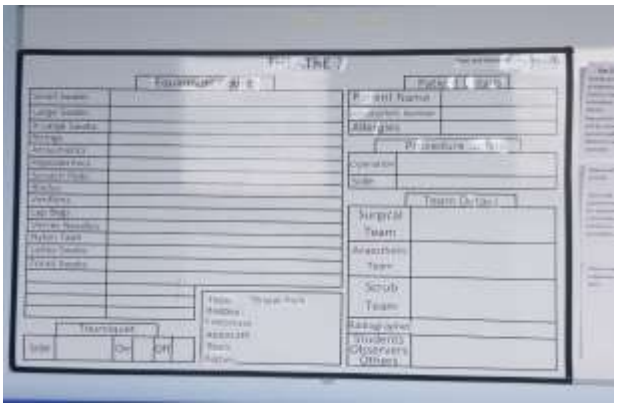
In addition, surgical checklist audits have been undertaken for a number of years and have focused on documented completion of safety critical moments. Despite evidence of good documentation we have had three significant incidents where surgical safety fell below the standards required. We have recognised many other contributing factors towards surgical errors, hence our quality priority 'safer surgery work stream'.

A Safer Surgery Collaborative has been established to drive process and system changes to improve safety. Focusing on the formalisation of LocSSIPs and through better understanding of human factors we aim to improve the reliable delivery of safer invasive procedure standards. During the year the collaborative has delivered a range of projects:

- Re-designed paperwork – the Intra-operative Care Pan and WHO Check, for use in theatres, is being tested
- Agreement and approval of the safety standards for main theatres
- The national NATSSIP audit tool has been adapted for local use and is on the trust electronic audit system, Meridian. This has been tested and redesigned. The tool has not yet been used due to the suspension of planned surgery as a result of Covid-19.



- Standardisation of the white-boards across 19 theatres which are used to record a range of safety critical information. Standardisation ensures that whichever theatre is used teams are familiar with the layout of the board and the information is demonstrated in a consistent place, thus minimising errors.



- Creation of a video to demonstrate how safety briefings should be routinely undertaken. Based on human factors the video demonstrates teamwork, role definition and completion of documentation
- Delivery of human factors training amongst theatre teams

As stated in section 1.3 the Safer Invasive Procedures launch has brought together a range of disciplines, as below, to standardise processes and share learning. The non-theatres specialities are working alongside surgical colleagues to further develop LocSSIPs within their specialties.

An Invasive Procedure Group has been established to oversee the work which is currently focusing on ensuring all areas undertake an assessment of their current practices against the national standards. The work is operationalised by local teams with oversight from divisional committees such as the Theatre Board and Out-patients Board. The group is also responsible for overseeing the implementation of relevant safety alerts.

It is intended that 80% of invasive procedures undertaken at the trust will have published LocSSIPs by March 2021.

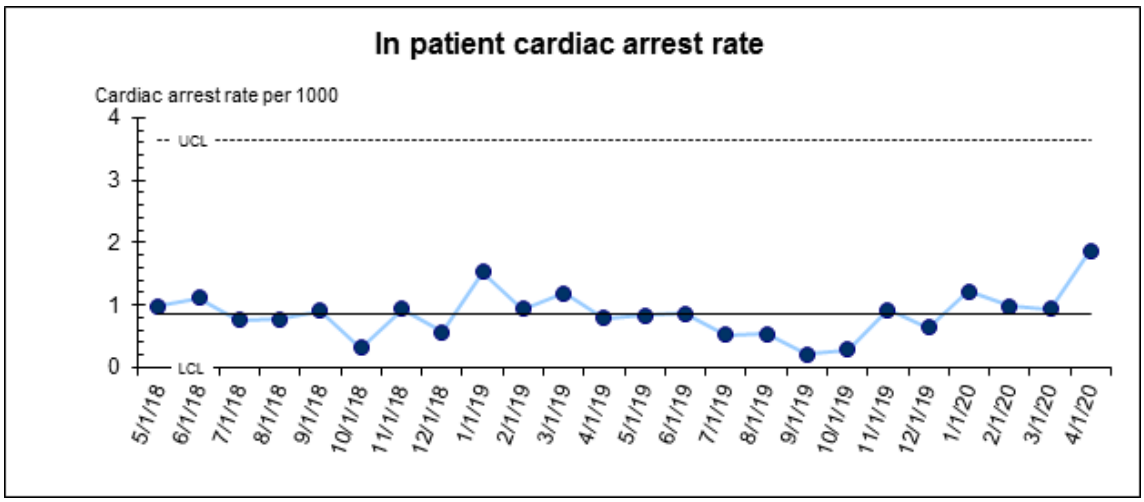
2.4 Deteriorating patient

	Aim	Achieved
Reduce rate of cardiac arrests	<0.8%	0.9%
Audit of compliance with timely observations	> 95% reliability all observations	Variable
Launch escalation module and develop a means of monitoring the escalations	Launch	Partial progress

Cardiac arrests

Cardiac arrest data is routinely submitted to the National Cardiac Arrest Audit (NCAA) database. Trust data has historically included cardiac arrests that have occurred within the Emergency Department. However, other Trusts do not include Emergency Department data so our benchmark data, although improving, is not directly comparable to other trusts.

The chart below shows that trust cardiac arrest data demonstrates a sustained a reduction in in-hospital cardiac arrests, with an average rate of 0.8 per 1000 admissions.

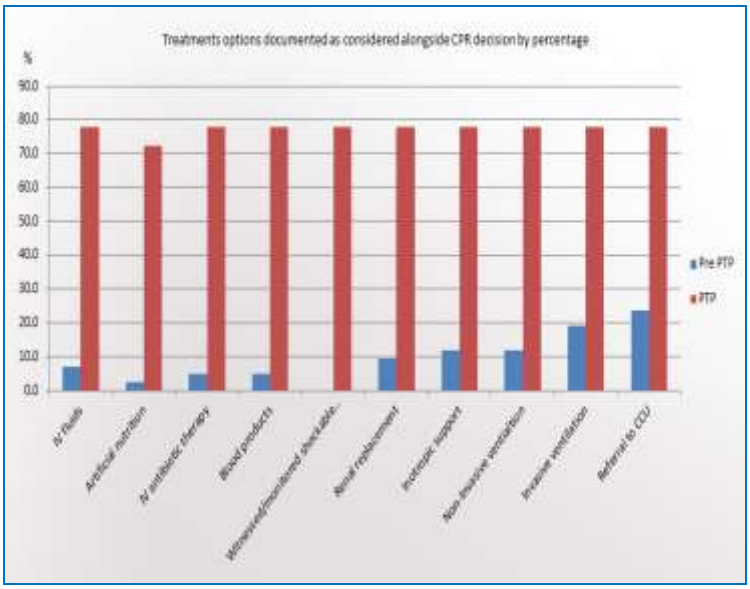


DNACPR and Treatment Escalation Plans (TEP)

Previous audits undertaken have demonstrated that 40% of resuscitation events were not in the patient's best interests i.e. intervention to support a comfortable end of life care plan may have been more appropriate.

A pilot study was undertaken to assess the impact of introducing a personalised treatment plan (PTP). This was supported through the governance of the End of Life Board, the Deteriorating Patient Collaborative and the Patient Safety Committee

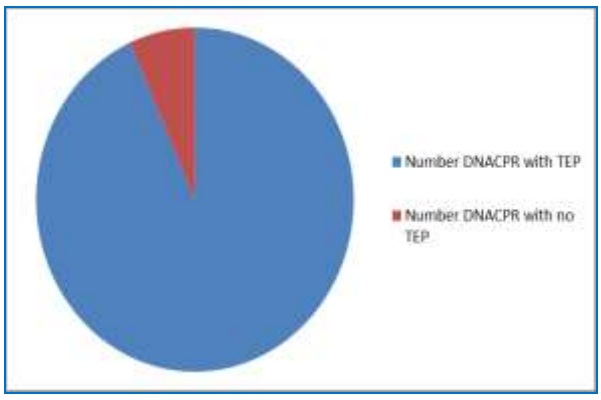
Learning demonstrated there was poor documentation of discussions or planning for interventions in the event of deterioration; and only 5% of patients, where a 'do not attempt cardiopulmonary resuscitation' (DNACPR) decision had been made, also had details of what interventions should be considered appropriate for that patient. Through iterative testing within the pilot areas, there has been an increase in documented decisions around treatment options. The categories of these options pre and post the pilot phase are noted on graph below.



This demonstrates a significant improvement which assists staff in giving the best and most appropriate care possible. Following the successful pilot the final treatment escalation plan (TEP) was launched in December 2019 (see Annex 1).

The TEP was launched with phase one being a mandatory requirement for its use with all new DNACPR decisions and a recommendation placed to adopt its use for patients at risk of deterioration.

The most recent audit revealed that 93% of DNACPR forms were accompanied by the new TEP. The few areas where a TEP was not complete were offered support and guidance for future learning and improvement. The audit further revealed that a total of 60% of patients Trust-wide had a TEP in place and 12% of patients were for active CPR.



This improvement has also realised benefits for staff who report feeling more confident in considering and discussing appropriate treatment options with patients and colleagues.

National recognition was given to the contribution of the work undertaken by the resuscitation team to review and learn from cardiac arrests, helping staff in clinical areas use the root cause analysis tool to reflect on events pre-arrest that occurred.

Timeliness of observations

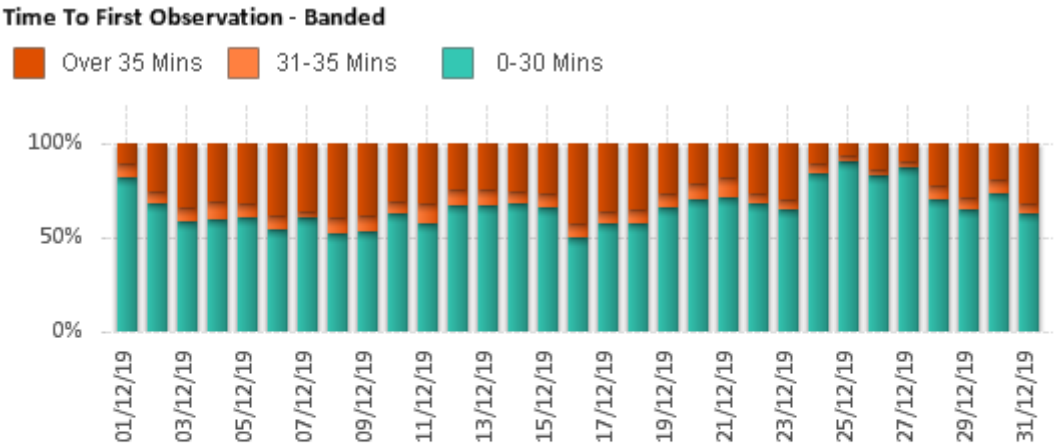
The ENHT Deteriorating Patient Collaborative consists of a group of subject matter experts including critical care outreach, resuscitation, sepsis, acute kidney injury and learning disabilities.

Observations such as blood pressure, pulse etc provide a means of monitoring a person's wellbeing. Taking regular observations enables staff to identify changes in this wellbeing. Where concerns become apparent the frequency of taking the observations increases ie increased monitoring, so that treatment can be instigated quickly. To monitor a patient's wellbeing these observations must be undertaken regularly within a pre-defined timescale.

A key process measure to improve the recognition and management of the deteriorating patient has been identified as the reliability of recording observations.

There is now improved transparency and visibility of the reliability of daily observations against set timeframes (i.e. on admission, 30min, 1 hrly, 4 hrly etc.).

An example screenshot from the Qlikview system is given below showing compliance with undertaking observations.

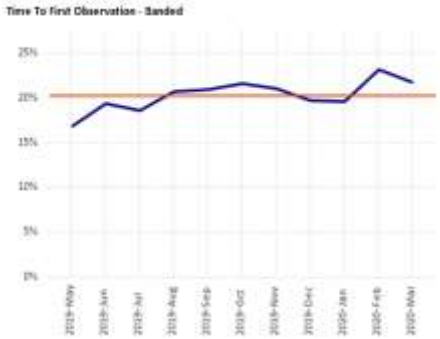
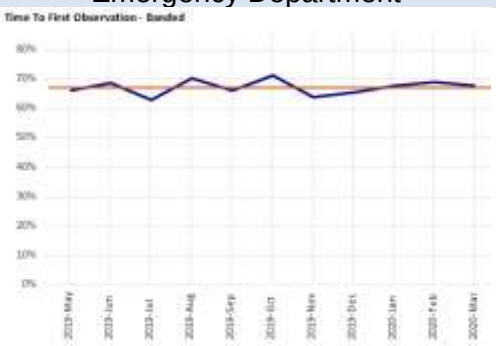
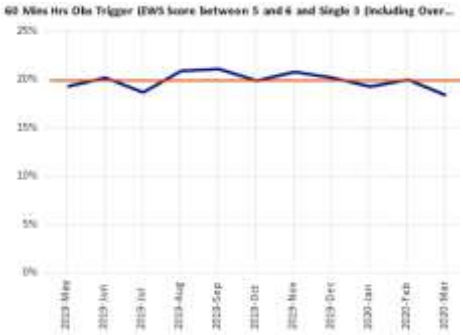
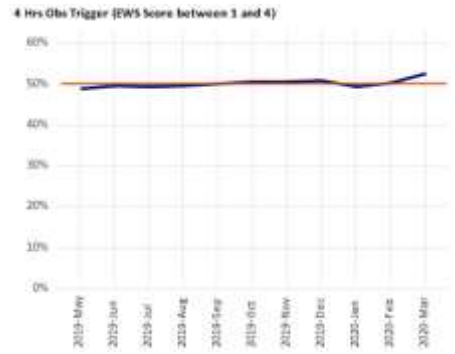
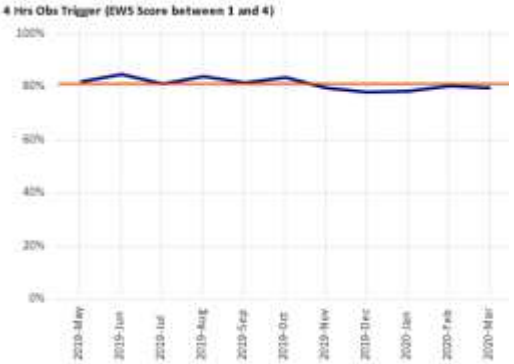


Time To First Observation - Banded

	01/12/19	02/12/19	03/12/19	04/12/19	05/12/19	06/12/19	07/12/19	08/12/19	09/12/19	## ##
0-30 Mins	82%	67.8%	58.3%	59%	60.2%	54.4%	60%	51.9%	53%	
31-35 Mins	7.72%	6.38%	7.99%	9.58%	7.34%	7.44%	3.48%	8.33%	9.12%	
36-60 Mins	9%	18.3%	18.6%	22.5%	22.9%	19.4%	16.5%	27.2%	28.8%	
61-120 Mins	1.29%	4.35%	9.76%	5.99%	8.26%	14.9%	15.4%	11.1%	6.84%	
Over 120 M...	0%	3.19%	5.33%	2.99%	1.22%	3.88%	4.64%	1.39%	2.28%	

This information is also available by month shown as a graph to demonstrate trends across time for each clinical area.

The reliability of observations for in-patient areas and emergency departments is shown in the graphs below. These show there is little variation in the areas being measured which demonstrates good reliability ie consistency in practice. To date the level of compliance has only reached the target of >95% in the emergency department, when measuring observations at 8 hour intervals.

In patient	Emergency Department
	
	
	
	
	

Compliance across the other timeframes is variable. Further investigation has identified:

- Observations must be undertaken within the timeframe, not at the timeframe, for it to be recorded as compliant
- Observations must be entered into the electronic system immediately after taking them
- Sharing of equipment amongst staff reduces its availability. An audit has been completed to review equipment required to reliably carry out observations, including equipment needed, equipment availability and equipment location
- Ongoing macro level improvements with the digital team around the collection of data from nervecentre and data analytics to enhance accuracy and ensure data is valid

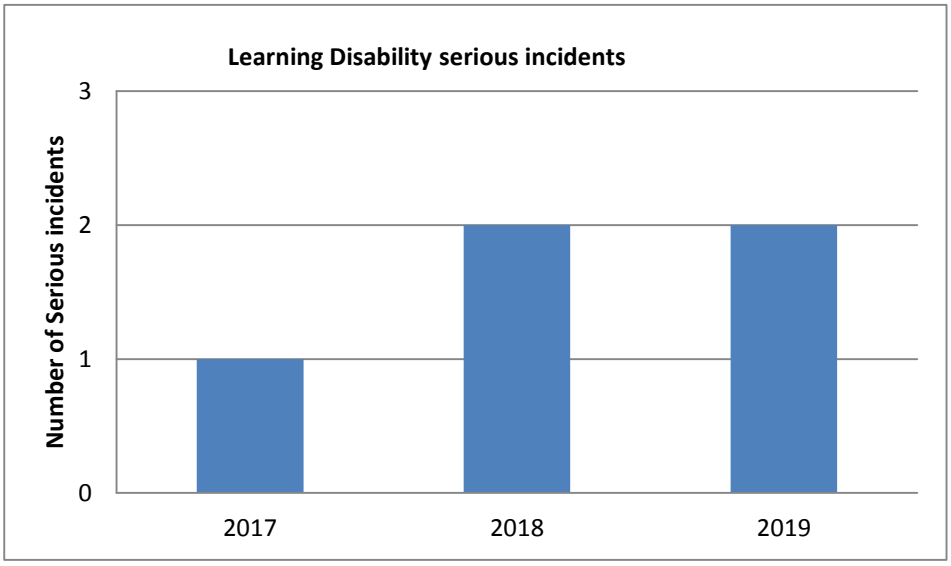
Escalation module

Review of the digital escalation module within nerve centre is underway but by year-end this facility has not been achieved. To be successful an increase in the number of hand-held devices, upon which to enter observation results, is required alongside a complex digital set-up. Efforts to implement the module will recommence as the trust comes out of focusing on covid-19 related priorities.

2.5 Safeguarding Adult and Children

	Aim	Achieved
Ensuring reduction of harm of patients with known learning disability	Ascertain baseline data and set trajectory	Same

The trust is committed to providing high quality services for people with learning disabilities. The table below demonstrates the baseline data for serious incidents within our learning disability patient population.



Learning and monitoring of improvement actions post incidents are monitored through the trust Learning Disability Steering Group, chaired by the Director of Nursing.

During 2020/21 incidents, complaints and mortality data will be triangulated to collate information on harm relating to our patients with a learning disability. This is particularly relevant as it is becoming apparent that the trust is in line with the national picture of disproportionate numbers of patients with a learning disability dying from coronavirus. Where the triangulated information identified themes for action these will either influence existing workstreams or generate new improvement initiatives.

The Trust's director of nursing is the executive lead for safeguarding, supported by an integrated safeguarding team.

Adult safeguarding is an integral part of care provision within the Trust. It is prioritised to a level which reflects our statutory responsibilities as outlined in the Care Act 2014. The main work of the team can be summarised as follows:

- Throughout 2019/20 the Trust continued to work closely with the refuge IDVA service (independent domestic violence advisors) to support victims of domestic abuse. Numbers of referrals generated by Trust staff to the IDVA services on behalf of victims increased during the year with more victims being offered practical support to escape abusive relationships. 21% of safeguarding referrals generated by Trust staff during the year related to domestic abuse
- We work in partnership with organisations such as the local authority and the police to raise awareness of modern slavery and to increase victim's recognition. We also promote and utilise the established referral pathways to support individuals to escape from exploitative situations
- The Trust has developed services to support adults with particular needs. For example, adults with learning disabilities are supported when accessing Trust services by the health liaison nursing team. Our clinical staff continue to receive best practice education on dementia care by our admiral nurse; our patients and carers for individuals with dementia also benefit from direct support provided by our admiral nurse. Our Carers Lead Nurse continues to work with both patients and their carers to introduce enhanced practices that aim to improve patient experience
- The Trust continues to place a high priority on the care of individuals with a learning disability. We have a dedicated committee to ensure that standards set out by NHS England / NHS improvement are met
- A number of clinical areas have achieved, or are in the process of gaining, a Purple Star accreditation through a scheme run by Hertfordshire County Council in recognition of the work the teams and various services have done to develop learning disability-friendly environments and procedures
- All inpatient clinical areas hold three times a day safety huddles to ensure local reporting of safeguarding concerns is undertaken. Concerns identified at ward huddles are communicated at site safety huddles and are addressed by senior nursing staff
- 85% of service user facing Trust staff and line managers have undertaken level 3 PREVENT awareness training as a requirement of the Government's anti-radicalisation strategy
- All Clinical staff in the Trust continue to receive training and education on the clinical application of the mental capacity act. Work is currently being undertaken to ensure education is delivered to staff in preparation for the introduction of the mental capacity amendment act 2019 which is expected to come into statutory force in October 2020.
- An increased focus has been placed on the awareness and use of services to support individuals who are self-neglecting. A focus for 2020/21 is to further increase staff awareness of the impact of self-neglect on the most vulnerable individuals in society.

During 2019/20 there was an increase of 34% in adult safeguarding concerns being raised by Trust staff in comparison to 2018/19. The majority of these concerns were raised by personnel in the emergency department relating to ongoing welfare concerns originating in

the community. The increase in referrals is evidence of improved staff safeguarding awareness and recognition of abuse which has been achieved through staff education.

Deprivation of liberty safeguards (DoLs) applications increased by 21% during 2019/20 in comparison to the previous year which is a clear indication that the mental capacity act 2005 is being routinely applied to the care of our service users.

Children's Safeguarding services promote the welfare of children and prevent them from harm. The annual audit to ensure compliance against Section 11 of The Children's Act was undertaken in April 2019 and resulted in a very positive review of the service provided.

The Trust continues to work closely with partner organisations and services with the trust represented at the Hertfordshire Safeguarding Children's Partnership (HSCP) and various working groups. Other key highlights are as follows:

- During 2019/20 the Children's safeguarding service has continued to manage a continued increase in workload including referrals to children's services and information requests
- Safeguarding training is provided in line with recommendations from the Intercollegiate Document Roles and Competencies for Healthcare Staff 2019
- The children's safeguarding team carry out safeguarding supervision and peer review sessions for all staff within the service. A multi-agency (HSCP) audit was completed in early 2020 with initial feedback on results looking very positive in relation to how staff find this beneficial for their practice
- The service has been actively involved with the organisation's emphasis on patient safety including the site safety meetings to ensure the promotion of safeguarding and escalating areas of concern
- The children's safeguarding team have continued to ensure the safeguarding policies in place remain up to date and in line with new recommendations, research and learning from incidents within the organisation – including producing a new policy in relation to "Was not Brought" in response to an audit undertaken for children and young people not brought to their appointments or for no access visits within the community setting
- The safeguarding midwifery staffing has increased providing the ability to succession plan within the service
- The "Better births" agenda has brought about the development of continuity teams within the maternity service. This will bring new opportunities to develop safeguarding practice over the coming years.
- The Trust paediatric liaison service continues to be commissioned and operates within the safeguarding children's team. Over the past 2 years there has been a 60% increase in referrals that have met threshold for additional liaison work with partner agencies.

