June
2022

East and North Hertfordshire
NHS Trust

Quality Account 2021/22

PART 1

1.1 How we are accountable for quality

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)

The Trust's vision is "Proud to deliver high-quality, compassionate care to our community".

The Trust has five Strategic Priorities:

- **Quality** – to deliver high-quality, compassionate services consistently across all our sites.
- **People** – to create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.
- **Pathways** – to develop pathways across care boundaries, where this is in the best interests of patients.
- Ease of Use – to redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff.
- **Sustainability** – to provide a portfolio of services that is financially and clinically sustainable in the long term.

These are underpinned by our PIVOT values: **Putting** patients first; striving for excellence and continuous **improvement**; **valuing** everybody; being **open** and honest; and working as a **team**.

Trust strategy and values refresh

During 2021/22, the Trust has been undertaken an extensive refresh of its strategy, including a bottom-up review of service ambitions and a strategic review of the Trust's vision, mission and strategic objectives. This work will be concluded during 2022/23. The Trust is also in the process of refreshing its values, which will be reported in next year's Quality Account.

The Trust has a number of enabling strategies to support the delivery of the Clinical Strategy and quality priorities including the People Strategy 2020 and the Quality Strategy 2019. The strategic priority for quality and its guiding principles are shown in the section below. Details of how the strategic priority will be delivered are outlined within our Quality Strategy.

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.

- **Putting patients first**, through patient co-design and innovation of quality improvements plans.
- **Striving for continuous improvement** and continually learning that becomes integral in everything we do.
- **Valuing everybody** through providing robust governance and improvement frameworks that celebrate excellence.
- **Being open and honest** with candid, supportive skills that ensure fair balance of accountability and kindness.
- **Recognising the importance of teamwork** 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 analytical capabilities, 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'?

Five components of the Quality Strategy have been identified to provide a structure in which to focus our efforts of continuous improvement. These are:

Each component represents key priorities identified through triangulation of data and information across the Trust. These priorities are linked through small to large scale programmes of work, with detailed measurement plans, strategic and local leadership and robust monitoring and tracking processes. The relationship between these components and the quality account priorities are shown at the top of each section within this report.

People Strategy 2020

The People strategy was launched in January 2020 setting out its compelling vision for the people in the organisation. The strategy detailed plans under the four pillars of: work, grow, thrive and care. The people strategy is just beyond two years since implementation. It has been strongly tested with exceptional challenges on the workforce due to Covid, which was unforeseen at the time, and directions given from the national team within the People Plan. The People and Organisation Strategy is set out below.

An integrated business and workforce plan has been developed to 2030 over the past year and this clearly signals what, where and how we need to focus to enable change to delivery models, workforce composition and the types of roles needed in the future to meet the demands of the community we serve.

Organisational Structure

The Trust has two operational Divisions: Planned Care, and Unplanned Care. Each division has a Divisional Medical Director, who is a senior clinician, a Divisional Nursing and Quality Director, and an Operations Director. This triumvirate structure is replicated at specialty level.

Supporting the clinical divisions are corporate teams covering areas including: finance and planning, digital; medical practice, education and research; nursing practice; strategy; estates and facilities; transformation, and workforce and organisational development.

1.2 Statement from the Chief Executive

As we emerge from the pandemic and begin to live with Covid, it's important that we stop and reflect upon the achievements of our colleagues after what has been an unprecedented two years. This 2021/2022 Quality Account outlines our achievements, identifies where improvements could be made and sets out our future continuous quality improvement plans.

I am proud of the work colleagues across the Trust have done in response to the pandemic throughout the last 12 months. Not least the achievements of our research and development team, whose efforts have directly led to innovative treatment for our patients. The pandemic has also highlighted the unique role of NHS staff in identifying those patients who are the most vulnerable – I am pleased that the work delivered by our safeguarding team has helped support our staff with identifying and providing advice to those patients who may be at risk, including through initiatives such as the White Ribbon Campaign and the 16 days of action.

Despite the challenges of the pandemic, I am delighted that we've been able to continue with the Pathway to Excellence® programme and the implementation of our Clinical Excellence Accreditation Framework which saw 16 wards achieve gold or silver accreditation; demonstrating the excellent quality of care provided. We have also been able to celebrate our nursing and midwifery colleagues who go above and beyond through the Cavell Star Awards with more than 20 staff recognised.

The commitment that all our staff continue to show is also demonstrated through the results of the Friends and Family Test, where more than 90% of patients in almost all departments would recommend the service to their family and friends. Despite the ongoing challenges which we have seen across the country in terms of longer than average waiting times in emergency departments, I'm pleased that our patients reported our staff continued to provide caring and supportive care, with good communication and clear explanations regarding their treatment.

Despite the successes of the last year, it's important to recognise the impact that the pandemic has had on quality performance – including on elements of patient safety, inpatient falls and the number of serious incidents reported – full details of which are set out within the report. We know there are other areas where further improvements are needed, including reducing the delays in Lister Hospital's emergency department and improving the efficiency of discharge and patient flow. As an organisation we are committed to making these improvements, working closely with our system partners and service users to do this.