2.6 VTE Risk Assessment

A blood clot in the leg (deep vein thrombosis) or lung (pulmonary embolism), collectively known as a venous thrombo-embolism (VTE), may develop for a number of reasons eg. reduced mobility. Patients in hospital tend to be less mobile than at home and therefore may be at a greater risk developing a clot. As part of the admission process patients should be assessed as to their risk of developing a clot, and be prescribed anti-coagulant (blood thinning) medication if required.

	AIM	Achieved
Improved compliance with VTE risk assessment part 1 and part 2	>95% compliance with part 1 and parts 2-4	Records survey: 88% (part 1) Pharmacy survey:90% (part 1) 60% (part 2)

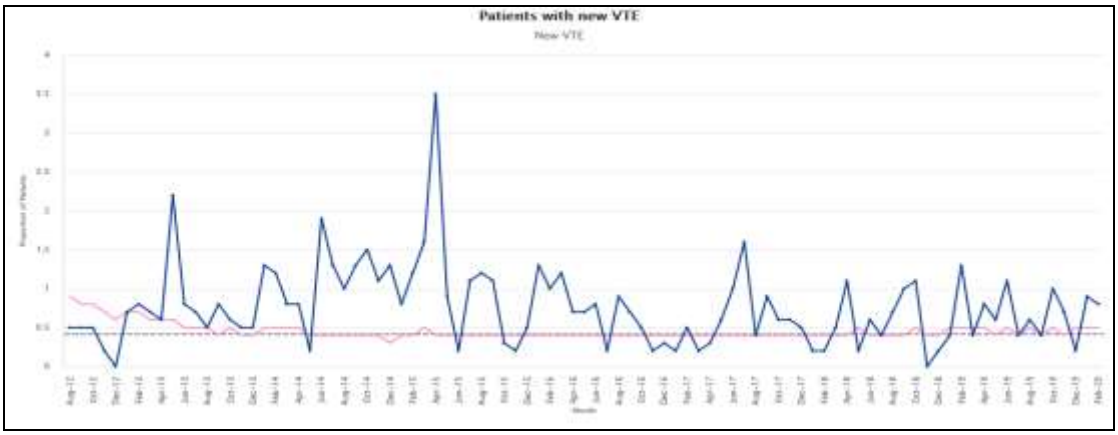
The part 1 risk assessment is that measured at the point of admission. The part 2 reassessment is required 24 hours after admission or when there is a change in a patient's situation.

VTE Risk assessment is measured in several ways within the trust:

- National safety thermometer- a point prevalence audit on one day each month
- Medical records – all in-patients within 24 hours of admission. This is shown in the trust integrated performance report
- Pharmacy - random sampling in real time in the patient setting

Safety thermometer:

The chart below demonstrates the breakdown of harms identified relating to a new venous thromboembolism. The latest available data shows the trust rate of 0.8% against a national average of 0.5% (February 2020 data).



Health records review:

A review of health records is undertaken at pre-defined intervals to assess whether patients have had a VTE risk assessment undertaken on admission.

The aim is for 95% of patients to have the assessment completed. Compliance is given in the chart below demonstrating consistent compliance at around 88%.

Metric	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
VTE risk assessment	95%	88.2%	89.8%	90.2%	87.8%	87.2%	83.5%	88.8%	87.5%	87.9%	88.0%	tbc	tbc

In patient sampling:

The data below shows data collected by the pharmacy team who review 10 samples each month, looking at stage 1 (on admission) and stages 2-4 (reassessment after 24 hours; when there has been a change).

This data is now accessible through Qlikview with example charts as below.

Stage 1 Risk assessment data shows an average of 90% compliance; stages 2-4 show less reliable completion of VTE risk re-assessments nearer to 60% compliance.

Root cause analysis learning is undertaken when potential hospital associated thrombosis (HAT) cases are identified. Although the number of cases is very small trends can be seen whereby the re-assessments may be missed or a change to the patient pathway has resulted in omitting sufficient thrombo-prophylaxis medication upon discharge home.

Areas for improvement include:

- Adjusting current drug charts to provide allocated space for 'time' of VTE review. This is currently missing and therefore not allowing accurate documentation of when risk assessments were completed. The new drug chart has been designed and will be implemented in 2020.
- Whole system review to establish a more co-ordinated, sustainable core HAT prevention team
- Progression towards the appointment of a VTE specialist nurse
- Increasing the reliability of providing patient information on discharge (and on admission)
- Improving VTE recording on discharge summaries
- Reviewing the HAT process to improve the time taken to complete the root cause analysis reviews to expedite learning and actions taken

Oversight of VTE outcomes, strategy and action planning is undertaken by the Thrombosis Action Group and the Harm Fee Care Group.

Priority three: Respect our patient's time through improving the flow through inpatient and outpatient services

Reason: Whilst steady progress has been made there is still improvement to reach the required aims

Monitoring: Quality & Safety Committee, Finance & Performance Committee

Reporting: Scheduled update to the Quality & Safety Committee

Responsible Directors: Chief Operating Officer

	Theme	Measure	19/20	20/21
3.1	Improving discharge processes	Reduce number of discharge summaries not sent to GP within 24 hours of discharge	90% reduction	Stabilise
		Patients discharged by midday	>15%	>15%
		Reduce proportion of beds occupied with length of stay > 14 days	<19%	<19%
3.2	Improve access	Improve cancer waits from 2018/19 position	National standard	Meet all national standards
		Improve delivery of 7 days services	Ascertain baseline and agree Trajectory	Agree trajectory and monitor implementation
		Reduce delays in ED 4 hour waiting time	National standard	>80%

3.1 Improving discharge processes

	Aim	Achieved
Reduce number of discharge summaries not sent to GP within 24 hours of discharge	90% reduction	1224 by year end
Patients discharged by midday	>15%	13.6%
Reduce proportion of beds occupied with length of stay > 14 days	<19%	20%

Discharge summaries

During 2018/19 it was identified that a significant number of discharge summaries had not been sent to the patient's GP within 24 hours of discharge. Any delay in sending the discharge summary poses a potential risk to a patient's future management if tests are not requested or medications not prescribed in a timely way.

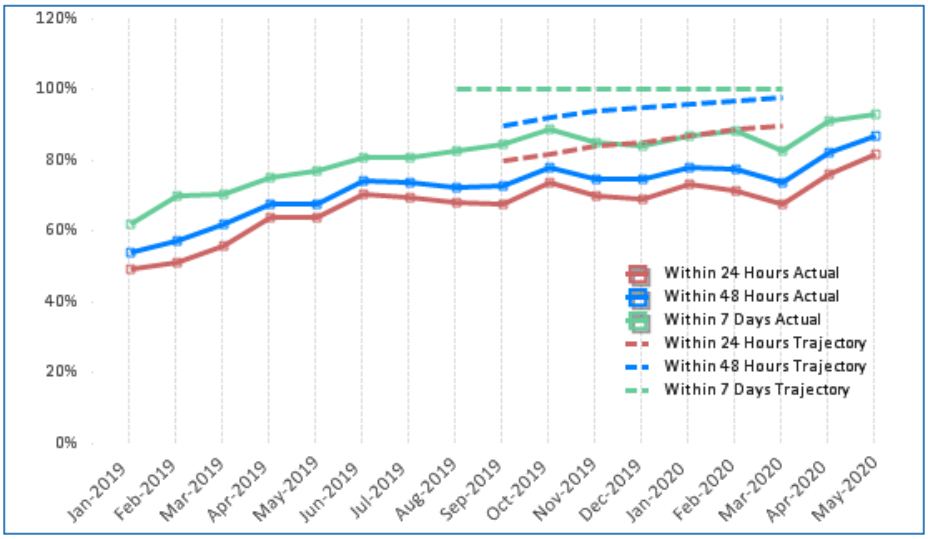
A project was established with the aim of creating a more sustainable approach to continuously improve the number of discharge summaries being sent to GPs within 24 hours of discharge. Interventions have included:

- Engagement with staff involved in the discharge process
- Training and education for the creation and distribution of the discharge summary
- Review of templates standardising format
- Daily monitoring through improved data

- Improvement to process, removing unnecessary steps in the discharge process

The back log has reduced to 1224 by the end of the financial year.

The data below shows an increase of reliability sending summaries within 24 hours and within 7 days. However, the trust acknowledges that the required targets have not been met and this will be a continued focus for 2020/21.



Mid-day discharges

The number of patients arriving at the Emergency Department increases during the morning. Some of these will require admission. If in-patient beds are not available then the number of patients waiting within the ED will increase and the flow of patient through the department will be hindered. To maintain an effective and efficient flow of patients within the ED it must be made possible that beds become available on the wards into which patients can be transferred.

Good planning to ensure medication, transport, discharge summaries etc are ready in a timely way allows a patient to go home in the morning, thus freeing up a bed to accommodate demand from the ED. On average 13.6% of discharges occurred before midday.

Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Discharges before midday	13.3%	13.1%	13.8%	13.6%	12.5%	12.6%	12.9%	13.4%	15.0%	13.6%	14.2%	15.3%

Reduce proportion of beds occupied with length of stay > 14 days

Length of stay reviews occur weekly within divisions, measurement throughout the year has shown normal variation. The trust continues to work with community partners to safely expedite patient discharge in a timely way. On average 20% of beds were occupied by patients where the length of stay was more than 14 days.

Metric	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Proportion of beds occupied by patients with length of stay over 14 days	17.4%	17.7%	16.8%	20.0%	17.8%	20.1%	20.1%	23.7%	19.2%	21.7%	22.6%	23.6%
Proportion of beds occupied by patients with length of stay over 21 days	9.2%	9.6%	8.2%	10.9%	9.9%	10.9%	11.7%	14.5%	10.5%	11.6%	13.5%	13.7%

3.2 Improve access

	AIM	Achieved
Improve cancer waits from 2018/19 position	National standard	Met 5 of 8 national standards
Improve delivery of 7 days services	Ascertain baseline and agree Trajectory	Baseline agreed
Reduce delays in ED 4 hour waiting time	National standard (95%)	80.2%

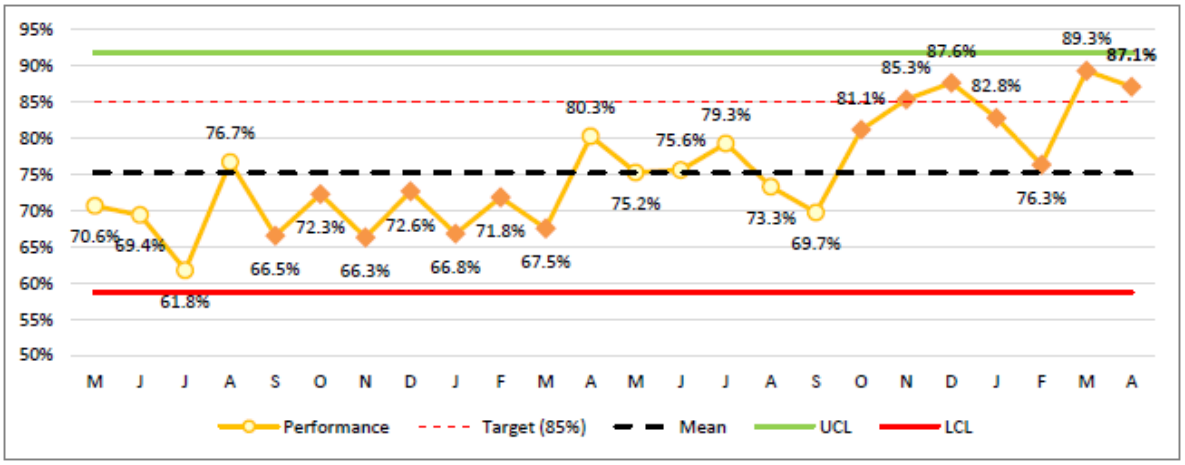
Improve cancer waits from 2018/19 position

Significant improvements were made during 2019/20 regarding cancer performance.

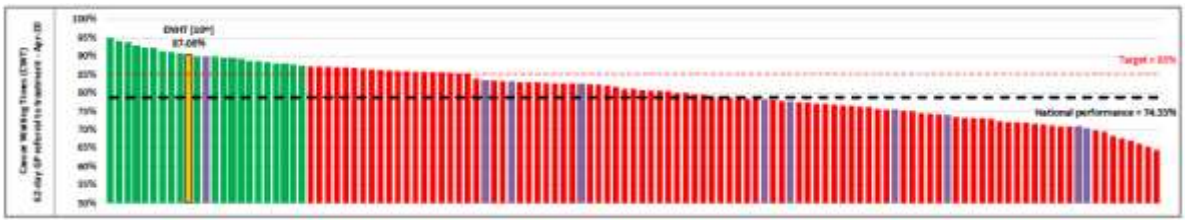
Across all of the cancer standards, the year-end position was compliance with 5 of the 8 standards, an increase from 3 in 2018/19. During March the trust met 7 of the standards. Of the 8 standards, the Trust has achieved the two week wait and 31-day subsequent treatment (radiotherapy) standards in every month of 2019/20. The Trust already complies with the new standard for 2020/21 on confirming or ruling out diagnosis within 28 days.

12 months' performance - all standards	Standard	Target	2019-20 Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
	Two week waits Suspected cancer	93%	95.94%	95.59%	96.66%	96.15%	94.88%	97.23%	98.50%	97.43%	97.87%	96.47%	98.08%	98.77%	96.95%
	Two week waits Breast symptomatic	93%	88.68%	92.68%	93.39%	94.78%	87.38%	95.76%	95.37%	98.39%	95.52%	97.96%	95.70%	97.14%	94.38%
	31-day First definitive treatment	96%	93.53%	94.93%	93.90%	97.01%	96.97%	95.98%	96.88%	99.00%	98.29%	97.83%	98.98%	97.89%	96.57%
	31-day subsequent treatment Anti-cancer drugs	98%	98.19%	97.81%	99.29%	99.07%	99.42%	99.41%	99.68%	100.00%	99.45%	98.16%	99.43%	99.50%	99.10%
	31-day subsequent treatment Radiotherapy	94%	96.30%	98.27%	98.86%	96.32%	97.53%	97.27%	98.25%	96.54%	99.26%	98.81%	99.36%	98.06%	97.96%
	31-day subsequent treatment Surgery	94%	96.77%	80.00%	78.95%	77.42%	83.33%	85.19%	65.52%	84.21%	93.55%	79.07%	86.21%	95.83%	83.55%
	62-day GP referral to treatment	85%	80.25%	75.25%	75.58%	79.26%	73.38%	69.71%	81.14%	81.31%	87.60%	82.76%	76.32%	89.27%	79.83%
	62-day Specialist screening service	90%	81.82%	100.00%	63.64%	56.00%	82.35%	73.68%	100.00%	69.23%	100.00%	100.00%	44.44%	66.67%	76.67%

The Trust achieved the 62 day cancer target for the first time since 2014 in November and December 2019 and the Trust's performance against this standard remains above the national average at year end, as shown in the graph below.



In March the Trust was in 57th place for the 62 day waiting time standard compared with other trusts, surpassing the national average performance. In April performance placed the trust in 10th place nationally.



Improve delivery of 7 day services

Whilst hospitals function for 24 hours every day the level of services offered maybe different during the weekend. The NHS is moving towards offering the same level of service every day of the week.

An assessment of current provision towards meeting the 7 day objectives using the Seven Day Hospital Services Board Assurance Framework has been undertaken. The results of the assessment against four standards are shown below.

Standard	Requirement	Outcome	2019/20
2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission	44% for weekday admissions; 33% for weekend admissions	Not met
5	Inpatients must have scheduled 7 day access to diagnostic services	All diagnostic requirements have been met but with limited provision of MRI scanning which is restricted at the weekend to the diagnosis of spinal cord compression only	Met
6	Inpatients must have timely 24 hour access to key consultant-directed interventions	Interventions available, although interventional radiology is available on an ad hoc basis	Met
8	Patients with high dependency needs should be seen by a consultant twice daily; then daily once a clear plan of care is in place	100% compliance with twice daily review 89% compliance with daily consultant review (May 2019 data)	Not Met

The delivery of consistently high quality care to patients across the entire week has been a challenge for the Trust. Although there is no significant difference in mortality between those patients admitted at the weekend and during the week there is an observable trend. Actions identified to improve the service delivery include:

- Improvement of data recording of time and day
- Clearly documenting pathways for delegation of review
- Review of resources required to meet the standards

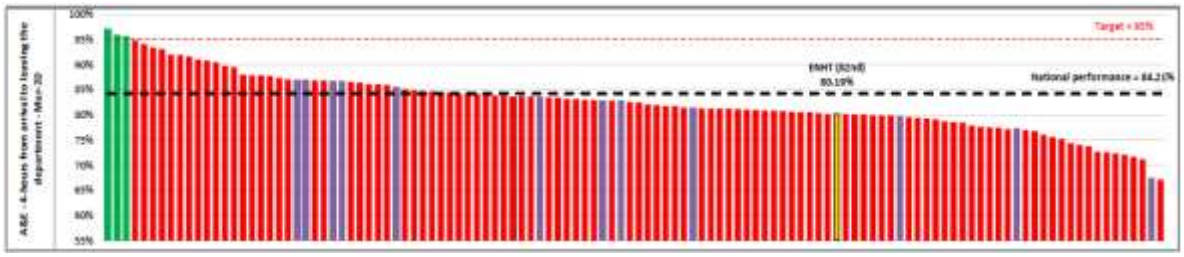
Due to service redesign as a result of covid-19 the plans to progress 7 day services have been put on hold. The plans will re-commence as the trust moves towards opening services during 2020.

Reduce delays in ED 4 hour waiting time

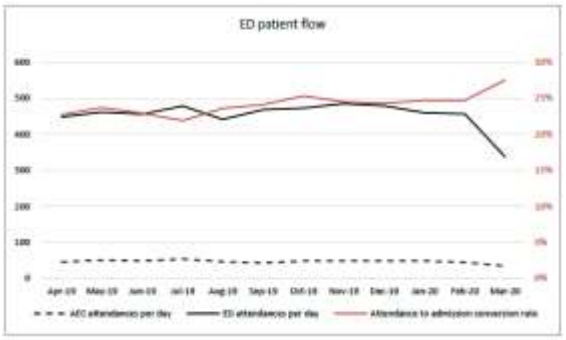
The Emergency Department 4-hour standard requires 95% of patients being seen, treated and either admitted or discharged within four hours of arrival.

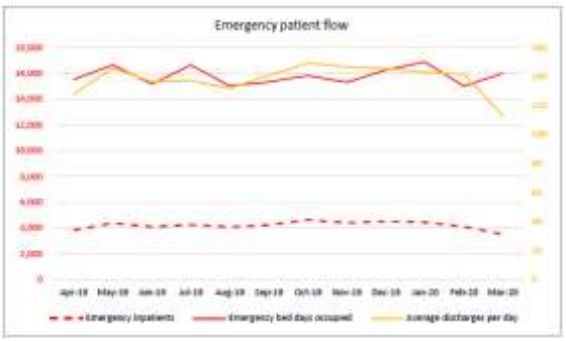
The Trust's year end performance was 80.2%. There was some variation in the Trust's performance during the year and was broadly similar to that of 2018/19.

It is noteworthy that relatively few NHS trusts achieve this target nationally.

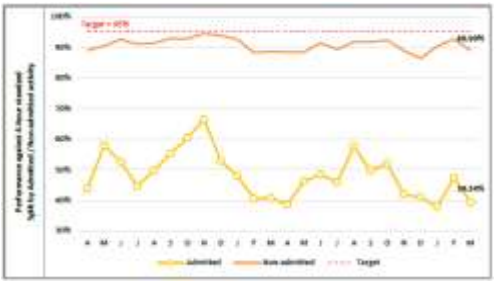


Approximately 400 patients attend the ED each day with 24% of them requiring in patient admission. In addition the number of admissions very closely aligns with the number of discharges so any delay to discharges will have a detrimental effect upon the ability to move patients through the emergency department to a ward.





Although an average 4 hour standard is measured it is interesting to note that the standard has almost been reached throughout the year for patients being treated but not admitted. The challenges in meeting the standards for patients requiring admission are demonstrated clearly on the graph.



Priority four: Patient & Carer Experience

Reason: Quality goal within ENHT Quality Strategy is to improve the opportunities for our patient's voice to contribute to quality improvements.

We believe our patients and carers should have opportunities to provide real time feedback during their care. We shall support all staff to prioritise local goals in alignment with real time patient carer feedback.

Monitoring: Patient Experience Committee

Reporting: Scheduled update to the Quality & Safety Committee

Responsible Director: Director of Nursing

	Theme	Measure	19/20	20/21
4.1	Patient feedback	Maintain Friends & Family Test scores (average) for in-patients, out-patients, maternity (birth) and emergency department	IP 96.7% OP 94.8% Mat 93% ED 89.6%	IP >95% OP >95% Mat >93% ED >90%
4.2	'Always events'	Evaluate cancer team project	Capture lesson learnt	N/A – superseded by QI programme
4.3	Improve partnership working with patients and carers within key Quality Strategy goals	Design and support patient co-design within planning, design and testing phases of quality improvement initiatives.	Ascertain organisational readiness and agree Trajectory	Demonstrable involvement of patients and carers

4.1 Patient feedback

	Aim	Achieved
Maintain Friends & Family Test scores (average) for in-patients, out-patients, maternity (birth) and emergency department	IP 96.7% OP 94.8% Mat 93% ED 89.6%	IP 96.89% OP 95.55% Mat 95.76% ED 90.85%

Patients are asked, as part of the Friends and Family Test (FFT) framework, to provide feedback on their inpatient/day case, emergency department, maternity or outpatient experience. Patients are asked 'how likely they would be to recommend the service to their friends and family'.

The table above confirms that the aim was achieved in all of the survey areas.

- The highest proportion of positive comments from inpatient / day case patients relate to staff being attentive, friendly and caring with good communication and care and treatment provided. Negative comments relate to the environment, noise at night and food
- Members of the public attending the outpatients department have complimented staff for being kind and helpful, and for the care, treatment and information provided. There are concerns about waiting times in clinics, appointment letters, administration of appointments, direction to clinics and the cost of the car park

- In maternity the majority of women have complimented the staff for the support, care and information provided to them during their birth experience. Women would like a quieter environment, provision of recliner chairs for partners and for partners to be able to stay
- The majority of feedback from patients in the ED is positive particularly in relation to staff being friendly, kind and caring, providing an excellent service and good communication. Negative feedback mainly relates to the length of waiting times

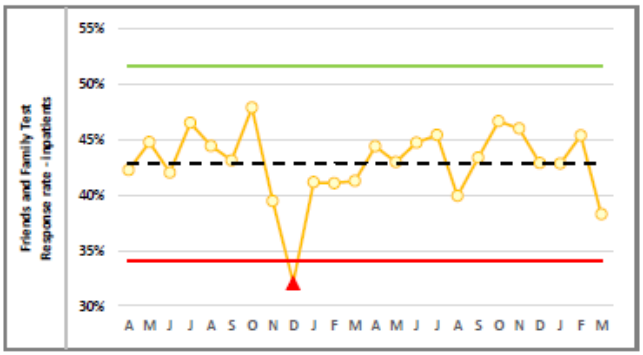
Alongside the feedback the trust is also monitoring the response rate. A high response rate provides greater opportunity for improvement. The monthly tracking of responses, rates and proportion of positive responses is shown in the table below.

Domain	FFT	Metric	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Friends and Family Test	Inpatients	Proportion of positive responses	95%	96.7%	96.4%	96.9%	97.0%	96.9%	96.9%	96.3%	97.6%	96.3%	96.7%	96.8%	97.3%
		Total number of responses	1,778	1,994	2,022	2,095	2,263	1,760	1,959	2,102	2,071	1,847	1,975	1,948	1,788
		Response rate	40%	44.6%	43.0%	44.8%	45.6%	39.9%	43.6%	46.7%	46.0%	42.9%	42.9%	45.4%	38.3%
	A&E	Proportion of positive responses	90%	92.5%	93.9%	92.7%	83.8%	94.0%	88.9%	90.0%	89.3%	88.5%	91.3%	94.4%	93.1%
		Total number of responses	1,241	546	559	1,008	624	498	676	727	439	358	424	356	188
		Response rate	10%	4.0%	3.9%	7.2%	4.1%	3.6%	4.7%	4.8%	2.7%	2.1%	2.7%	2.5%	1.6%
	Maternity	Antenatal care Proportion of positive responses	93%	100.0%	92.8%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%
		Birth Proportion of positive responses	93%	96.1%	99.4%	97.3%	96.5%	92.9%	98.1%	95.6%	90.3%	94.6%	95.4%	93.9%	98.2%
		Birth Total number of responses	137	128	159	74	115	98	106	135	124	93	65	114	110
		Birth Response rate	30%	30.5%	34.6%	17.4%	24.5%	22.3%	23.7%	28.6%	27.9%	21.2%	15.9%	28.5%	25.7%
		Postnatal ward Proportion of positive responses	93%	87.4%	89.7%	86.5%	92.2%	88.8%	94.3%	88.4%	83.9%	85.9%	86.2%	83.3%	92.7%
		Postnatal community Proportion of positive responses	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Outpatients	Proportion of positive responses	95%	94.5%	96.2%	95.8%	95.4%	95.4%	94.5%	94.8%	95.0%	95.8%	96.8%	95.9%	96.4%
		Total number of responses		1,980	4,100	3,943	3,613	3,313	2,448	3,127	2,133	1,777	2,429	2,273	1,276

The overall response rate for the year is given in the table below.

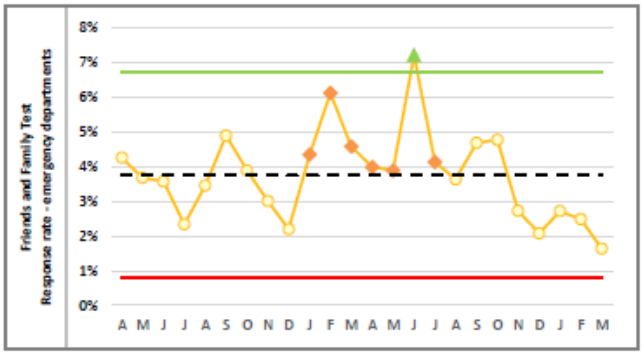
	2018-19	2019-20	Aim
Inpatient / Day Case FFT response rate	42.26%	43.73%	40%
Maternity response rate (birth)	33.79%	25.14%	30%
Emergency department response rate	3.85%	3.67%	10%

Inpatient/Day Case: The response rate to the inpatient/day case FFT remains consistently above the national average and above the Trust target of 40%.



Maternity: Within maternity services the response rate to the birth and postnatal element averages 25% (below the 30% target) but responses to the antenatal and community midwifery elements are much lower. The community midwives have a link to the FFT survey on their laptops and are able to offer the FFT survey to women to complete at or around their 36 week antenatal appointment and at the end of their community midwifery care. It is hoped that responses will improve when the surveys can be completed at any time during a woman's maternity experience (from April 2020).

Emergency Department: Responses within the emergency department remain significantly below the 10% target. Survey responses are collected on paper within the department and using a small credit card sized version of the survey that staff can easily keep handy in their pockets. From April 2020 when patients are able to complete the survey at any time, and as many times as they wish, copies of the survey will be made freely available for patients to fill in at any time.



From 1 April 2020 the FFT question is changing to 'overall, how was your experience of our service. Six response options will range from *very good* to *very poor*. Another key change is that patients will be able to give feedback when they want to rather than at specific times. Communications around the FFT will be refreshed to raise the importance of collecting patient feedback and using this to drive quality improvements.

The requirement to ask at least one free text question, alongside the mandatory question, will not change. The trust asks two free text questions after the FFT:

- What was good about your stay/visit?
- What would have made your experience better?

Responses to these questions enable teams to focus on what they are doing well and areas where improvements can be made.

4.2 Always Events

	Aim	Achieved
Evaluate cancer team project	Capture lesson learnt	Halted due to covid--19

Always Events® are defined as "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system". It's a way of working to promote optimum experience.

A quality improvement project started within Cancer Services around 'What matters most for our staff'. The project aimed to deliver services that better meet the needs of patients. A

key component of ‘always events’ is that patients are involved in the project – known as co-production. The project was not ultimately badged as an always event but was supported by a QI coach and introduced QI methodology which builds co-production into the project. Due to COVID-19 the project was halted but will carry on in the future when the QI programme is re-established.

4.3 Improve partnership working with patients and carers within key Quality Strategy goals

	Aim	Achieved
Design and support patient co-design within planning, design and testing phases of quality improvement initiatives.	Ascertain organisational readiness and agree Trajectory	Partial

There is an objective within the RCN Clinical leadership programme to actively gain patient involvement within the quality improvement projects. The quality improvement team are working closely with the patient engagement team to explore infrastructure to proactively involve patients e.g. consent form, role and responsibilities documents etc.

Examples of actions to improve patient and carer experience during the year include:

- Established patient and public involvement and engagement forum to work with patients to design and improve research within the Trust
- The ENHT Charity supported projects to improve patient experience in the Neonatal unit, maternity, Macmillan Cancer Centre, men’s health, the Butterfly service to provide companionship for end of life patients etc
- Improved access to the one-stop breast clinic with two new Breast Radiologists appointed thereby improving the imaging pathway for breast patients
- Re-launched the Visitors’ Charter and reviewed the visiting times information on the Trust website
- Introduced a ‘Dementia bus stop’ within elderly care wards which allows patients to have a calm place to sit during their admission to hospital
- Volunteers continue to support patients across the hospital. A new role of ‘elderly buddy’ has been introduced where a volunteer is allocated to vulnerable/elderly patients attending elderly care clinics to support the patient during their hospital visit
- Introduced ‘golden discharges’ to improve timely discharge of patients from hospital
- Increased the number of patient information leaflets available on the Trust website to 470
- Held a ‘young carers’ take over day in August 2019 to increase awareness of young carers in the NHS
- Introduced a new suite of nursing documentation and care plans to ensure consistent high quality nursing care is evidenced.

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

April – June 2019

Ward/Dept.	You Said	We Did
Pre-operative Assessment (POA)	Not having swabs.	Certain tests, e.g. swabs, ECG's, blood tests and BMI are necessary at pre-op assessment to prevent the patient from being cancelled prior to, or on the day of procedure.
Cardiac Suite	To have clear instructions on what can be eaten and drank prior to the procedure.	We try to provide patients with as much information as possible before their procedure so they are fully informed and know what to expect. We do this through information leaflets that are sent out in the post before the procedure and we also pre-assess patients in person or on the telephone before they come in.
Acute Cardiac Unit (ACU)	Better information on my health welfare, i.e. better updates on the condition of my health.	The nurses are always available to answer any queries you may have, and we also have a specialist cardiac rehab team who are available to give advice.
AMU Assessment	My room never got cleaned. A hot drink first thing in the morning.	The team has been reminded to be vigilant in keeping an eye on the cleanliness of patients' environment. The night team have been reminded to offer hot drinks to patients before their shift ends.
Consultant Led Unit	My elective caesarean section could have been improved regarding: Length of wait; processing of bloods; moving the date.	We have been working to improve the efficiency of our elective theatre list. The elective list has been adversely impacted by the number of bank holidays during April and May and this has meant that the same number of elective procedures have been performed in fewer days. As part of this work we have been improving the process for the pre-assessment clinic to reduce the chance of bloods not being ready. Unfortunately we do have to reschedule some electives, this is often because we are trying to fit in a woman with higher priority needs.
10AN	Unable to sleep well at night due to noise.	Earplugs are provided to all patients that require them to minimise the noises they hear at night. Please ask a member of staff if you need them.
10B	Staff are nice and caring but can take a little time to answer call bells at times.	We monitor our staffing levels continuously to make sure there are enough staff to care for the patients on the ward. Please talk to a member of staff if you have any concerns.

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

July – September 2019

10A	Doctors to be more considerate towards patient's circumstances and better bedside manners.	We have shared this feedback with the medical staff to ensure that effective communication skills are observed to maintain a meaningful and trustworthy relationship between the doctors and patients.
10B	You would have liked a television and a day room.	Patients are able to hire a bedside TV, please ask a member of staff if you would like more information about this or see our carers board for details. We are working towards identifying a day room on the ward for patients and visitors to use.
9B	Less noise from disruptive patients.	We have a bay watch bay, where we care for patients who are disruptive or confused, and one member of staff is allocated to constantly watch and attend to their needs. The Trust's Specialling team are also actively involved to calm these patients down and engage them with activities to settle them.
8A	More staff on duty.	We are constantly reviewing our staffing levels on a daily basis. Recruitment of new staff members is a priority and vacancies are actively being recruited to. All vacancies are going through our recruitment process.
8B	Faster scans.	The ward staff make every effort to liaise with the relevant team and escalate delays when patients are waiting for scans or procedures.
6A	Faster discharge.	The Trust has a SAFER discharge planning in place now and a Ward Pharmacist is allocated to each area to speed up allocation of patients' medicines to take home.
Swift Ward	I would have liked my treatment and future care explained more.	As a patient we understand you need to know everything about the next steps in your care. Please ask a nurse who will be happy to explain your treatment and the future plan regarding your care.
5A	I would have also liked a toothbrush, some toothpaste and tissues too!!!	We realise that if you have had an emergency admission it is not always possible to bring personal items into hospital with you. In these situations if you need a toothbrush, toothpaste and tissues just ask one of the nurses who will be able to supply these for you.
5B	My experience would have been better had the nurses had more time to talk to me …	Our staff do try to talk to our patients but sometimes when the ward is very busy it can prove difficult. If you are feeling lonely then please tell one of the staff as we do have volunteers in the hospital that would be happy to come and talk to you for a while.

2.2 Statements of assurance from the Board

Review of services

During 2019/20, the East and North Hertfordshire NHS Trust (ENHT) provided and/or subcontracted 23 relevant health services. The ENHT has reviewed all the data available to them on the quality of care in 23 of these relevant health services. The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant services by the ENHT for 2019/20.

Participation in clinical audits

Clinical Audit (CA) forms part of the NHS Standard Contract requirements as well as being part of the Care Quality Commission (CQC) Key Lines of Enquiry. A robust CA programme is vital to ensure we continually strive to provide safer, more clinically effective and reliable care.

Audit activity

In January 2019 the Healthcare Quality Improvement Partnership (HQIP) published their annual list of audits to be considered for implementation in 2019/20. This list was used by the Clinical Audit and Effectiveness Team to produce the annual Trust CA Priority Guidance from which specialties confirmed their intentions to undertake relevant audits. The resulting list is known as the clinical audit forward plan (CAFP).

360 audits were identified and included within the forward plan with a further 21 audits subsequently identified ‘in year’. Two were later withdrawn making a total of 379 audits to be conducted during 2019/20. Of these 46 are continuous nursing audits with 333 audits having fixed completion dates. The categories of audits are listed in the table below together with the relevant numbers of audits planned.

Priority Level/ Category	Total number of audits			
	Total	*FP*[1]	*In-year*[2]	**Final Total (i.e. excluding withdrawn audits)**
Mandatory				
CORP[3]	8	8	-	**8**
CQUIN	14	14	-	**14**
National inc. QA[4]	88	87	1	**87**
NICE	1	1	-	**-**
Other National[5]	116	114	2	**116**
Trust	89	88	1	**89**
Nursing	46	46	-	**46**
Subtotal	***362***	***358***	***4***	***360***
Specialty interest audit				
Specialty	19	2	17	**19**
TOTALS	**381**	**360**	**21**	**379**

Key
[1]FP = audits listed in 2019/20 Forward Plan (includes audits in progress carried forward from previous year)
[2]In-year = audits that emerge after publication of the 2019/20 Clinical Audit Forward Plan (CAFP)
[3]CORP = Confidential Outcome Review Programme
[4]QA = Quality Account,
[5]Other National - include audits commissioned by NHS England, CCG and other national bodies

Quality Account audits 2019/20

During 2019/20 67 national clinical audits and 8 national confidential enquiries covered relevant health services that ENHT provides.

During that period ENHT participated in 63 (94%) national clinical audits and 8 (100%) national confidential enquiries of the clinical audits and national confidential enquiries which it was eligible to participate in.

The two tables below show:

- The National Clinical Audits and National Confidential Enquiries that ENHT was eligible to participate in during 2019/20
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2019/20, and for which data collection was completed during 2019/20, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
Antibiotic Consumption - Reducing the impact of serious infections (anti-microbial resistance and sepsis)	Yes	Yes	TBC
Antimicrobial Stewardship - Reducing the impact of serious infections (anti-microbial resistance and sepsis)	Yes	Yes	TBC
Assessing Cognitive Impairment in Older People/Care in Emergency Departments	Yes	No	Lack of financial resources to participate[1]
BAUS Urology Audits - Cystectomy	Yes	Yes	15 cases submitted
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	Yes	Yes	9 cases submitted
BAUS Urology Audits - Nephrectomy audit	Yes	Yes	18 cases submitted
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	0 cases submitted
BAUS Urology Audits - Radical Prostatectomy	Yes	Yes	84 cases submitted
Care of Children in Emergency Departments	Yes	No	Lack of financial resources to participate[1]
Case Mix Programme (CMP) (ICNARC)	Yes	Yes	Continuous data collection
Elective Surgery (National PROMs Programme)	Yes	Yes	Continuous data collection
Endocrine and Thyroid National Audit	Yes	Yes	Continuous data collection
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	Yes	Yes	Continuous data collection
Falls and Fragility Fractures Audit programme (FFFAP) – Fracture Liaison Service Database	No	No	N/A
Falls and Fragility Fractures Audit programme (FFFAP) - Vertebral Fracture Sprint Audit	No	No	N/A
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Yes	Yes	Continuous data collection
Inflammatory Bowel Disease (IBD) Registry Biological Therapies Audit	Yes	Yes	Continuous data collection
Inflammatory Bowel Disease (IBD) Service Standards	Yes	Yes	Continuous data collection
Major Trauma Audit (TARN)	Yes	Yes	Continuous data collection
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	Continuous data collection

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
Mental Health - Care in Emergency Departments	Yes	No	Lack of financial resources to participate[1]
National Adult Community Acquired Pneumonia (BTS)	Yes	Yes	60 cases submitted
National Asthma and COPD Audit Programme (NACAP) - COPD in Secondary Care	Yes	Yes	Continuous Data Collection
National Asthma and COPD Audit Programme (NACAP) - Adult asthma in secondary care	Yes	Yes	Continuous Data Collection
National Asthma and COPD Audit Programme (NACAP) - Paediatric asthma in secondary care	Yes	Yes	Continuous Data Collection
National Asthma and COPD Audit Programme (NACAP) – Pulmonary rehabilitation – organisational and clinical audit	Yes	Yes	Continuous Data Collection
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Continuous Data Collection
National Audit of Cardiac Rehabilitation	Yes	Yes	Continuous Data Collection
National Audit of Care at the End of Life (NACEL)	Yes	Yes	1 case submitted, 40 case note reviews, 1 Quality survey
National Audit of Dementia (care in General Hospitals)	No	No	NA
National Audit of Pulmonary Hypertension (NAPH)	No	No	N/A
National Audit of Seizure Management in Hospitals (NASH 3)	Yes	Yes	Continuous Data Collection
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Yes	TBC
National Bariatric Surgery Registry	No	No	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Continuous Data Collection
National Cardiac Audit Programme (NCAP) National Heart Failure Audit	Yes	Yes	76.5%
National Cardiac Audit Programme Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	TBC
National Cardiac Audit Programme (NCAP) – National Audit of Cardiac Rhythm Management	Yes	Yes	TBC
National Cardiac Audit Programme (NCAP) – Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	465 cases submitted from 01/04/19 to date
National Cardiac Audit	No	No	N/A

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
Programme (NCAP) – National Adult Cardiac Surgery Audit			
National Cardiac Audit Programme (NCAP) - National Congenital Heart Disease (CHD)	Yes	Yes	TBC
National Clinical Audit of Anxiety and Depression (NCAAD)	No	No	N/A
National Diabetes Audit - Adults - NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	Yes	40 cases registered
National Diabetes Audit - Adults - National Core Diabetes Audit	Yes	Yes	TBC
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia)	Yes	Yes	89 cases submitted
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	Yes	Yes	Continuous Data Collection
National Diabetes Audit - Adults - National Diabetes Foot Care Audit	Yes	Yes	Continuous Data Collection
National Diabetes Audit – National Diabetes Transition	No	No	N/A
National Early Inflammatory Arthritis (NEIAA)	Yes	Yes	TBC
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Continuous data collection
National Gastro-intestinal Cancer Programme - National Bowel Cancer (NBOCA combined with NOGCA)	Yes	Yes	Continuous data collection
National Gastro-Intestinal Cancer Programme - National Oesophago-gastric Cancer (NBOCA combined with NOGCA)	Yes	Yes	Continuous data collection
National Joint Registry (NJR) – Ankles	Yes	Yes	Continuous data collection
National Joint Registry (NJR) – Elbows	Yes	Yes	Continuous data collection
National Joint Registry (NJR) – Hips	Yes	Yes	Continuous data collection
National Joint Registry (NJR) – Knees	Yes	Yes	Continuous data collection
National Joint Registry (NJR) – Shoulders	Yes	Yes	Continuous data collection
National Lung Cancer Audit (NLCA)	Yes	Yes	97 cases submitted
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	TBC
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Continuous Data Collection

National Clinical Audits	Eligible	Participated	Numbers submitted (by % or total number)
National Non-Invasive Ventilation - Adults (BTS)	Yes	Yes	100% cases submitted
National Ophthalmology Audit - Adult Cataract surgery	Yes	No	No data submitted[2]
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100% cases submitted
National Prostate Cancer Audit	Yes	Yes	TBC
National Smoking Cessation Audit	Yes	Yes	TBC
National Vascular Registry - Carotid endarterectomy	Yes	Yes	16 cases submitted
National Vascular Registry - Lower limb angioplasty/stenting	Yes	Yes	5 cases submitted
National Vascular Registry - Lower limb bypass	Yes	Yes	3 cases submitted
National Vascular Registry - Major lower limb amputation	Yes	Yes	7 cases submitted
National Vascular Registry - Repair of abdominal aortic aneurysm (both elective and emergency)	Yes	Yes	6 cases submitted
Paediatric Intensive Care Audit Network (PICANet)	No	No	N/A
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	Continuous Data Collection
Prescribing Observatory for Mental Health (POMH-UK) – Use of depot/LAI antipsychotics for relapse prevent	No	No	N/A
Prescribing Observatory for Mental Health (POMH-UK) – Antipsychotic prescribing on people with a learning disability	No	No	N/A
Prescribing Observatory for Mental Health (POMH-UK) – Prescribing Valproate	No	No	N/A
Prescribing Observatory for Mental Health (POMH-UK) – Prescribing for depression in adult mental health services	No	No	N/A
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	TBC
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	Continuous Data Collection
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	TBC
Surgical Site Infection Surveillance Service (GIRFT)	Yes	Yes	26 cases confirmed as submitted
UK Cystic Fibrosis Registry	No	No	N/A
UK Parkinson's Audit	Yes	Yes	21 cases submitted

[1] Lack of financial resources to subscribe to the audit which is a subscription based programme.
[2] Lack of financial resources to purchase and install the necessary software to submit audit data

National Confidential Enquiries	Eligible	Participated	% Cases submitted
NCEPOD Child Health Clinical Outcome Review Programme - Long-term ventilation in children, young people and young adults	Yes	Yes	7 (100%)
Acute Bowel Obstruction Audit	Yes	Yes	6 (100%)
Dysphagia in Parkinson's Disease	Yes	Yes	5 (100%)
In Hospital Management of Out of Hospital Cardiac Arrest	Yes	Yes	7 (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries	Yes	No cases to submit this year	
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality surveillance and mortality confidential enquiries	Yes	Yes	1 case submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality and Morbidity confidential enquiries	Yes	Yes	TBC
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	Yes	Yes	12 cases submitted

The reports of some of the national clinical audits the provider participated in 2019/20 were reviewed and ENHT have evidenced the following to improve the quality of healthcare provided.

National Audit for Cardiac Rehabilitation
The Cardiac Rehabilitation team has been recognised by the British Association for Cardiac Rehabilitation and the National Audit for Cardiac Rehabilitation.

Patients with heart problems are seen on the ward and are invited to attend exercise classes. The classes are designed for individual needs and take place in our communities. Patient feedback has been positive and the programme is showing an improvement in patient outcomes**.**

National Early Inflammatory Arthritis Audit
The Rheumatology team have been recognised by the British Society of Rheumatology as being in 7th place across the country for their use of the National Early Inflammatory Arthritis Audit.

National Asthma & COPD Audit
The respiratory team has been recognised as one of the top performing sites in the country by the National Asthma and COPD Audit Programme (NACAP) for the number of records they have entered in the NACAP good practice repository web tool. The team has been invited to share the work they are doing in the first edition of the adult asthma good practice repository.

The National Asthma and COPD Audit Programme (NACAP) will develop a good practice repository for the adult asthma secondary care audit. The repository will highlight examples of good practice in data collection and entry as well as good practice in a series of indicators included in the clinical audit.

The reports of some of the local clinical audits the provider participated in 2019/20 were reviewed and ENHT have evidenced the following to improve the quality of healthcare provided.

BLISS Audit - Neonatal unit takes first step to accreditation
The trust's neonatal unit have successfully completed their first Bliss Baby Charter audit and have been awarded the Bliss Baby Charter Pledge of Improvement. The certificate acknowledges that they are committed to working towards Bliss Baby Charter accreditation to deliver high-quality, family-centred care.

CQUIN Antimicrobial use
The colorectal team at Lister Hospital have achieved 95% compliance with the CQUIN for appropriate antibiotic use following colorectal surgery in quarter 2 and 90% compliance in quarter 1. This helps in the work to tackle antimicrobial resistance.

CQUIN for anti-microbial resistance (lower urinary tract Infections, UTI's)
This time last year the trust took on a challenging multi-disciplinary CQUIN for anti-microbial resistance (lower urinary tract Infections, UTI's) in patients under 65.

From a zero starting point, the antimicrobial pharmacists, supported by a team from across the trust, have worked extremely hard to make significant improvements, reaching 79% compliance in January 2020.The team is keen to keep the momentum going and to achieve its target of 90% compliance in March.

Annual Audit Heroes Awards
The Plastic Surgery Department were Highly Commended in the Team of the Year category of the HQIP Annual Audit Heroes awards on 29 November 2019. The judging panel reported "This multidisciplinary team worked together to achieve a significant and sustainable improvement in the inpatient and outpatient patient pathway, patient care and outcomes for patients with lower limb skin tears across the period 2017-2019. The data collected examined all aspects of the inpatient pathway, from admission, to surgical management, to discharge. Information was also gathered regarding the initial patient clerking and management, incorporating NICE guidance on management and investigation of falls. The team also investigated post-admission 90-day mortality in light of the vulnerability of this patient group. Judges were impressed that the experience of one patient prompted what was to become wide-ranging systemic change involving acute and community services and incorporating a vast array of specialties.

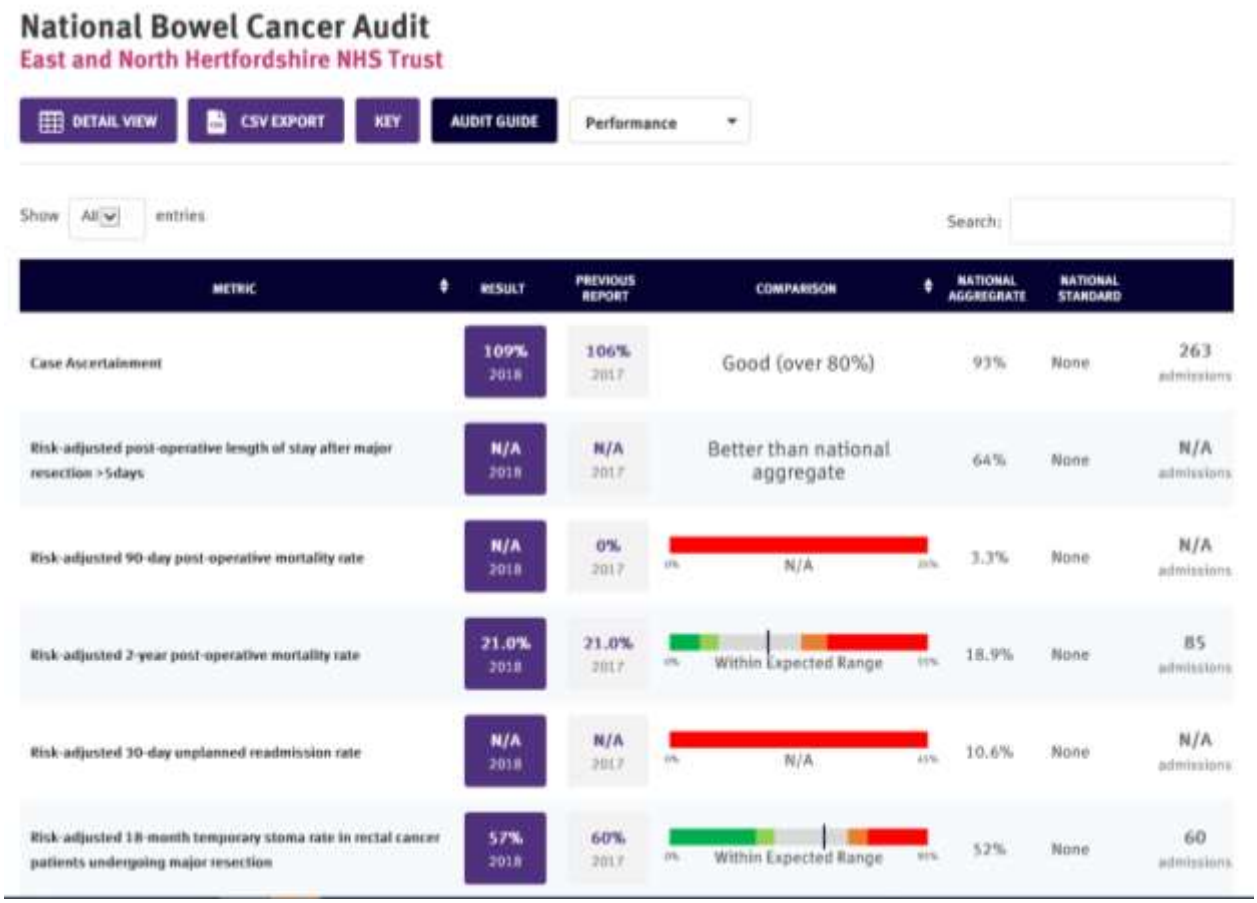
CAE team achievements and plans

- Ongoing promotion of adding to the Risk Register where audit standards have not been sufficiently met to ensure the risk is sighted and managed appropriately
- Further development of monitoring systems to simplify, streamline and automate the reporting of audit information and progress
- The CAE ran three sessions in the Lister HUB during the November national CA awareness week, to help promote and advertise clinical audit within the Trust
- Increase the understanding of QI techniques / knowledge and how this works alongside as a means of improvement
- Continue to make use of the common themes from serious incidents, risks, mortality reviews, claims and complaints to help inform the Clinical Audit Forward Plan.

National Clinical Audit Benchmarking Results (NCAB)

NCAB is an initiative originally created in collaboration between HQIP and the Care Quality Commission, with a vision to enhance the way medical directors, local clinical audit teams and others engage, interact with and share clinical audit data. NCAB provides a visual

snapshot of individual Trust audit data set against individual national benchmarks. Examples are given below.



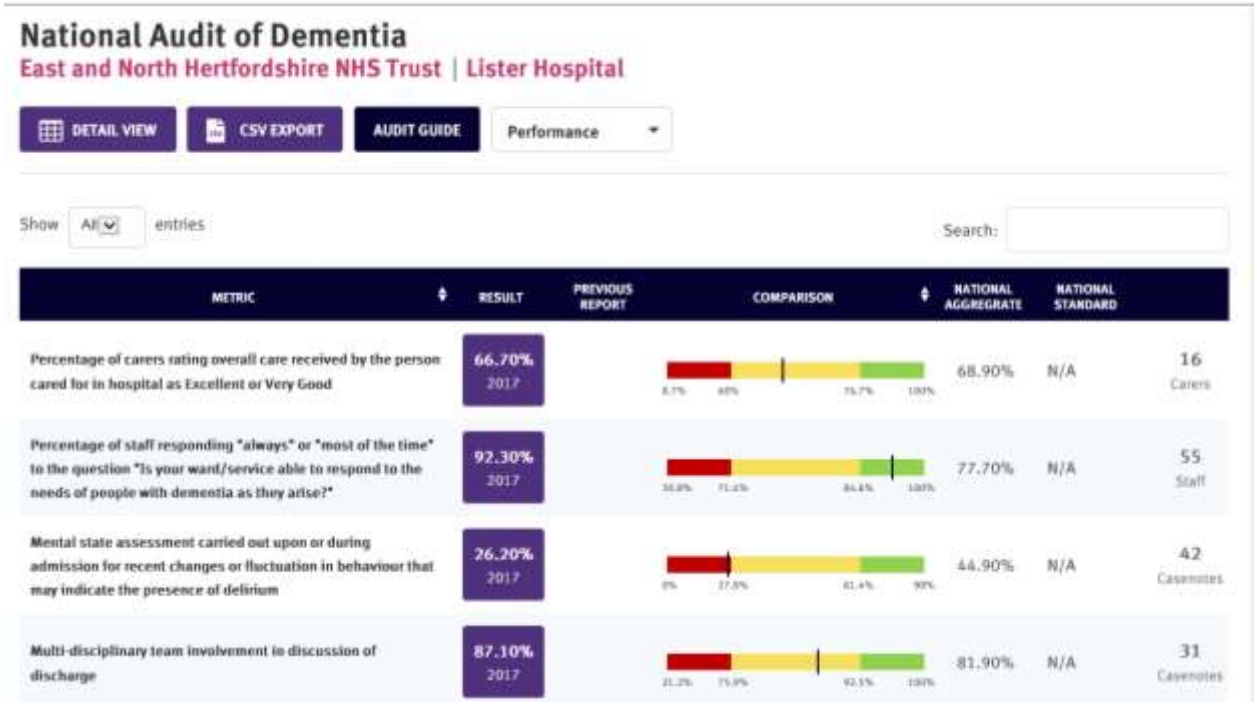
National Bowel Cancer Audit

East and North Hertfordshire NHS Trust

DETAIL VIEW | CSV EXPORT | KEY | AUDIT GUIDE | Performance

Show All entries | Search:

METRIC	RESULT	PREVIOUS REPORT	COMPARISON	NATIONAL AGGREGATE	NATIONAL STANDARD	
Case Ascertainment	109% 2018	106% 2017	Good (over 80%)	93%	None	263 admissions
Risk-adjusted post-operative length of stay after major resection >5days	N/A 2018	N/A 2017	Better than national aggregate	64%	None	N/A admissions
Risk-adjusted 90-day post-operative mortality rate	N/A 2018	0% 2017	N/A	3.3%	None	N/A admissions
Risk-adjusted 2-year post-operative mortality rate	21.0% 2018	21.0% 2017	Within Expected Range	18.9%	None	85 admissions
Risk-adjusted 30-day unplanned readmission rate	N/A 2018	N/A 2017	N/A	10.6%	None	N/A admissions
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection	57% 2018	60% 2017	Within Expected Range	52%	None	60 admissions



National Audit of Dementia

East and North Hertfordshire NHS Trust | Lister Hospital

DETAIL VIEW | CSV EXPORT | AUDIT GUIDE | Performance

Show All entries | Search:

METRIC	RESULT	PREVIOUS REPORT	COMPARISON	NATIONAL AGGREGATE	NATIONAL STANDARD	
Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good	66.70% 2017			68.90%	N/A	16 Carers
Percentage of staff responding "always" or "most of the time" to the question "Is your ward/service able to respond to the needs of people with dementia as they arise?"	92.30% 2017			77.70%	N/A	55 Staff
Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium	26.20% 2017			44.90%	N/A	42 Casenotes
Multi-disciplinary team involvement in discussion of discharge	87.10% 2017			81.90%	N/A	31 Casenotes

Heart Failure Audit

East and North Hertfordshire NHS Trust | Lister Hospital

DETAIL VIEW | CSV EXPORT | AUDIT GUIDE | Performance

Show All entries Search:

METRIC	RESULT	PREVIOUS REPORT	COMPARISON	NATIONAL AGGREGRATE	NATIONAL STANDARD	
Case ascertainment	80.00% 2019	84.90% 2018	Better than national aggregate	76.0%*	N/A	612 Cases
Crude proportion of inpatients admitted with Heart Failure (HF) who receive input from the specialist team	88.90% 2019	82.70% 2018	Better than national aggregate	82.00%	100%**	455 Cases
Crude proportion of inpatients admitted with HF who receive cardiology follow up	53.70% 2019	42.50% 2018	Worse than national aggregate	56.70%	90%***	455 Cases
Crude proportion of patients with HF with reduced fraction who are discharged from hospital on: an ACEI/ARB	87.60% 2019	96.40% 2018	Better than national aggregate	83.80%	80%***	455 Cases
Crude proportion of patients with HF with reduced fraction who are discharged from hospital on: Beta-blocker	94.70% 2019	95.60% 2018	Better than national aggregate	89.30%	80%***	455 Cases
Crude proportion of patients with HF with reduced fraction who are discharged from hospital on: Mineralocorticoid receptor antagonist (MRA)	30.70% 2019	38.30% 2018	Worse than national aggregate	54.70%	80%***	455 Cases

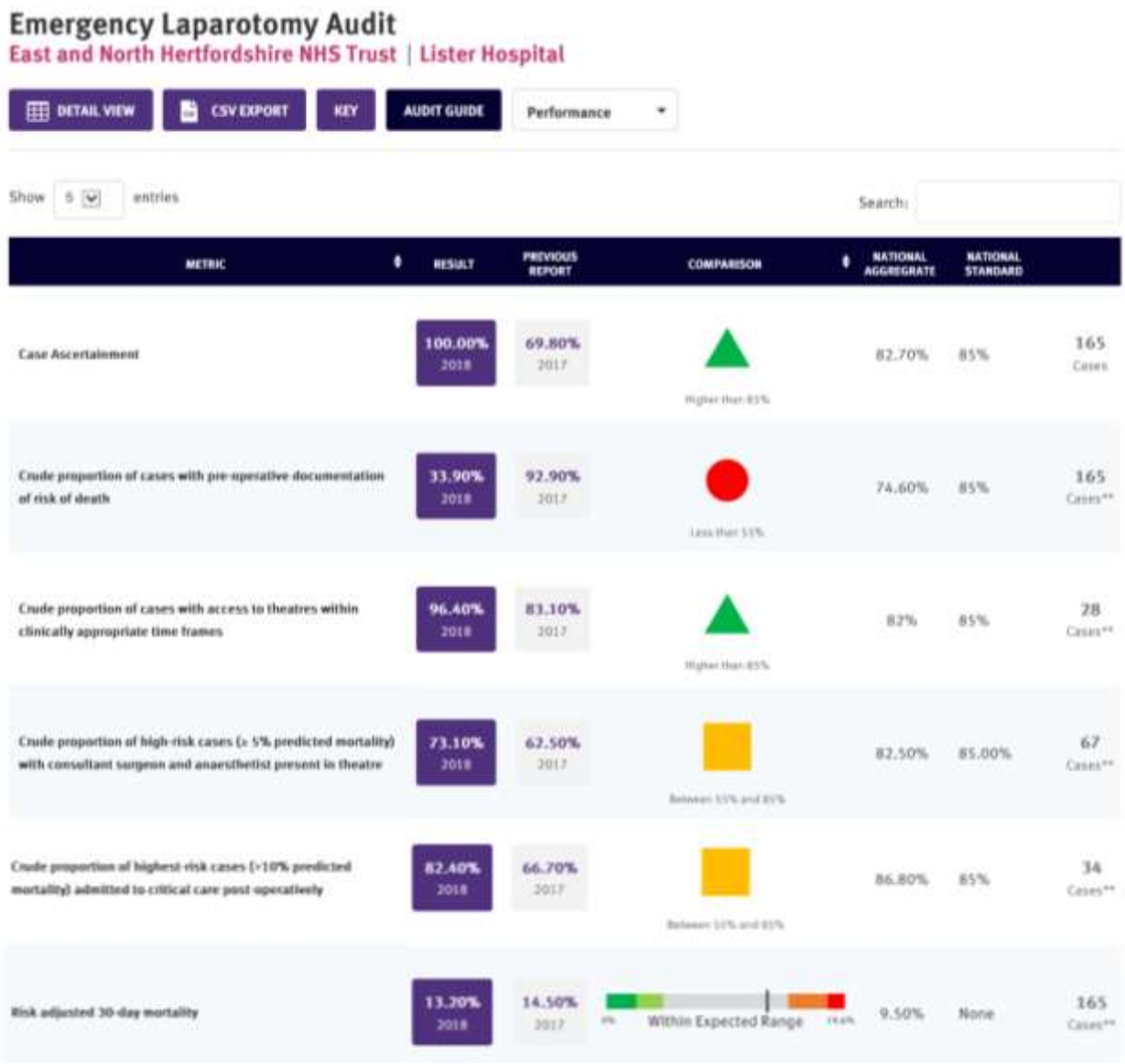
National Neonatal Audit Programme

East and North Hertfordshire NHS Trust | Lister Hospital

DETAIL VIEW | CSV EXPORT | AUDIT GUIDE | Performance

Show All entries Search:

METRIC	RESULT	PREVIOUS REPORT	COMPARISON	NATIONAL AGGREGRATE	NATIONAL STANDARD	
Mothers who deliver babies between 24 and 34 weeks gestation and were given any dose of antenatal steroids	89.70% 2018	88.90% 2017	Within Expected Range	89.07%	85%*	123 cases
Mothers who deliver babies below 30 weeks gestation given Magnesium Sulphate in the 24 hours prior to delivery	62.90% 2018	48.15% 2017	Within Expected Range	65.07%	None	21 cases
Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5°c and 37.5°c	59.60% 2018	66.00% 2017	Within Expected Range	64.47%	90%*	50 cases
Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission	92.40% 2018	92.10% 2017	Better than Expected	94.73%	100%*	749 cases
Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity	98.00% 2018	97.40% 2017	Within Expected Range	94.43%	100%**	60 cases
Babies with gestation at birth <30 weeks who had received documented follow-up at 2 years gestationally corrected age	66.40% 2018	80.00% 2017	Within Expected Range	62.33%	100%*	37 cases



Research and development

The number of patients receiving relevant health services provided or sub-contracted by the ENHT in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 2970.

Our Trust website has a dedicated section for Research where you can access further details.

Research supports the Trust vision in the following ways:

- Trust Vision: Proud to deliver high-quality, compassionate care to our community.
- Research Vision: To support high-quality, compassionate care to our community through research and innovation.
- Public & Patients: To ensure that the public and patients have the opportunity to contribute to a) the setting of the Trust's research priorities, b) the design of research studies, and c) to take part in wide range of research.
- Culture: Well trained and professional staff working within in an environment that is safe, well governed and fit for purpose.

- Principal drivers: Public and patient engagement, patient benefit, interested lead researchers, income generation, research metrics

The Trust is part of the National Institute for Health Research which has a national vision "*to improve the health and wealth of the nation through research*". The number of participants in studies adopted to the NIHR Portfolio was 2,852.

Research at the Trust was noted in the 2019 CQC report which stated in the summary that "*Leaders encouraged innovation and participation in research*". Other comments included "*Clinical research is a feature at MVCC. It is expected that all consultants should be research active contributing both to national and international studies as well as developing their own research interests. Current areas of research activity include the development of advanced radiotherapy planning for gastrointestinal (GI) tumours, immunotherapy for renal cancer and melanoma, novel radiotherapy techniques for prostate cancer and functional imaging for assessing response to chemotherapy and radiotherapy."*

Our research is led by 60 lead investigators and our research activity includes participants across 18 specialty areas. We fund 120 people (70 whole time equivalent) including consultants, doctors, research nurses, non-clinical support and management staff.

The Trust has robust structures and processes to develop and support an environment where patients, service users and the public have the opportunity to participate in health and social care research. This means new treatments, care and other services can be developed through ethical and scientifically sound research for the benefit of patients, service users and the public. Research is now embedded in the Trust's clinical strategy.

In June we launched our Patient and Public Involvement in Research panel. Many patients and public members attended and we have a fantastic resource now in place to ensure the research we support is patient-driven and patient-centred, contact: involvementinresearch.en-tr@nhs.net

During 2016-2019 the Trust successfully delivered a research strategy (see Figs 1-4) and this has been maintained during 2019/20. The number of recruiting studies has decreased as we have focussed on those studies that we are best able to deliver given the resources available.

Fig 1 Participation in NIHR Research

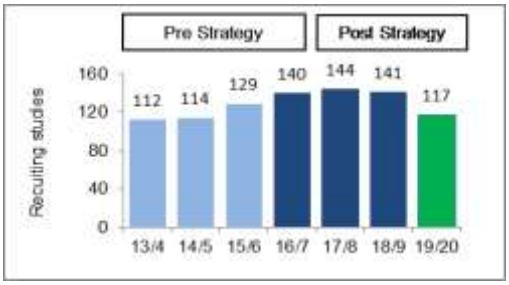


Fig 2 Recruiting NIHR Research studies

Fig 3 No of research-active specialties

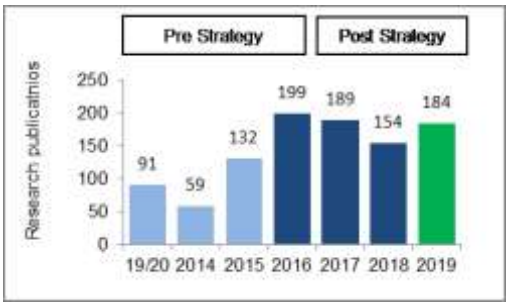


Fig 4 No of research publications

Examples of research activity are given in Annex 2.

Commissioner's contractual requirements (CQUIN)

A proportion of the ENHT's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the ENHT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at www.enht-tr.nhs.uk. The CQUINs for 2019/20 agreed with the Clinical Commissioning Group are set out in the table below.

Domain	CQUIN	Performance (Q3 – cumulative)
CCG1: Antimicrobial Resistance	Lower Urinary Tract Infections in Older People	70%
	Antibiotic Prophylaxis in colorectal surgery	92.48%
CCG2: Staff Flu Vaccinations	Staff Flu Vaccinations	68.5%
CCG3: Alcohol and Tobacco	Screening (18-19 performance 75%)	91.33%
	Tobacco Brief Advice	94.59%
	Alcohol Brief Advice	96.15%
CCG7: Three high impact actions to prevent Hospital Falls	Three high impact actions to prevent Hospital Falls	53.20%
CCG11: Same Day Emergency Care (SDEC)	Pulmonary Embolus	91.67%
	Tachycardia with Atrial Fibrillation	97.27%
	Community Acquired Pneumonia	95.24%

The results show performance for the first three quarters of the financial year to 31 December. Due to COVID-19 there was no expectation for audits to be completed, or submissions made for quarter 4. Therefore, in line with national guidance, agreement was reached with the Clinical Commissioning Group that overall 81% compliance was reached for 2019/20.

Care Quality Commission

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

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

The Care Quality Commission has not taken enforcement action against the ENHT during 2019/20.

The ENHT has not participated in any special reviews or investigations by the CQC during 2019/20.

The Care Quality Commission inspected eight of the core services provided by the Trust across Lister Hospital, the New QEII Hospital and Mount Vernon Cancer Centre in July 2019. The Well Led Inspection took place in September 2019 and the Use of Resources inspection in August 2019.

The inspectors focused on **Safety, Effectiveness, Responsiveness, Care and how well led services are** in eight core service lines:

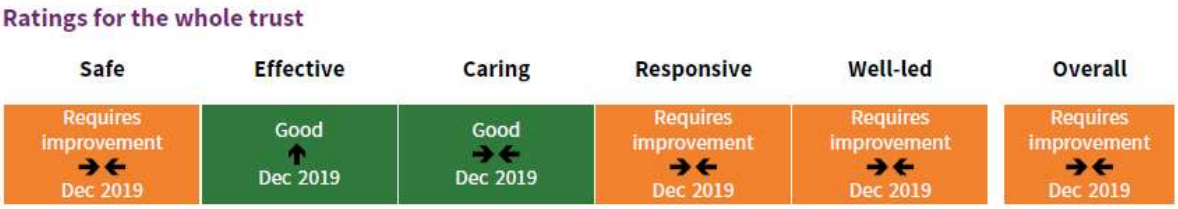
- Surgery (Lister)
- Critical Care (Lister)
- Children's and young people (Lister)
- End of life care (Lister)
- Outpatients (The New QEII, Lister and MVCC)
- Urgent and Emergency Care (The New QEII)
- Medicine (MVCC)
- Radiotherapy (MVCC)

Summary of the Trust's Ratings

Our Trust wide rating stayed the same - **requires improvement**.

We were rated as **good** for caring and effectiveness and **requires improvement** for safe, responsiveness and well led.

We were rated as **requires improvement** for use of resources.



	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019
Queen Elizabeth II Hospital	Requires improvement ↑ Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019
Mount Vernon Cancer Centre	Requires improvement → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019
	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

Examples of outstanding practice were found in children and young people's services at Lister Hospital and in radiotherapy services at Mount Vernon Cancer Centre.

The New QEII and Lister Hospitals both showed improvements, with surgery at the Lister Hospital and Urgent Care Centre at the New QEII both moving from an inadequate to requires improvement rating.

The inspectors found that:

- Staff continued to deliver compassionate care and treated patients and their loved ones with respect and dignity
- Leaders at all levels worked hard to be visible and approachable
- At the Lister Hospital the children and young people's play team delivered an outstanding service to young patients and those whose parents were acutely unwell
- At the New QEII it was easy for people to give feedback about their care, and action was taken as a result
- At Mount Vernon Cancer Centre, the staff worked together as a team and were committed to continually learn and improve services – including pilot schemes to improve access and reducing referral time for head and neck cancer patients from 50 days to 17 days

The report also highlighted areas for the Trust to improve, particularly around medicines management, maintaining equipment and premises, and ensuring that audits are conducted across the Trust. The CQC have issued a number of requirement notices and set out a number of areas for improvement - "Must Do's" and "Should Do's".

An action plan was been developed with the teams against all of these requirements and was submitted to the CQC in January 2020. Progress is reported to Board through the Quality and Safety Committee and reported to CQC through regular engagement visits. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded and sustained across the organisation. To support sustained delivery a new Compliance Framework has been developed and approved by the Quality and Safety Committee.

Data quality

The ENHT submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and the patient's valid General Medical Practice Code is given in the table below.

	Included valid NHS Number	Included valid General Medical Practice Code
Admitted patient care	99.7%	100%
Out-patient care	99.9%	100%
Accident & Emergency care	99%	100%

The results should not be extrapolated further than the actual sample audited.

The Data Quality Steering Group continues to meet regularly within new agreed governance structures and drives continuous improvement efforts to implement a data quality improvement plan by service/division.

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

- The Data Quality (DQ) strategy and DQ policy was ratified by the Audit Committee
- Introduced a framework and systematic approach to assessing quality of data across all services with overall ratings, define areas for improvement, indicating short term and long term issues
- Promote awareness of the importance of DQ and set out expectations of staff responsibility, provide training and support
- Identify divisional champions
- There is a bi- monthly Data Quality Steering Group and weekly divisional data quality meetings
- Implement a data quality improvement plan by service/division
- Provide exception reports for staff to manage improvements
- Agree and set up Trust wide data quality key performance indicators and governance structures
- Trust wide cleansing and review of legacy data

Information Governance / Data security

The Trust has assessed itself against NHS Digital's Data Security and Protection Toolkit (DSPT).

The Trust's assurance framework and risk register include the risks associated with the management and control of information. In this respect, the Trust has established a framework to support compliance with the ten data security and protection standards and the General Data Protection Regulations.

In response to the COVID-19 pandemic, the Trust opted to extend the deadline for the submission of the Data Security and Protection Toolkit to September 2020.

Progress with completion of the DSPT is monitored at the Trust's Information Governance Steering Group meetings which are held quarterly.

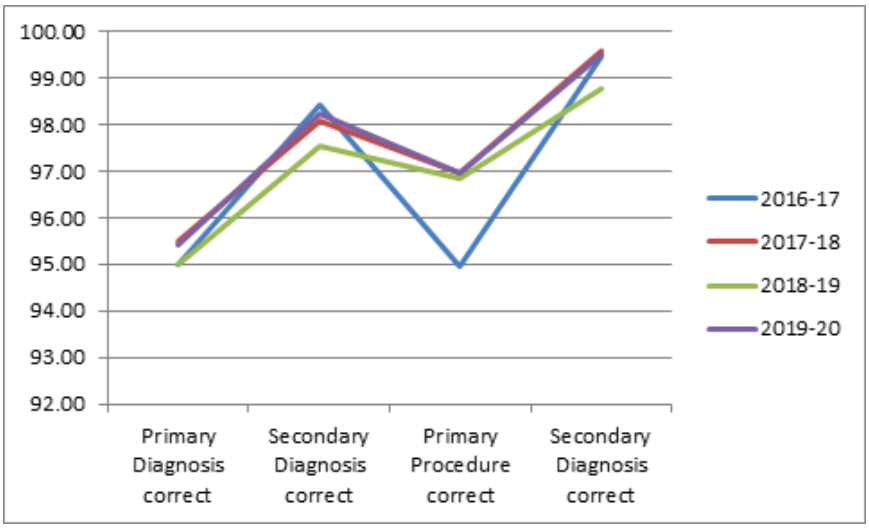
During 2019/20 we have not declared any incidents classified as Level 2 or that meet the requirements to report to the Information Commissioner's Office. All information governance incidents are reviewed by the Information Governance team and potential and actual serious incidents are reviewed in line with the national guidance through the Trust's incident review process to support learning.

Clinical coding

The ENHT was not subject to the Payment by Results clinical coding audit during 2019/20. However the Trust undertook a General Data Protection Regulation Standard 1 audit with results at Level 3 (highest level) as follows:

Year	Primary Diagnosis correct	Secondary Diagnosis correct	Primary Procedure correct	Secondary Diagnosis correct	Level
2016-17	95.00	98.43	94.96	99.46	3
2017-18	95.50	98.10	96.98	99.58	3
2018-19	95.00	97.55	96.86	98.77	3
2019-20	95.41	98.25	96.97	99.51	3

Comparisons since 2016-17 are shown in the chart below.



Learning from deaths

Reducing mortality is one of the Trust's key objectives and processes have been established to undertake mortality reviews, monitor mortality rates and ensure learning from the learning from deaths work. It also incorporates information and data mandated under the National Learning from Deaths Programme.

Mortality review process

- Stage 1 is undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It is a structured, evidence based review comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections
- Potential areas of concern (ACON's) found by reviewers trigger a Stage 2 review by the relevant Specialty with discussion and identification of learning/actions points at their Clinical Governance Forum
- Outputs feed into Stage 3 where the case is considered by the Mortality Surveillance Group, a subset of the Trust's Quality and Safety Committee. Here the adequacy/appropriateness of actions/learning points suggested by Specialties is considered and an avoidability of death score is agreed (using the scoring criteria adopted from the Royal College of Physicians methodology). Scores of ≤3 have been used to answer this question. A quality of care rating is now also agreed using the scale adopted from the PRISM methodology

As part of the mortality review process where ACONs are identified these are themed to provide an at-a-glance summary. These themes are reviewed against incident themes etc to identify learning and to plan improvements.

Fig 3: 2019-2020 ACON Key Themes

The quarterly Learning from Deaths report includes a summary of key themes emerging from the cases reviewed. This detail is shared with all Trust Specialties and with interested working groups such as Deteriorating Patient, End of Life and Seven Day Services Steering Group.

Work is currently underway in conjunction with Business Informatics and the Head of Coding to gather appropriate data and set up reports to monitor, provide assurance and in time learning from the COVID period.

During the initial COVID planning phase, and in anticipation of significant clinical pressures, all mortality reviews were initially suspended. A plan was created to recommence reviews early in 2020/21 particularly of vulnerable patients, together with a selection of COVID and non COVID patients.

Statutory ref.	**Response** (using prescribed wording)
27.1	During 2019/20 1430 of ENHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 416 in the first quarter • 347 in the second quarter • 299 in the third quarter • 368 in the fourth quarter
27.2	By 31 March 2020, 856 case record reviews and 59 investigations have been carried out in relation to 1430 of the deaths included in item 27.1. In 47 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: • 194 in the first quarter • 198 in the second quarter • 269 in the third quarter • 195 in the fourth quarter
27.3	1 representing 0.07% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: • 1 representing 0.24% for the first quarter • 0 representing 0% for the second quarter • 0 representing 0% for the third quarter • 0 representing 0% for the fourth quarter *[Note: this does not mean that no 2019-20 deaths will be identified within the item 27.3 definition, but that by 31 March 2020 only 1 concluded ACON investigation had fallen within this definition. As detailed in 27.8 below, investigations concluded after the end of the current reporting period will be reported in next year's Quality Account].* These numbers have been estimated using the Trust's Mortality Review process described above.
27.4	1 2019-20 death has so far been identified within the item 27.3 definition. This information is based on concluded ACON investigations considered by the Mortality Surveillance Committee by 31 March 2020. [Refer to note in 27.3] This death was declared a formal serious incident with ensuing investigation and report provided to and approved by our Commissioners. The Mortality Surveillance Committee considered the case in February 2020. It noted that Cardiology had accepted that they should have taken stronger ownership of this case. Failings in the longer term care of the patient were identified (rather than in the final admission). The Committee concluded that

Statutory ref.	**Response** (using prescribed wording)
	there was strong evidence of avoidability of the death.
27.5	The following were the key actions/learning as a result of the SI investigation of the death: i) Follow NICE guidelines for Acute Coronary Syndrome patients ii) All outpatient investigations/tests to be requested by an appropriate doctor i.e. Consultant/SpR or delegated doctor with appropriate training/supervision. iii) Ensure correct date and time is displayed on an ECG recording iv) Ensure that 24 hour ECG monitor tapes are reported depending on clinical priority
27.6	Integrated Care Plan for ACS patients have been updated and made more accessible; appropriate reminders issued to staff regarding entering the date each time an ECG recording is completed via Matron's weekly bulletin, Safety huddles and Learning from incidents governance board - impact not yet assessed; work remains on-going to standardise cardiology appointment practices.
27.7	84 case record reviews and 49 ACON investigations completed after 1 April 2019 which related to deaths which took place before the start of the reporting period.
27.8	*5 [of the 51 cases reported in 27.7 above]* representing 0.34% of the patient deaths before the reporting period *[ie 2018/19]* are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the mortality review process methods detailed above in 27.3.
27.9	5 representing 0.34% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient *[this represents a revised total figure incorporating the sum of 27.3 from last year's report and 27.8 above]*.

2.3 Performance against national core indicators

In this section the outcomes of a set of mandatory indicators are shown. This benchmarked data, provided in the tables, is the latest published on the NHS Digital website and is not necessarily the most recent data available. More up to date information, where available, is given.

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

Mortality

Mortality rates have improved over the last 5 years as measured by both of the major methods: HSMR and SHMI.

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers patients who died either while in hospital or within 30 days of discharge.

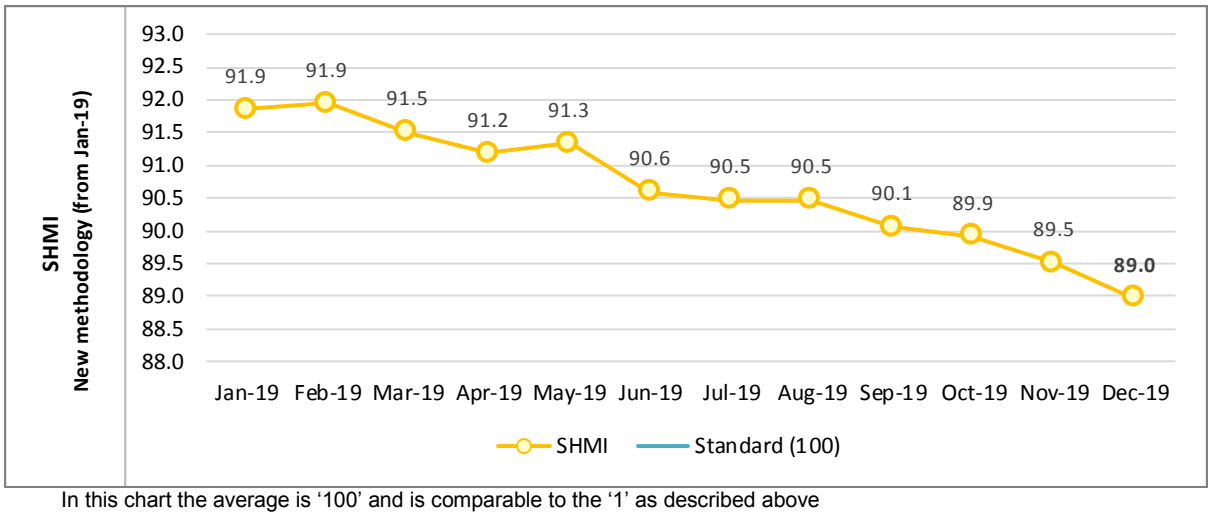
SHMI data is not adjusted for palliative (end of life) care. This is because there is considerable variation between trusts in the coding of palliative care. However, to support the interpretation of the SHMI, various contextual indicators are published alongside it, including indicators on the topic of palliative care coding.

SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
SHMI	Value	0.889	Jan-Dec 19	0.999	0.688	1.199	1
	Banding	2 - As expected		As expected	-	-	N/A
% deaths with palliative care code	N/A	34		37.6%	60	10	N/A

The national average is always reported as ‘1’ with a smaller number representing a better outcome. The SHMI for the twelve months to December 2019 is **0.89**, slightly better than the national average and within the ‘as expected’ range. SHMI is generally available 6/12 in arrears. This places us 19th nationally out of all acute non-specialist trusts.

Over the last four years the SHMI has reduced by 16 points with a temporary rise, as expected, following the introduction of Lorenzo in September 2017 when mortality rates were affected by changes to the depth of coding. This phenomenon is commonly seen following the introduction of a new patient administration system, but is temporary.

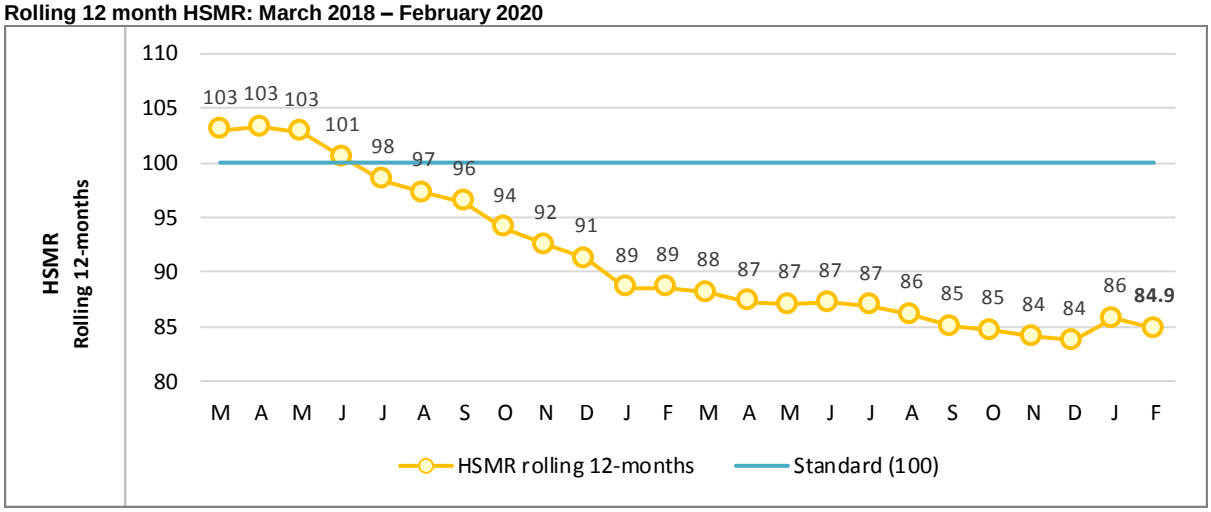


In this chart the average is '100' and is comparable to the '1' as described above

A different measure of mortality is the Hospital Standardised Mortality Ratio (HSMR) which measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics eg. demographics.

The England average is always 100 (blue line in the graph below) and a lower number indicates better than average. Performance has remained in the 'as expected range' and there was a predictable, unsustained increase in HSMR following the introduction of the Lorenzo system as described earlier. HSMR is generally available 3 months in arrears and the latest HSMR for the rolling 12 months to February 2020 is 84.9 and within the 'as expected' range. It should be noted that mortality data is now taken from CHKS rather than Dr Foster. This has resulted in an apparent reduction in HSMR of approximately 10 points. This is due to the fact that the CHKS data rebases once every 12 months, whereas Dr Foster rebases monthly. This does not affect our ability to compare our performance with peers.

Rolling 12 month HSMR: March 2018 – February 2020



The ENHT considers that this data is as described, as it is based on data submitted by the Trust to a national data collection, and reviewed as part of the routine performance monitoring. The ENHT has taken the following actions to improve these scores, and so the quality of its services, by presenting and tracking monthly data to identify and investigate changes. The mortality data is also captured by diagnosis so any deviation can be investigated at the case by case level.

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement, knee replacement and up to September 2017, varicose vein and groin hernia surgery in England.

Indicator	Measure	Trust result	Time period	Trust previous result*	Best performing trust	Worst performing trust	National average
Groin hernia	EQ-5D	Data no longer collected	April-Sept 2019 (Prov)	0.09	Data submission ceased in October 2017		
	EQ-VAS			0.94			
Varicose vein surgery	EQ-5D			0.12			
	EQ-VAS			3.05			
	Aberdeen			-11.11			
Hip replacement surgery	EQ-5D	**		0.46	0.55	0.39	0.47
	EQ-VAS	**		14.1	23.76	9.02	14.38
	Oxford	**		22.37	25.47	18.74	22.52
Knee replacement surgery	EQ-5D	**		0.33	0.44	0.26	0.35
	EQ-VAS	**		7.27	15.05	2.49	8.74
	Oxford	**		17.14	21.28	14.45	17.64

*Hernia and varicose vein information from year; Hip and knee information for April 18 – March 19 (final data))

Patients are given questionnaires to complete before and after surgery, from which the improvement is measured. Three methods of data collection are used:

EQ-5D: The score comprises five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. The score ranges from -0.594 (worst possible health) to 1.0 (full health).

EQ-VAS: The score records the patient's self-rated health on one scale ranging from 0 (worst) to 100 (best).

Oxford Score: The score records the views of patients on 12 aspects of their daily living with the total score ranging from 0 (worst) to 48 (best).

In October 2017 the collection of groin hernia and varicose vein patient reported outcome measures ceased, hence data is not provided.

The ENHT considers that this data is as described, as it is based on data submitted by users of the service to the national data collection team. The number of submissions of forms is insufficient to generate outcomes measures within the provisional data. ENHT has taken the following actions to improve this score, and so the quality of its services, by monitoring data to confirm the data is correct. Of note, is that elective surgery was suspended as a result of covid-19 service re-design.

Emergency readmissions

This indicator measures the percentage of patients readmitted to hospital within 28 days of being discharged from hospital after an emergency admission.

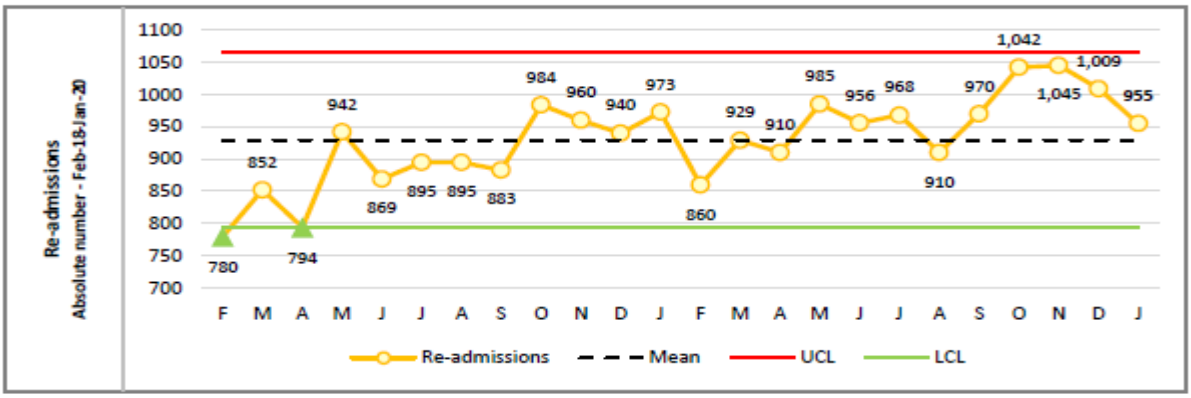
Indicator	Measure	Trust result	Time period	Trust previous result*	Best performing trust	Worst performing trust	National average
28 day emergency readmission rate	Age 0-15	13.3	2018/19	13.4	1.8	69.2	12.5
	Age 16 and over	13.3		12.5	2.1	57.5	14.6

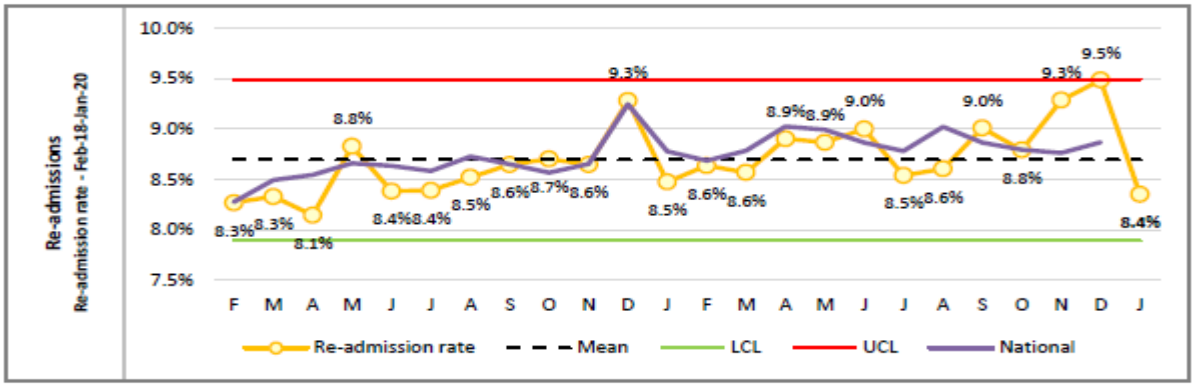
*Providers in 2017/18

Nationally there is an ongoing review by NHS Digital of emergency readmissions indicators. It is intended that new indicators will not be published until 2021.

Data now being collected relates to readmission to hospital within 30 days of discharge.

The Trust's re-admission rate has generally been consistent with the national performance. The most recent comparable month was Oct 2019 where the trust re-admission rate was 8.8% compared with the national average at 8.5%. Data over the last two years has indicated an increasing number of re-admissions and a readmission rate between 8% and 9.5% as shown in the charts below.





Responsiveness to patient needs

The indicator is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to hospital. The questions, together with their scores (scale 0-10) from the 2018 survey, are given in the table below. Results of the 2019 survey are not due until later in the year.

Indicator	Measure	Trust result	Time period	Trust previous result*	Best performing trust	Worst performing trust	National average
Responsive to needs	Involved	68	2018/19	69.2	87.8	62.4	72.8
	Fears	-		-	-	-	-
	Privacy	93.4		94	98.7	90.6	94.8
	Side effects	41.5		43.8	74	34.1	46.5
	Contact	-		-	-	-	-

*2017/18

The scores in the table below show the scores (out of 10) together with the comparison with other trusts.

Question	Trust Score	Compared with other Trusts
Were you involved as much as you wanted to be in decisions about your care and treatment?	6.8	Same
Did you find someone on the hospital staff to talk to about your worries and fears?	4.8	Same
Were you given enough privacy when discussing your condition or treatment?	8.2	Same
Did a member of staff tell you about medication side effects to watch for when you went home?	4.1	Same
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.2	Same

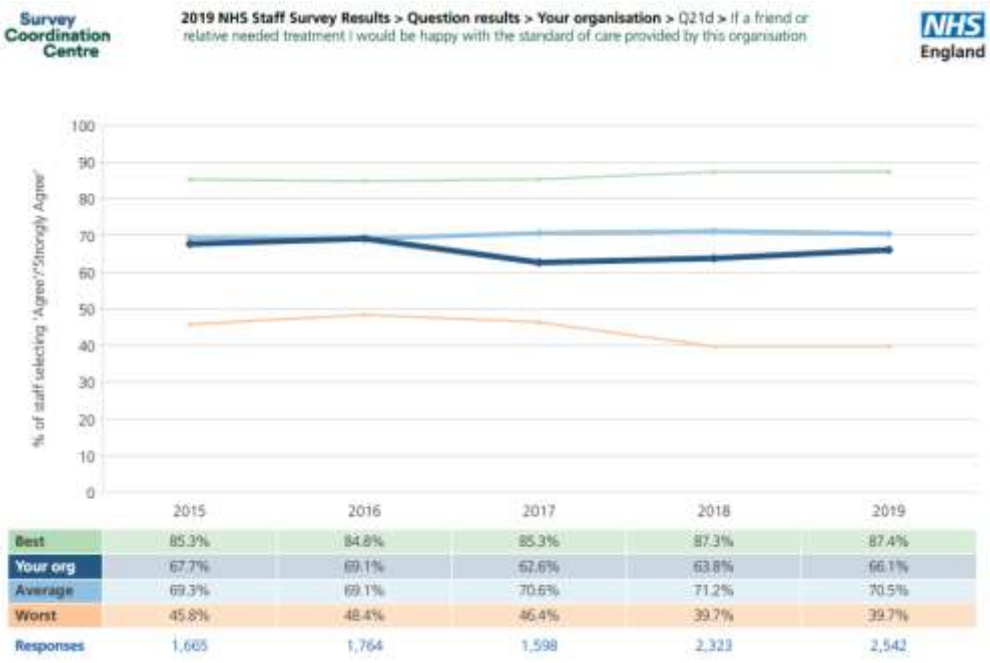
ENHT considers that this data is as described, and it is based on data submitted directly by patients to the national survey. ENHT continues to take action to improve patient and carer experience and this is detailed within the divisional patient experience action plans submitted to, and monitored by, the Patient and Carer Experience Committee.

Staff recommending the Trust

Indicator	Measure	Trust result	Time period	Trust previous result*	Best performing trust	Worst performing trust	National average
Recommend the Trust	Staff	66%	2019/20 Q2	64%	95%	41%	71%

* Previous Trust result for staff survey was 2018; patient survey January 2020

2605 members of staff completed the NHS national staff survey in 2019 representing a 45% response rate. Of those surveyed, 66.1% of staff state they would recommend the organisation as a place to receive treatment. This represents an improving picture over the last three years as shown in the chart below, but remains below the national average.



Throughout the survey there are some mixed scores although the year on year trend is wholly positive and almost all scores are improving. However, when benchmarked by sector, we are below average for 7 out of the 11 themes, with the lowest from average scores for safety culture and bullying and harassment.

2019/20 saw the launch of the Trust's People Strategy which sets the organisation's ambitions and expectations for its people. It is set out to respond to the issues that we are aware of and that are demonstrated within the staff survey results. The strategy is structured into key themes:

- Work Together
- Grow Together
- Thrive Together
- Care Together

The trust is embarking on a 'what matters to you' programme which will build on staff feedback to further develop the organisation into a place where people are proud to work and to receive treatment.

The ENHT considers that this data is as described, as it is based on data submitted directly by staff to the national surveys programme. The ENHT has taken the following actions to improve this score, and so the quality of its services, by reviewing the survey responses and producing initiatives to improve staff engagement.

Patients recommending the Trust

Detailed information on this indicator is given in section 4.1.

For the purpose of this section the findings are shown compared with other organisations.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
Recommend the Trust	Patients	IP 97% A/E 94% Mat 94%* OP 96%	Feb 2020	IP 97% A/E 91% Mat 97% OP 97%	100% 99% 100% 100%	73% 40% 86% 76%	96% 85% 97% 94%

*Maternity indicator is a measure relating to birth experiences only

The ENHT considers that this data is as described, as it is based on data submitted directly by patients to the national surveys programme. The ENHT has taken the following actions to improve this score, and so the quality of its services, by reviewing the survey responses and producing initiatives to improve patient engagement; and by reviewing patient survey responses alongside other sources of patient feedback to determine improvements.

Venous Thromboembolism (VTE)

The data below shows the percentage of adult inpatients admitted who have been risk assessed for VTE on admission. A national threshold of 95% has been set.

Indicator	Measure	Trust result	Time period	Trust previous result*	Best performing trust	Worst performing trust	National average
VTE assessments	N/A	88.07%	2019/20 Q3	94.68% Q3	100%	71.59%	95.33%

* 2018/19

The ENHT considers that this data is as described, as it is based on data submitted directly into the national system. The ENHT has taken the following actions to improve this score, and so the quality of its services:

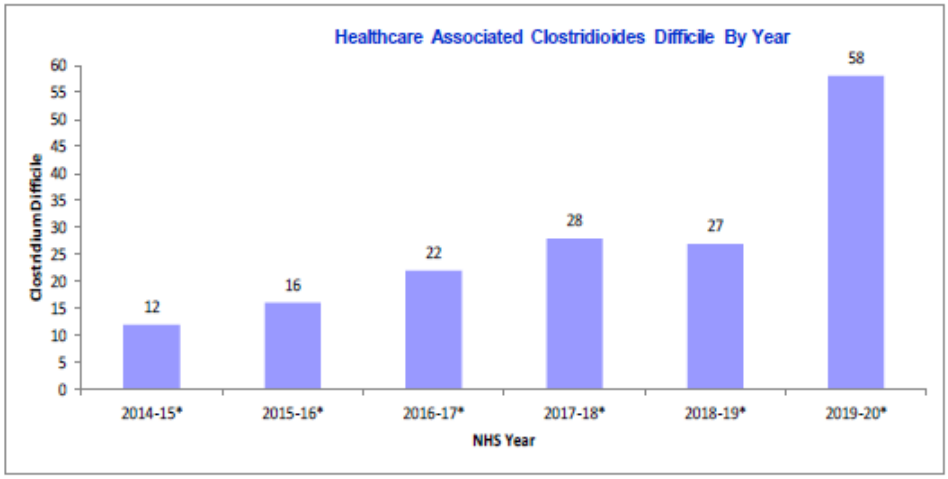
- Regular data collection via multiple means as reported in priority 2.6 earlier in the report
- Data review by the Thrombosis Action Group.

Clostridium difficile

This indicator measures the number of hospital acquired Clostridium difficile infections per 100,000 bed days.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
Clostridium Difficile infection rate	Number of incidents	70	2018/19	87	0	366	-

In 2019/20 the trust reported 58 cases of *c.difficile* against a planned ceiling of 52 cases.



For 2019-20, new definitions for Healthcare Associated *C.difficile* cases were introduced, resulting in a significant increase in reportable cases. Cases are now assigned as follows:

- Hospital Onset Healthcare Associated (HOHA): Detected in hospital 3 or more days after admission (previously 4 or more days after admission)
- Community Onset Healthcare Associated (COHA): Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 4 weeks (these cases were previously assigned to the community but are now hospital attributed)
- Community Onset Indeterminate Association (COIA): Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 12 weeks but not the most recent 4 weeks
- Community Onset Community Associated (COCA): Detected in the community (or within 2 days of admission) when a patient has not been an inpatient in the Trust in the previous 12 weeks.

The year-end position represents 41 HOHA and 17 COHA cases. This is equivalent to 29.73 cases per 100,000 bed days (Public Health England data for Apr 19-Mar 20) against the ceiling target of 25.30 cases. The England average rate was 23.49.

Metric	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Number of c.difficile incidences Healthcare-associated	4	2	3	3	4	6	5	9	7	5	2	4	6
Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	11.4	16.6	17.1	23.0	34.6	29.8	51.1	41.1	28.4	11.2	23.9	33.5

All cases are reviewed by a joint Trust & CCG panel to ensure any learning is identified and appropriate actions are put in place, and to agree cases that should be exempt from financial sanctions. Of the 31 cases presented to date, 26 have been provisionally accepted for exemption and further information has been requested for 2 cases. Two of the cases investigated have been found to be as a result to lapses in care. However, learning has been identified by the teams involved and the Infection Prevention and Control team. Presentation of the remaining cases has been postponed due to the Covid-19 pandemic.

Patient safety incidents

Incidents are reported on the electronic reporting system, Datix. The patient safety incident data is uploaded into a national system where incident reporting patterns, types of incidents etc can be analysed. The rate of incidents is the number reported per 1,000 bed days.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
Patient safety incidents	Number of incidents	4253	April – Sept 2019	3940	-	-	-
	Rate	40.7		38.1	103.8	26.3	
	Number of severe harm / death	26		30	0	95	-
	% of severe harm / death	0.6		0.7	0	1.6	-

*Acute non-specialist trusts

The ENHT has taken the following actions to improve this score, and so the quality of its services by implementing a range of initiatives to continuously improve incident management, promoting a safety culture and improving feedback to staff on learning.

The graph below shows the number of patient safety incidents reported by quarter over the last three years. The number has risen, although a dip is seen in quarter 4 of 2019/20 due to covid-19 and the reduction in the number of patients attending the Trust. The rate of patient safety incidents, per 1,000 bed days has increased and information from the national reporting and learning system indicates that there is no evidence of under reporting.

The staff survey 2019 results demonstrate continuous improvement in areas relating to incident management as shown in the series of graphs below. However we know that staff do not always report errors that they witness and this will be a focus for patient safety improvement during 2020/21.

Part 3

3.1 Review against selected metrics

Patient safety

Indicator	17/18	18/19	19/20	Aim (19/20)	Aim (20/21)
Never events	6	6	**3**	0	0
MRSA Bacteraemia (post 48 hours)	1	2	**6**	0	0
Number of inpatient falls	859	845	**816**	<832*	TBC**
Number of inpatient falls resulting in serious harm	12	12	**2**	≤15	TBC**
Number of preventable hospital acquired pressure ulcers	33	101	**151** **(0.62 PU per 1000 bed days)** **2 cat 4**	≤25 Zero Cat 4	0.49 PU per 1000 bed days Zero Cat 4

* 2018/19 report gave aim as <845
**Due to the COVID-19 pandemic the trajectories have not been agreed, but the Trust will continue to implement falls prevention measures

Never events

A never event is an incident that should never happen if the correct procedures are in place and being followed to prevent an occurrence. The table below indicates the number of never events reported in the trust during the last three years.

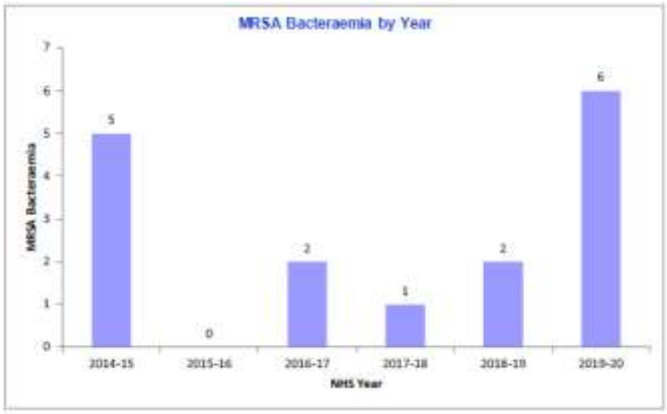
	2017/18	2018/19	2019/20
Wrong site surgery	1	4	1
Retained object	3	0	1
NG Feeding	1	1	0
Blood transfusion	1	0	0
Oxygen tubing to air	N/A	1	1
Trust	**6**	**6**	**3**

A trust Never Event oversight group is now active and oversees risks associated with the NHS Improvement Never Events policy and framework. Risk assessments have been undertaken in many of the clinical areas but completion has been hindered due to covid-19. The final results will be collated into a heat map gap analysis and an action plan created where indicated.

The findings following in-depth investigation of the never event incidents have been incorporated into the safer surgery workstream and the never event audit programme.

MRSA Bacteraemia (post 48 hours)

MRSA bacteraemias are classified as Hospital Onset if the sample is taken later than the day following admission. Six MRSA bacteraemias have been reported during the year against a plan of zero. This is an increase by four compared to 2018/19.



Metric	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Number of MRSA incidences	0	1	0	0	1	0	1	0	0	2	1	0	0
Rate of MRSA incidences per 100,000 bed days	0.6	5.7	0.0	0.0	5.8	0.0	6.0	0.0	0.0	11.4	5.6	0.0	0.0

Benchmarking data for Trust apportioned MRSA bacteraemias is not recorded by Public Health England.

Each incidence has undergone local root cause analysis investigation and action plans are monitored through the cross-division MRSA Bacteraemia Improvement Group which was convened to establish Trust wide actions to address the MRSA incidents. The learning associated with these incidents is generally around the insertion and checking of intravenous cannula which are used for giving medications and fluids (a drip). The trust continues to promote minimising the time the cannulae are in place; and the use of the aseptic not-touch technique when managing IV devices.

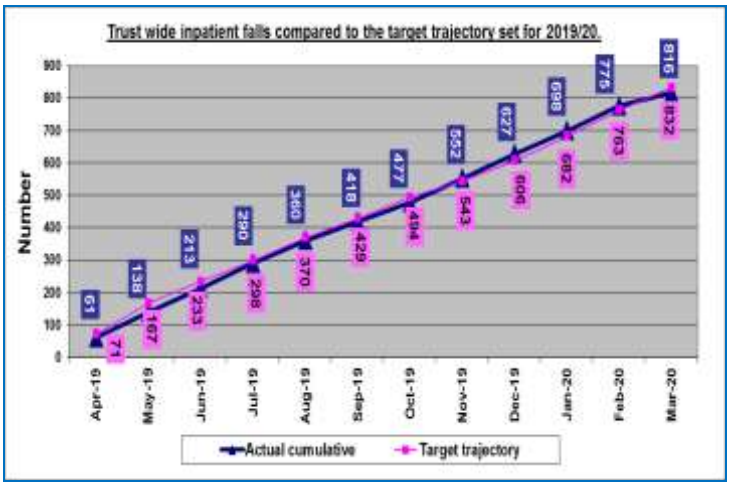
Actions are underway to move towards national, rather than trust, policies and processes and to use a national tool to align clinical practices across the Trust as it has been identified that practices have not been standardised across all divisions.

Number of inpatient falls

During 2019/20 there were 816 inpatient falls. This represents a 2% reduction when compared to 2018/19 and meets the reduction target of fewer than 832 set for the year. This is the lowest annual number of inpatient falls recorded in the Trust historically.

Themes for continuous improvement include:

- Improving processes to support safe care at night
- Review and test changes to falls risk assessment tools



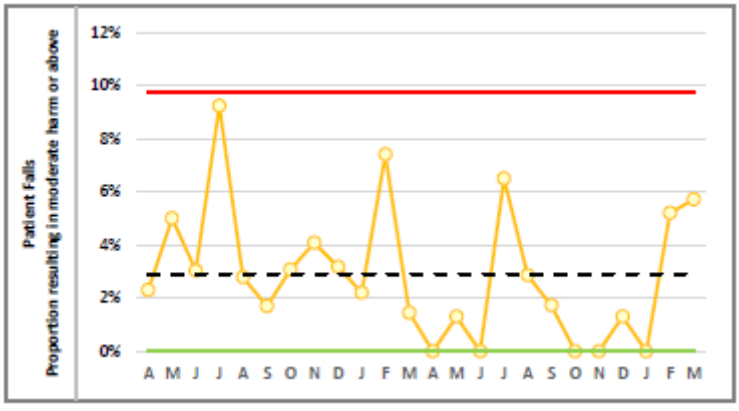
Number of inpatient falls resulting in serious harm

On admission patients are assessed as to their risk of falling. Once the assessment is complete an action plan is written which provides an individual plan of care for the patient to minimise their risk of falling. Where a patient is deemed at high risk of falling there are a number of actions that can be taken such as the use of bed rails; one to one supervision; close supervision in a bay – known as Baywatch.

Occasionally a patient will fall despite best efforts to prevent it. Approximately 5 falls per 1,000 overnight stays have been recorded each month.

Domain	Metric	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Patient Falls	Number of patient falls	72	61	77	75	77	70	58	59	75	77	70	77	55
	Rate of patient falls per 1,000 overnight stays	4.0	4.1	5.1	5.4	5.1	5.2	4.3	4.1	5.5	5.2	5.0	6.3	2.8
	Number of patient falls resulting in serious harm	0	0	0	0	1	0	0	0	0	0	0	0	1

The graph below shows the trends in falls resulting in moderate harm (temporary harm that requires further treatment), severe harm (permanent harm) or death.



During 2019/20 there were two falls resulting in serious harm. Both were investigated as serious incidents with learning identified and practices improved.

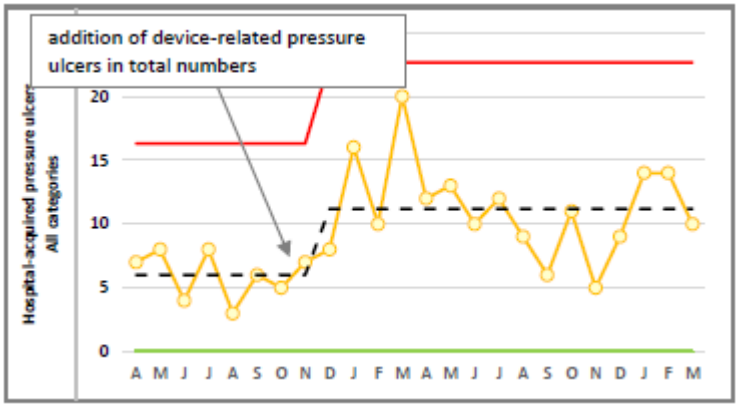
Number of preventable hospital acquired pressure ulcers

The trust is currently reporting an average of 12.5 pressure ulcers (PU) per month with a rate of 0.62 per 1000 bed days. 2019/20 is the first full year of the trust reporting full

compliance with the new NHS improvement recommendations that were implemented in late 2018.

	2016/17	2017/18	2018/19	2019/20
Number of patients with reportable PU	27	33	101	151

The trust is now reporting fully against all categories of damage (excluding PU1) regardless of avoidability; and declaring all ulcers that are not found on the first skin inspection (within 6 hours of admission) as 'hospital acquired'. The trend over the last two years is shown in the graph below.



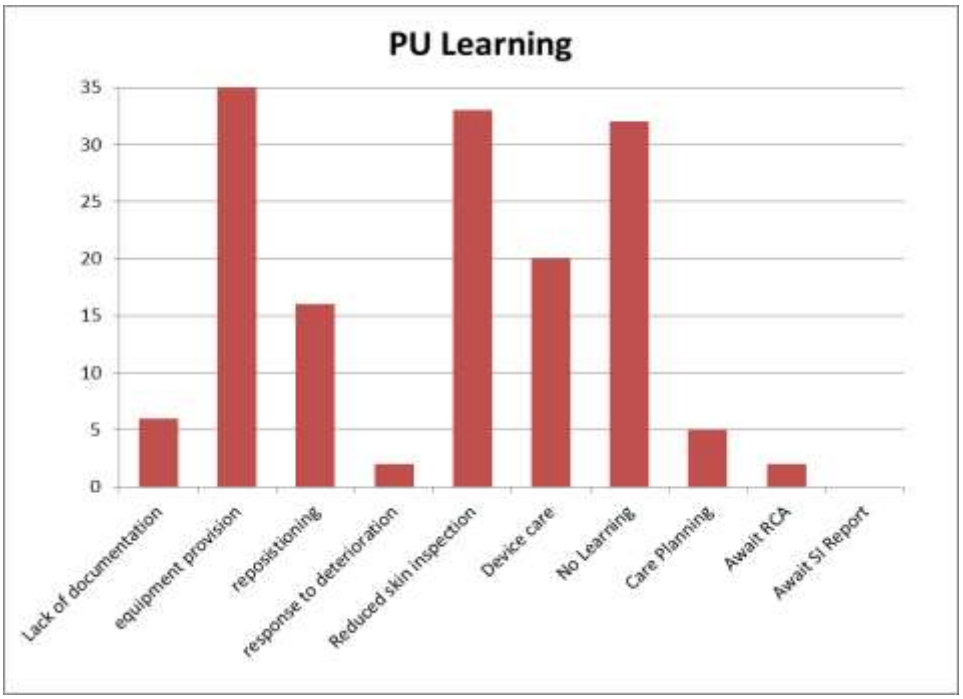
The spread of incidence by category is detailed in the table below.

Cat 2	Cat 2 (d)	Cat3	Cat 3 (d)	US	US (d)	Cat 4	SDTI	SDTI (d)	MM (d)
25	10	1	1	9	10	2	74	14	5

Category 2 (open wound or blister), 3 (affecting deeper skin layers), 4 (deep possibly reaching muscle and bone)
Unstageable – involves skin or tissue loss of unknown depth
Suspected deep tissue injury – discoloured intact skin or blood filled blister
Moisture lesion – increased moisture making the skin susceptible to damage

The table above demonstrates a high incidence of SDTI ulcers (n=88). Previously these would have been recorded by the tissue viability team but not incorporated into the numbers reported nationally. 53 (65%) of these SDTI ulcers are located on the patients heel. It is clear from the data gathered that the heel ulcer is the most prevalent type of ulcer at the trust and has become the focus of this year's Quality Improvement work.

Quality improvement work has also been informed by the common themes identified at root cause analysis as shown in the chart below, and through participation with cohort 1 of the NHS Improvement pressure ulcer prevalence and quality of care audit in May 2019.



NHS Improvement pressure ulcer prevalence and quality of care audit:

6039 patients across 23 hospitals in 13 NHS Trusts were included in the audit. Of those, 617 had one or more pressure ulcers demonstrating an overall prevalence of 10.2%.

Of the 509 trust patients audited 43 had one or more pressure ulcers, equating to a prevalence for this organisation of 8.45%, lower than the average of the participating trusts.

The audit also demonstrated a low compliance with conducting risk assessments with 57.4% being completed within 6 hours of admission. However care was planned for 88.3% of these patients. The audit identified that the quality of care planning could be improved, for example a repositioning regime was in place for 44.8% of patients at the time of the audit.

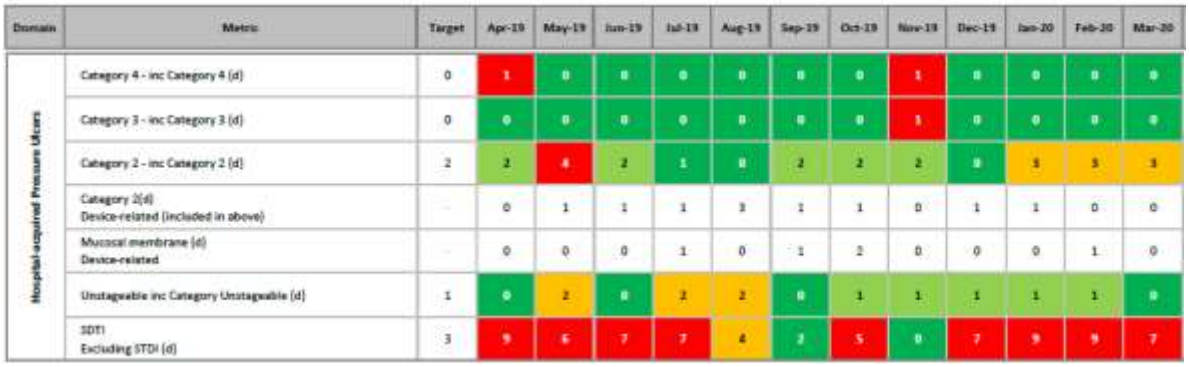
It was clear from the audit, however, that there is an excellent level of reporting of pressure ulcers within the organisation with only one pressure ulcer identified during the audit that not had previously been reported.

Following the audit the trust's Lead Tissue Viability Nurse engaged the trust in the NHS Improvement "Stop the Pressure" pressure ulcer reduction collaborative so that lessons learned from the audit could be shared and practice improved.

Two ward teams were selected to participate in the collaborative and plan QI work around the reduction of pressure ulcers. The programme sits within the wider National Wound Care Strategy and National Patient Safety Strategy, which is also linked to the NHS Long Term Plan published in January 2019. This QI work began in September with ward teams choosing to focus on the reduction of heel SDTIs. Driver diagrams were written and change ideas discussed and implemented in January 2020. Data collection against these change ideas is currently underway to inform our improvement cycles.

During 2020/21 the trust aims to reduce the rate of pressure ulcers by 20%. This will be achieved by the spread of the pressure ulcer reduction QI work from the 2 pilot wards across the organisation, supported by education from the Tissue Viability team. A focus will also be placed on reducing moisture associated skin damage as this can increase an

individual's risk of developing a pressure ulcer. The chart below shows a monthly record of pressure ulcers.



Domain	Metric	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Hospital-acquired Pressure Ulcers	Category 4 - inc Category 4 (d)	0	1	0	0	0	0	0	0	1	0	0	0	0
	Category 3 - inc Category 3 (d)	0	0	0	0	0	0	0	0	1	0	0	0	0
	Category 2 - inc Category 2 (d)	2	2	4	2	1	0	2	2	2	0	3	3	3
	Category 2(d) Device-related (included in above)	-	0	1	1	1	3	1	1	0	1	1	0	0
	Mucosal membrane (d) Device-related	-	0	0	0	1	0	1	2	0	0	0	1	0
	Unstageable inc Category Unstageable (d)	1	0	2	0	2	2	0	1	1	1	1	1	0
	SDTI Excluding STDH (d)	3	9	6	7	7	4	2	5	0	7	9	9	7

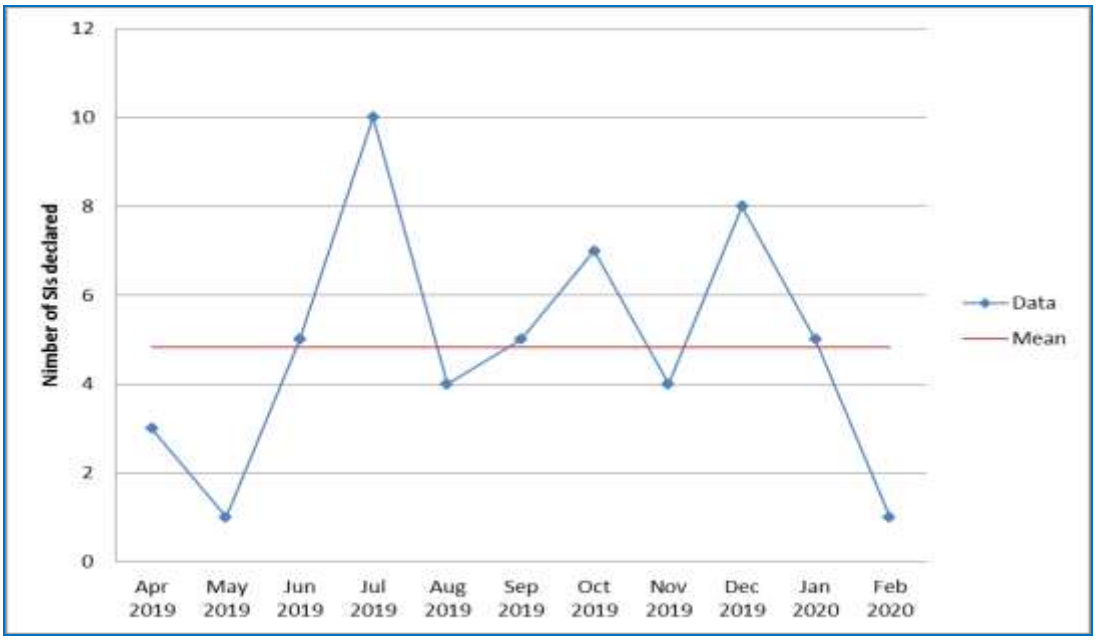
Serious incidents

When an incident occurs that might fulfil the criteria for a serious incident an initial investigation is undertaken. A short rapid incident review is completed and discussed at the twice weekly Serious Incident Review Panel. The panel will consider whether further investigation is required and, if so, what level of investigation. If the incident meets the definition as set out in the national Serious Incident Framework then a serious incident is declared.

The trust reported 53 serious incidents during the year across a wide range of categories as shown in the table below.

Category	Number	Category	Number
Care related incidents	13	Venous thromboembolism incidents	2
Medication incidents	5	Diabetes incidents	2
Resuscitation Related incidents	4	Pressure ulcer incidents	2
Treatment incidents	4	Radiological Related incidents	2
Falls	3	Safeguarding Adults	1
Obstetric incidents	3	Sharps/waste failure incidents	1
Diagnosis incidents	3	Violence & Aggression incidents	1
Admissions related incidents	3	Infection Control incidents	1
Operation/Theatre related incidents	2	Infrastructure incidents	1

The number of serious incidents reported is as per graph below showing on average 4.8 serious incidents declared per month.



Most investigations identify learning points where improvements are required. Some examples of actions completed or underway include:

- Development of medication chart as a result of hospiital associated thrombosis
- Influencing the deteriorating patient QI programme in relation to findings around observations, equipment and escalation
- Increased awareness of medication that masks the identification of a serious condition in people with diabetes
- Creation of a 'ward round' sticker to prompt completion of tasks
- Update of various policies and guidelines

The focus for 2020/21 is around implementing quick learning/actions and contributing to quality improvement initiatives.

Staff award - teams recognised for outstanding contribution to patient safety

Teams on Pirton and Barley wards; and main theatres recovery have been recognised by the resuscitation service for achieving 100% audit compliance, by ensuring their equipment trolleys were checked in line with Trust policy and ready for use in the event of a patient deteriorating.

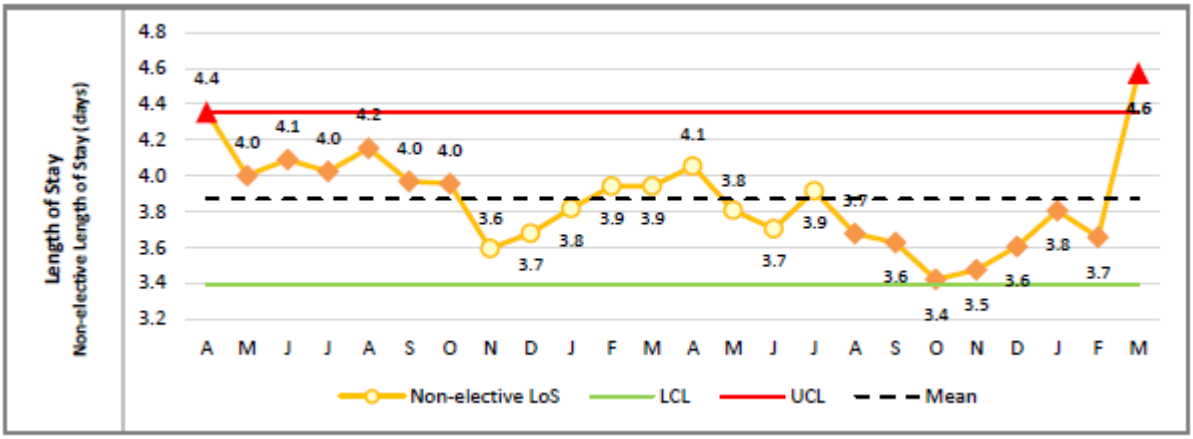
Clinical effectiveness

Indicator	17/18	18/19	19/20	Aim (19/20)	Aim (20/21)
Length of stay (non-elective / emergency)	3.5	4 (To Feb)	**3.78**	≤4.3	≤4.3
Stroke – thrombolysis rate	7.2%	12.3% (Feb)	**11.2%**	≥11%	≥11%
Crude mortality – rolling 12 month rate	15	12	**11**	Reduce	Reduce

Length of stay

Minimising the time that a person spends in hospital is better for them and better for the efficiency of the organisation. A range of length of stay indicators are monitored as part of the integrated performance report with the emergency length of stay demonstrating ongoing improvements during the year (with the exception of March 2020) resulting in a year average of 3.78 days; meeting the plan of ≤4.3 days.

The graph below shows the gradual improvements over the last two years. However March 2020 saw a sudden rise in emergency admissions in relation to the covid-19 pandemic.



Stroke – thrombolysis rate

The Trust measures a range of stroke indicators. Providing thrombolysis (anti-clot treatment) for patients consistently when their stroke has been confirmed has been variable during the year with the aim of ≥11% being surpassed in seven of the twelve months.

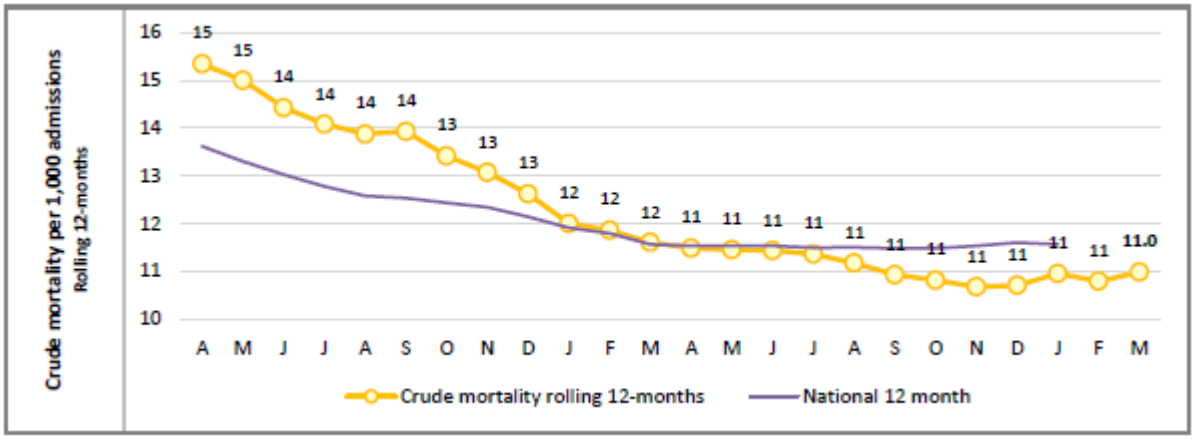
Almost half of the relevant patients received their thrombolysis within an hour of arrival representing an annual average of 11.2%. The figure dropped in March to 20% as a direct result of the demand within the emergency department and the reduced ambulance turnaround time due to covid-19 related demand and restrictions.

Crude mortality

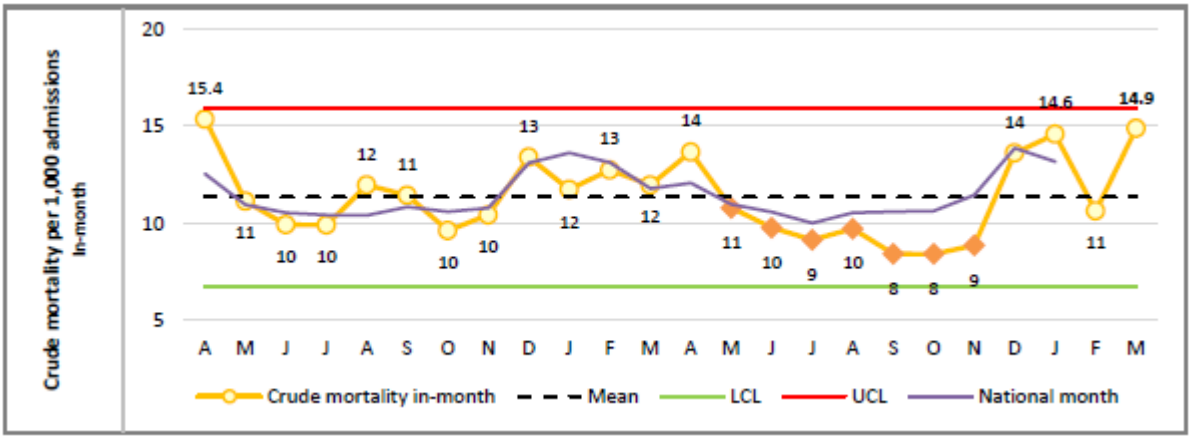
Crude mortality is based upon the number of patients who die in the Trust whilst an in-patient. It is measured per 1,000 admissions.

This measure is available the day after the month end and has demonstrated a consistent decrease over the last 5 years. The improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc. together with our continued drive to improve the quality of our coding.

Since May 2019 the rolling 12 month crude mortality rate has been consistently better than the national average as shown by the graph below. The rolling rate increased slightly to 11.0 deaths per 1,000 admissions in the 12 months to March, but remains lower than the most recently available national rate of 11.6 deaths per 1,000 admissions (Feb-19 to Jan-20).



The in-month crude mortality rate increased to 14.9 deaths per 1,000 admissions in March, the highest in-month crude mortality rate since April 2018. The impact of covid-19 is likely to explain this change.



Patient experiences

Indicator	17/18	18/19	19/20	Aim (19/20)	Aim (20/21)
Number of written complaints	1106	1036*	**1058**	<previous year	<previous year
Number of PALS concerns	4151	4502	**3693**	N/A	N/A
Complaints per level of activity - per 100 bed days	0.52**	1.2-2.2	**1.8**	<1.9***	<1.9
Complaints – response within agreed timeframe	67%	54%˜	**82%**	≥80%	≥80%

Source: Datix internal system & information held by local teams

*Previous report stated 1068

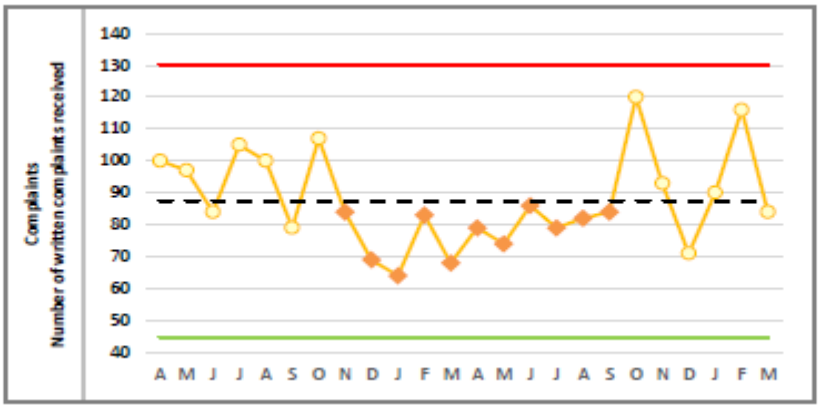
**Bed day data for quarter 4 not published so quarter 3 bed day data used for quarter 4

***Aim has been revised in light of changing methodology (2017/18 quality account stated <0.5)

˜Data updated

Complaints

The number of written complaints received in 2019/20 was 1058. This is similar to the number in the previous year. The reporting pattern is seen in the graph below.



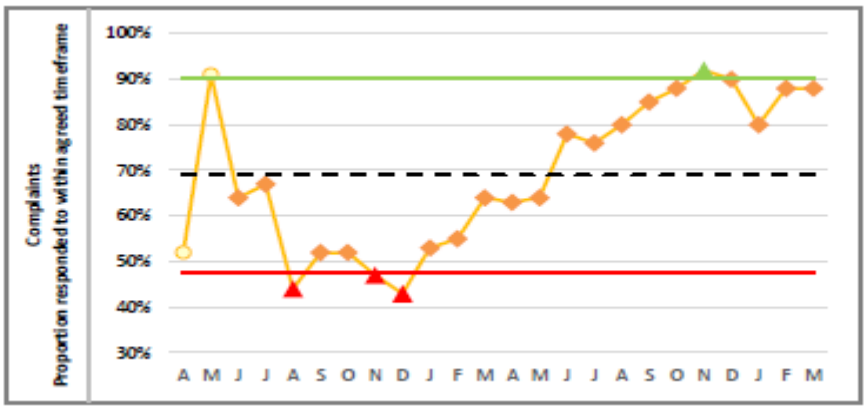
An average of 73 complaints were reported per month in 2019/20 compared with an average of 88 over the last two years. This equates to a rate of 1.8 complaints per 100 bed days and is better than the aim for the year at <1.9. Information by month is given on the chart below.

The Trust continues to achieve the mandatory time frame for acknowledgement of complaints with 100% of complaints being acknowledged within three working days of receipt.

The Trust aims to respond to at least 80% of formal complaints within an agreed timeframe. In January 2019 the Trust recognised that there were challenges in ensuring that comprehensive investigations were conducted and responded to in a timely manner.

To address this, a quality improvement project began which enabled the complaints team to develop a stronger relationship with staff across the trust to support the process.

The improvement in response time is demonstrated on the graph below and by the end of 2019/20 the average response time for the year was 82%.



Examples of learning outcomes following a formal investigation include:

- A review of delays with medical records being available for appointments at the Macmillan Cancer Centre was undertaken and discussions are being held to introduce an on-site storage facility
- Compassionate care training is now delivered to all staff groups
- Improvements in the dispensing of chemotherapy medication
- Revision of a patient information leaflet for a radiological procedure
- Improvements made to the recording of patients property in the Emergency Department
- Improvements made to the maternity referral form for scanning
- The Trust is working in collaboration with the Clinical Commissioning Group to reduce the waiting times for autism assessments
- A review of the appointment system was undertaken to improve the allocation of follow up appointments for patients awaiting biopsy results
- Improvements made to the Ophthalmology telephone line
- Implementation of a 'Virtual Fracture Clinic' to reduce the waiting time for appointments. X-rays and clinical information from the initial assessment is reviewed by a Consultant within 72 hrs of attendance to the Emergency Department.

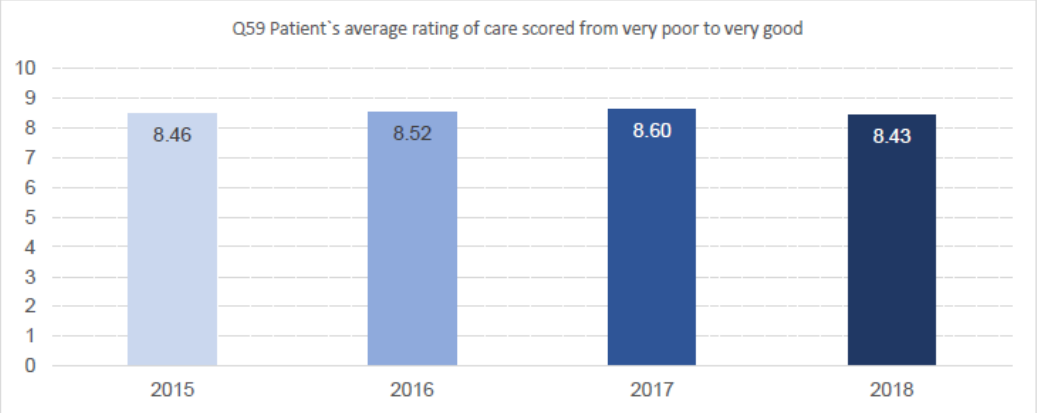
The Lynda Jackson Macmillan Centre at the Mount Vernon Cancer Centre has maintained its accreditation of the Macmillan Quality Environment Mark. The mark is a national standard for cancer facilities in the UK and sets a benchmark for patient experience.

National cancer survey

The national cancer survey 2018 was published in September 2019. 1122 patients completed the survey representing a response rate of 63%. 59 questions were asked about the care delivered.

8.5 The average rating given by respondents when asked to rate their care on a scale of zero (very poor) to 10 (very good)

Although the average rating is 8.5% this is less than the national average at 8.6%. The average rating per year since 2015 is given in the chart below.



A summary of the responses indicate:

73% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment

88% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment

82% of respondents said that it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist

83% of respondents said that, overall, they were always treated with dignity and respect while they were in hospital

90% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital

51% of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

However it is noted that a large percentage of the results are below the expected range. The cancer services division has created an action plan and implementing actions to improve the scores.

Staff

The following table represents some indicators relating to staff.

	Plan	Actual
Permanent staff (WTE)	5855	5364
Vacancy rate	9.8%	6.3%
Turnover rate	12%	13%
Appraisal	90%	79%
Statutory / mandatory training 100% compliant	90%	87%

Appraisal and statutory/mandatory training are key factors in supporting and enabling good staff performance. Since November 2015, incremental pay awards have been dependent on the completion of an annual appraisal, along with statutory and mandatory training compliance (for nine statutory competencies). At the end of March

- Appraisal rates are at 79%
- 87% staff are compliant with all mandatory competencies

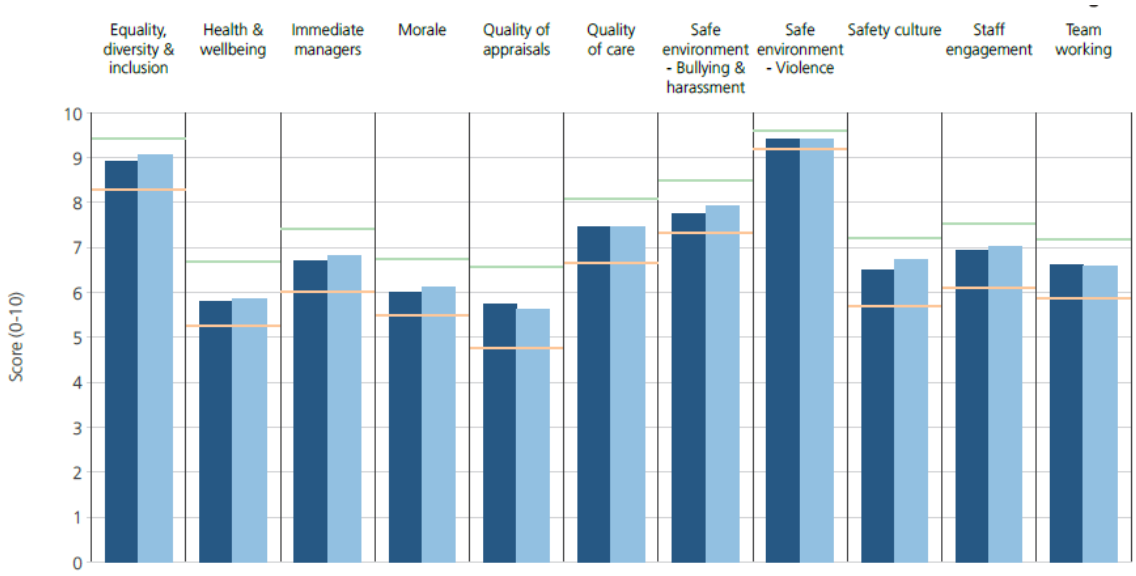
March 2020 has shown a drop in both appraisal and training rates. This is largely down to the staffing pressures caused by the demands on services due to the Covid-19 pandemic. During the summer the Trust will finalise a recovery plan to ensure all appraisals are up to date which will be supported by new materials and tool kits to improve the quality of the appraisal.

On 17 March a decision was made to pause all statutory and mandatory training so that staff could focus on providing front line care to patients. It was agreed that all statutory and mandatory training compliance would be extended by six months. A recovery plan will be put in place to recover the compliance rates of statutory and mandatory training.

The Trust has maintained its recruitment initiatives and a stable workforce is seen. At the end of the financial year planning is underway regarding the management of international recruitment to support deployment as soon as travel restrictions are lifted.

National staff survey

The national staff survey 2019 was published in September 2019. 2544 members of staff completed the survey representing a response rate of 44.6%. The overall findings are shown in the chart below.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	8.9	5.8	6.7	6.0	5.7	7.5	7.7	9.4	6.5	6.9	6.6
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	2,544	2,573	2,586	2,550	2,130	2,278	2,554	2,550	2,559	2,600	2,561

3.2 Performance against national requirements

National standards

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

	17/18	18/19	19/20	Aim
Max 18 weeks from referral in aggregate – patients on incomplete pathways	Not given	90.3% (To Feb)	**77.4%**	≥92%
Four hour maximum wait in A&E	83.6%	81% (To Mar)	**80.2%**	≥95%
62-day urgent referral to treatment of all cancers	75.7% (to Jan)	66.8% (To Jan)	**79.82% (full year)**	≥85%
Maximum 6 week wait for diagnostic procedures	Not given*	98.79% (Feb)	**99.48% (to Feb)****	>99%

* A problem with the reporting function of a new administration system meant this data was not available
**This average covers 11 months from April 2019.

2019/20 demonstrated relative stability in terms of operational performance. Details of emergency department waiting standards and cancer standards have been given in earlier sections. Tables demonstrating the 18 week referral to treatment performance and the 6 week diagnostics performance are shown below. In both cases performance is almost exclusively meeting the standards.

The Trust's preparation for the Covid-19 pandemic began to affect 'business as usual' operational performance in the final months of the year. Following national guidance, the Trust undertook a series of service and ward changes and reconfigurations, including the suspension of some services. This work undoubtedly affected the achievement of operational performance targets (seen in March 2020) to some extent, though the effects will likely be more keenly observed in the 2020/21 performance figures. Focus in 20/21 will be to recover the standards whilst maintaining access for Covid-19 patient.

Freedom to Speak Up / Raise Concerns

The Trust is committed to achieving the highest possible standards of quality, openness and accountability in all its practices. To achieve these, the Trust is committed to supporting any members of staff who are worried about any areas of poor practice,

attitudes or inappropriate behaviour within our organisation. We believe in promoting a departmental culture which encourages open communication between staff and managers to ensure that questions and concerns can be raised and, resolved quickly.

The Trust positivity encourages its staff to report any concerns they may have as well as provide advice and guidance. We have several ways in which our staff can raise a concern:

- Via our Freedom to Speak Up Guardian or our NED Whistleblowing Guardian
- Via the Speak in Confidence Service.
- Through the Employee Relations Advisory Service.
- The Chief Executive or any Executive Director
- The Deputy Director for Nursing or Workforce and OD
- Raising a concern on datix incident reporting system

Concerns can be raised in person, by telephone or in writing (including by email).

Our Commitment to our staff is:

- 'Speak up and we will listen'. We will agree any next steps together
- To fully explore concerns in a timely, impartial and confidential manner
- To listen, investigate and feedback
- To take action to address any concerns upheld
- To ensure that there is no detriment or repercussions as a result of raising concerns

The focus of any investigation is on improving the service we provide for our patients and the working environment for our staff. Where improvements can be made, we track them to ensure necessary changes are made, and are working effectively. Feedback is given to the individual raising the concern; although this is not always possible when the concern is raised anonymously.

During 2019/20, 30 cases have been raised via our Freedom to Speak Up Guardian/ Associate Director of Corporate Governance. As required actions are taken in conjunction with the human resources department and the organisation development team to ensure consistency in approach and offer support to staff such as team development work.

Rota gaps

Gaps to rotas of doctors and dentists in training are monitored on a monthly basis. The table below shows the average number of rota gaps in the first three quarters of the year.

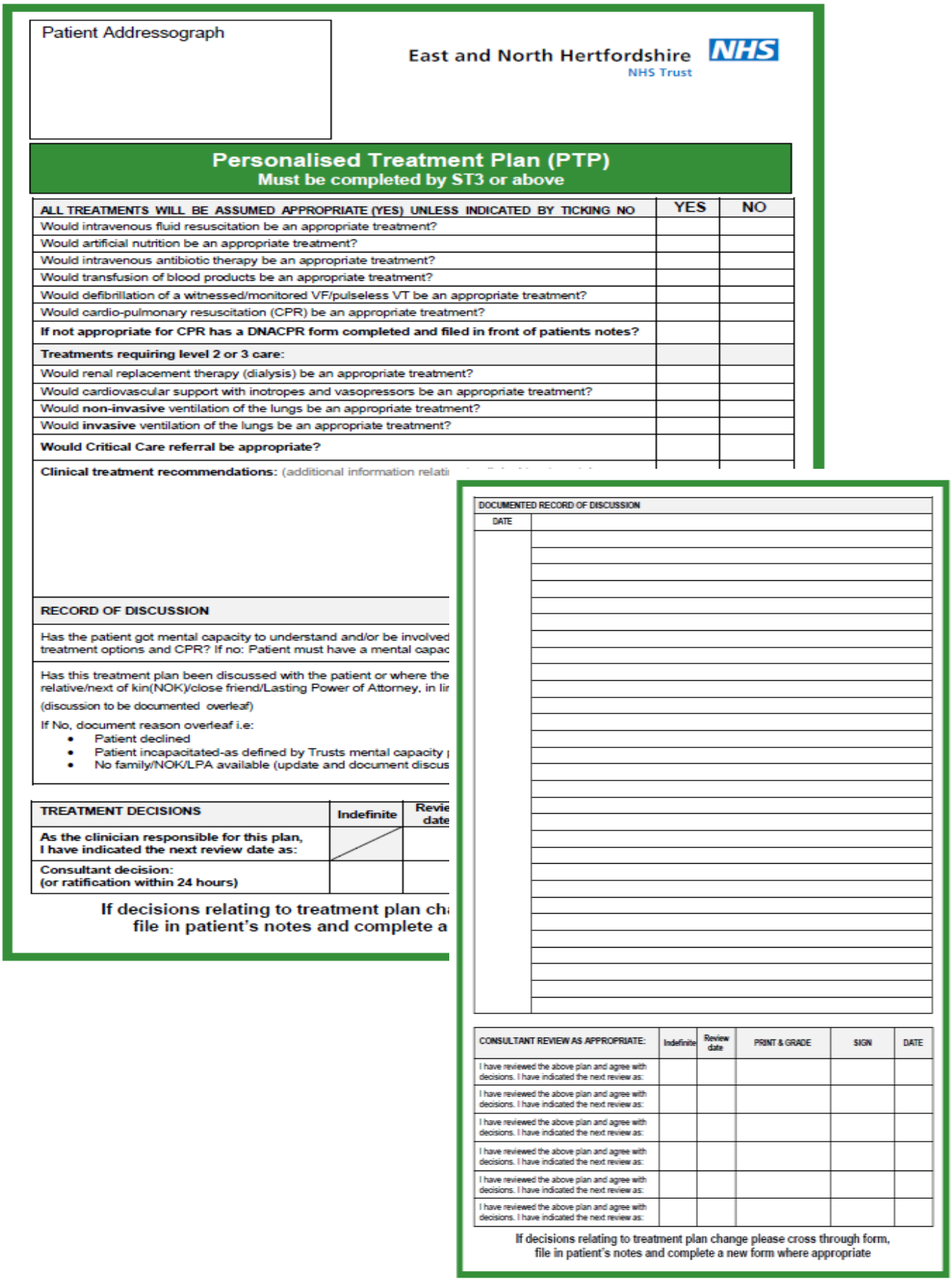
April-June	July-Sept	Oct-Dec	Jan-March
39.67	33.33	30.67	Not available due to covid-19

Actions taken to improve vacancies are:

Direct
- Recruitment of Trust Grade, Clinical Fellows in temporary posts
- Recruitment of other training grades (e.g. MTI – medical training initiative for foreign doctors)
- Recruitment of temporary Locums to cover gaps and provide the clinical service

Indirect
- Improve or enhance training posts to make posts more attractive to schools
- Reconfiguration of rotas to allow for fewer trainees

Annex 1 Personalised treatment plan



Patient Addressograph

East and North Hertfordshire NHS Trust

Personalised Treatment Plan (PTP)
Must be completed by ST3 or above

ALL TREATMENTS WILL BE ASSUMED APPROPRIATE (YES) UNLESS INDICATED BY TICKING NO	YES	NO
Would intravenous fluid resuscitation be an appropriate treatment?		
Would artificial nutrition be an appropriate treatment?		
Would intravenous antibiotic therapy be an appropriate treatment?		
Would transfusion of blood products be an appropriate treatment?		
Would defibrillation of a witnessed/monitored VF/pulseless VT be an appropriate treatment?		
Would cardio-pulmonary resuscitation (CPR) be an appropriate treatment?		
If not appropriate for CPR has a DNACPR form completed and filed in front of patients notes?		
Treatments requiring level 2 or 3 care:		
Would renal replacement therapy (dialysis) be an appropriate treatment?		
Would cardiovascular support with inotropes and vasopressors be an appropriate treatment?		
Would **non-invasive** ventilation of the lungs be an appropriate treatment?		
Would **invasive** ventilation of the lungs be an appropriate treatment?		
Would Critical Care referral be appropriate?		

Clinical treatment recommendations: (additional information relati

RECORD OF DISCUSSION

Has the patient got mental capacity to understand and/or be involved treatment options and CPR? If no: Patient must have a mental capac

Has this treatment plan been discussed with the patient or where the relative/next of kin(NOK)/close friend/Lasting Power of Attorney, in lir

(discussion to be documented overleaf)

If No, document reason overleaf i.e:

- Patient declined
- Patient incapacitated-as defined by Trusts mental capacity
- No family/NOK/LPA available (update and document discus

TREATMENT DECISIONS	Indefinite	Revie date
As the clinician responsible for this plan, I have indicated the next review date as:		
Consultant decision: (or ratification within 24 hours)		

If decisions relating to treatment plan cha file in patient's notes and complete a

DOCUMENTED RECORD OF DISCUSSION	
DATE	

CONSULTANT REVIEW AS APPROPRIATE:	Indefinite	Review date	PRINT & GRADE	SIGN	DATE
I have reviewed the above plan and agree with decisions. I have indicated the next review as:					
I have reviewed the above plan and agree with decisions. I have indicated the next review as:					
I have reviewed the above plan and agree with decisions. I have indicated the next review as:					
I have reviewed the above plan and agree with decisions. I have indicated the next review as:					
I have reviewed the above plan and agree with decisions. I have indicated the next review as:					
I have reviewed the above plan and agree with decisions. I have indicated the next review as:					

If decisions relating to treatment plan change please cross through form, file in patient's notes and complete a new form where appropriate

Annex 2 Research and development

Some of the 2019/20 research highlights:

Psychological risk factors for fatigue
We are investigating a number of factors which may influence levels of fatigue, distress and disability in patients with long-term conditions. We are specifically focusing on behavioural and psychological factors including quality of sleep, anxiety and depression, beliefs about fatigue and coping strategies. We use self-report questionnaires and interviews with patients to gain patients' personal perspectives. The information gained from the questionnaires will inform the development of an intervention which will target problem areas.

IBD Bioresource
Working with the NIHR Bioresource, we are proposing to develop a centralised national recallable bioresource of 25,000 patients with Crohn's disease or ulcerative colitis (collectively inflammatory bowel disease / IBD) to support scientific and clinical IBD research.

Perioperative Quality Improvement Programme: Patient Study
This application is to gather and analyse patient data using the PQIP Database. PQIP will measure complications after major planned surgery and seek to improve these outcomes through feedback of data to clinicians. This analysis will answer important research questions about variation in quality of care in major surgery. We expect that this substantial collaborative work will lead to valuable insights regarding the ways in which hospitals use data to drive improvements in care.

Haemodialysis Discrete Choice Experiment
Most patients who receive haemodialysis in a dialysis unit receive it three times a week for around four hours. One of the functions of dialysis is to remove excess water and waste products (for instance potassium and phosphate) that the kidneys would get rid of in urine if they were working. For some patients three times a week dialysis does not remove enough water and waste safely. The speed at which they are removed may be too quick, or at the end of the dialysis session some may be left behind. Some healthcare professionals offer some patients more dialysis to remove more water and waste. This study is about what patients would do if they were in this situation, and clinical staff offered them longer dialysis or dialysis more often, explaining the potential benefits and harms of these options. We are interested in learning what patients attitudes are to choosing more dialysis.

OPHELIA study - Causes of Gestational Diabetes
Gestational diabetes (GDM) affects approximately 35,000 pregnancies in the UK every year and is associated with adverse pregnancy outcomes affecting both mother and child. Although most cases of GDM are thought to occur due to pregnancy-hormone-induced insulin resistance, there is likely to be some variation in the contribution of autoimmunity, insulin resistance, insulin insufficiency and pregnancy hormone concentrations to the disease process.

National Registry of Rare Kidney Diseases (RaDaR)
The National Registry of Rare Kidney Diseases (RaDaR) is a Renal Association initiative designed to pull together information from patients with certain rare kidney diseases. This will give a much better understanding of how these illnesses affect people. It will also speed up research. RaDaR is open for recruitment for children and adults.

Investigating lifestyle determinants of muscle and physical function, and the impact on patient experience and support needs in kidney disease (DIMENSION-KD)
People with kidney disease (KD) have a loss of kidney function. Poor kidney function is related to other health problems such as diabetes and high blood pressure. Patients also suffer from poor physical functioning, low levels of physical activity, and increased levels of disability. This makes doing everyday activities difficult and reduced their quality of life. Patients have many symptoms such as muscle wasting, severe tiredness, and pain. This study aims to investigate the role and differing impact of KD and basic lifestyle factors on patient's physical function, symptoms, healthcare usage, and muscle function.

ORION-4: A double-blind randomized placebo-controlled trial assessing the effects of inclisiran on clinical outcomes among people with atherosclerotic cardiovascular disease
Previous trials have shown that lowering bad (LDL) cholesterol with statins reduces the risk of heart attacks and strokes. However, among individuals with a previous history of vascular disease, the risk of a further vascular event remains high, even after several years of statin treatment. Inclisiran is an investigational drug given by subcutaneous (under the skin) injection which lowers bad (LDL) cholesterol. This study aims to find out whether inclisiran, given every 6 months for about 5 years, safely reduces the risk of heart attacks, strokes or the need for urgent coronary angioplasty or bypass grafts, in people who already have known vascular disease.

Mount Vernon consultant speaks at largest global oncology conference
Trust oncology consultant Paul Nathan was invited to present the results of two trials at the 2019 American Society of Clinical Oncology (ASCO) Annual Meeting in Chicago - the largest oncology conference in the world with 35,000 attendees. The Mount Vernon Cancer Centre was one of the many international sites taking part.

Trust Sponsored research
As an NHS Trust we highly value the importance of research to improve outcomes for patients, patients' care and their experiences. We are a research active organisation with over 35 "Home-grown" research studies sponsored by East and North Herts currently taking place. These projects have been designed by local investigators and are managed and overseen by the Trust.

- **The PRIMM Study** led by Consultant Medical Oncologist Dr Paul Nathan at Mount Vernon conducting longitudinal analysis of the nutritional status and the composition and function of the gut in patients with melanoma to see whether gut bacteria influences responses to immunotherapy treatments. The Project is a multi-centre study involving key collaborations with organisations such as King's College, London.

- **The RISK-PPCI Study** led by Consultant Cardiologist Professor Diana Gorog at the Lister Hospital, investigated a novel biomarker to identify patients at increased risk of

heart attack despite current best treatments, due to increased stickiness of the blood and an inability to dissolve blood clots that form in heart arteries, causing heart attack. The study showed that these individuals are at 9 times higher risk of heart attacks or death than patients whose blood test shows they can dissolve clots effectively. This study involved an important collaboration with the University of Hertfordshire and was published in the highest ranking cardiology journal in the world.

- **The RaNGO (Rare Neoplasms of Gynaecological Origin) Study** led by Consultant Medical Oncologist Professor Marcia Hall at Mount Vernon is a multi-centre study carried out across the United Kingdom to obtain vital information about specific rare gynaecological cancers. The study seeks to understand how these diseases are diagnosed and managed with the overall aim of gaining information to guide treatment for patients affected by these rare cancers.

- **The PROCON Trial** funded by Charity Prostate Cancer UK and led by Consultant Clinical Oncologist Dr Roberto Alonzi was conducted to evaluate the safety and tolerability of oxygen-boosting drugs given during radiotherapy, aimed at improving treatment success in patients with prostate cancer. Analysis of trial results is now in progress and will be published online on the EU clinical trials register when complete.

- **Supportive Oncology Research**: The Supportive Oncology Research Team at Mount Vernon lead research projects in a range of areas psychosocial impact of cancer and exploring new ways of using technology to help assess and deliver care.

Annex 3 Statements from stakeholders

NHS
East and North Hertfordshire
Clinical Commissioning Group

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 2019/20, based on the data submitted during the year as part of the on-going quality monitoring process.

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

During 2019/20 ENHCCG has worked closely with ENHT, meeting regularly to review progress in relation to Quality Improvement initiatives as well as undertaking Quality Assurance Visits.

Following the Care Quality Commission's (CQC) inspection between July and September 2019, the Trust's rating remained as 'Requires Improvement'. It was positive to see the progress identified relating to surgery at the Lister Hospital and the Urgent Care Centre at the QEII; both moving from 'Inadequate' to 'Requires Improvement'; and the 'Good' rating for all areas inspected relating to the Caring domain.

However the CQC also found areas where significant improvement was required, particularly around medicines management, maintaining equipment and premises and ensuring that audits are completed. The CCG will continue to monitor progress against the Trust's CQC action plan, and looks forward to seeing improvements in the areas required.

During 2019/20 ENHT has had mixed results in relation to quality, patient safety and patient experience. The CCG is pleased to see the progress in relation to Quality Improvement and looks forward to seeing improved patient outcomes as a result of the Quality Improvement initiatives being undertaken. This is particularly key in relation to recognition of deteriorating patients, and early identification and action in relation to sepsis. The CCG remains concerned regarding the limited progress in relation to the timely administration of antibiotics for patients with sepsis and an improvement over the coming year is required.

The ongoing improvements in mortality rates are positive, with the SHMI data in the 'as expected' range throughout 2019/20. The performance in relation to omissions of critical medications, and improvements in complaints handling have also been positive. However the performance in relation to venous thromboembolism (VTE) risk assessment has been disappointing.

Following the identification of a significant backlog of discharge summaries that had not been sent to primary care during 2018/19, the CCG issued a Contract Performance Notice. Whilst the CCG recognises the focus that the Trust has had in

relation to strengthening processes, and improving the timeliness and quality of discharge summaries, the required standards have not yet been achieved and ENHCCG does expect an ongoing focus in this area.

During 2019/20 the Trust has reported 6 MRSA bacteraemia; this has resulted in ENHT having the highest rate of infection amongst Trusts within the region. Additionally the Trust has reported 57 cases of c.difficile; the Trust's rate per 100,000 occupied bed days is above that for England and the East of England region. The CCG therefore expects this to be an area of significant focus during the coming year and will monitor progress closely.

During 2019/20 the Trust reported 3 Never Events; this is a reduction compared to 6 reported the previous year. ENHCCG are pleased to note the ongoing focus on surgical safety and would expect to see a further reduction in Never Events occurring in 2020/21. We will continue to seek assurance that learning has been identified, and that relevant actions and improvements are being implemented to prevent reoccurrence.

Cancer performance in relation to two week wait from GP referral has remained good throughout the year, and the Trust achieved the 62 day cancer target for the first time since 2014 in November and December 2019; the Trust were also above the national average for 62 day performance at year end. The CCG is pleased to see the improvements made and would now like to see the Trust build on this in order to consistently deliver all 8 of the key cancer standards.

The 2019 annual staff survey results were variable; whilst there was improvement in over two thirds of the questions compared to the previous year, the Trust scored worse than the national average in over half of the questions and above the national average in only 2 questions. Areas requiring further focus and improvement include job satisfaction, errors and incidents and bullying and harassment.

Towards the end of 2019/20 the NHS has been significantly affected by the Covid-19 pandemic, and all organisations across our healthcare system have pulled together to redesign services and deliver safe care to our patients. The CCG recognises the efforts of the Trust and all of their staff at what has been an incredibly challenging time.

The CCG supports the Trust's 2020/21 quality priorities and is pleased to see that improving care of deteriorating patients, compliance with the sepsis pathway and improvements in compliance with VTE risk assessments are priority areas for the Trust.

Additionally ENHCCG wishes to see ongoing improvement in the timeliness and quality of discharge summaries as well as an ongoing focus on staff wellbeing and improvement in the staff survey results.

We look forward to working with and supporting ENHT in developing new ways of working in light of the Covid-19 pandemic, as well as the ongoing development of the

NHS
East and North Hertfordshire
Clinical Commissioning Group

Integrated Care System and Integrated Care Providers, in order to provide high quality services for our patients. We hope the Trust finds these comments helpful and we look forward to continuous improvement in 2020/21.

Sharn Elton
Interim Managing Director
June 2020

healthwatch Hertfordshire

Healthwatch Hertfordshire values the relationship with East and North Hertfordshire NHS Trust and looks forward to continuing to work closely with the Trust to help improve services for patients including supporting the quality priorities outlined in this Quality Account.

Steve Palmer, Chair Healthwatch Hertfordshire, April 2020

Annex 4 Statement of directors' responsibilities

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, 2012, 2017 and 2020).

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