I'd like to thank all our staff who have continued to deliver compassionate high-quality care to our patients – the work they continue to do is outstanding. To the best of my knowledge the information in this document is accurate.

Adam Sewell-Jones, Chief Executive

PART 2

2.1 Priorities for improvement

Priority One: Build ENHT Quality Improvement Capability and Capacity

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

Monitoring: Quality and Safety Committee

Reporting: Scheduled update to Education Committee

Responsible Directors: Chief Nurse / Director of Improvement

Theme	Measure	20/21	21/22	22/23
1.1 Clinical and non-clinical staff are offered opportunities to gain knowledge on Quality Improvement theory.	Quality Improvement for all Theory and Practitioner level	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.	QI introductory sessions for new FY1 doctors and new consultants. Induction sessions for all not achieved. 'What matters to you?' is a part of all QI projects supported by the QI team.	• Induction training for all • Improvement apprenticeship - 15 starters • Continue with bite-size training for 200 people
	Quality Improvement for Leaders	Align continuous quality improvement leadership through: • Patient safety • Patient experience • Clinical Leadership Programme priorities	**Patient safety:** • Harm free care collaborative set up • QI projects on 5 wards instigated and supported discharge leads in their improvement strategy • Deteriorating patient subject matters experts have set up projects in clinical areas **Patient and carer experience:** **Clinical leadership programme:**	• Increased numbers of clinical areas involved in safety improvement • Formalise structure for deteriorating patient collaborative • Formalise structure for Patient and carer experience collaborative • Improvement leads for patient and carer

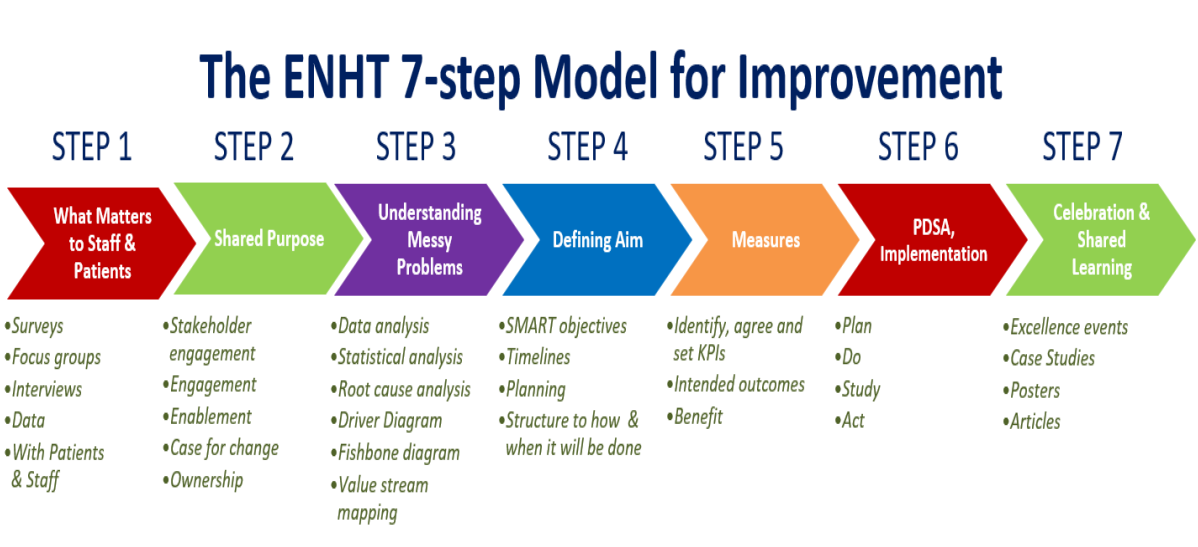
Theme	Measure	20/21	21/22	22/23
			• 22 leaders started in Cohort 2 and are currently completing a quality improvement project.	experience identified and increased number of experience related projects and learning from excellence.
	Organisational wide quality learning events	Deploy 'virtual' summer celebration with assistance of Organisation Development (OD) and communications teams	• Presentations at the quality huddle every 2 weeks celebrating and sharing the learning from QI projects. • Celebration of excellence in nursing and midwifery awards every quarter.	• Annual RCN celebration event- awards and recognition of learning event. • National Patient Safety day celebrations and recognition awards. • Pathways to Excellence recognition of QI contributions • Divisional Board updates
	Measurement masterclass sessions	Offer 1 virtual masterclass (inclusive of corporate and divisional leadership teams).	Measurement for improvement sessions run by QI team and plot the dots session for board.	Continue quarterly measurement masterclasses.
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.	Offer a virtual clinic every week with a QI coach to explore a QI idea.	Two virtual coaching clinics are offered weekly and coaches will also drop into clinical areas to run clinics locally for teams.	Offer coaching or learning coordination in clinical areas.
	Agree and deliver curriculum for Quality. Improvement coaches	Offer training to all band senior leaders (band 7s and 8s) from the corporate and divisional leadership teams	Engaged education and divisional colleagues to agree to set up an apprenticeship in QI with an accredited provider at level 3, 4, 5 and 6 to grow our	Deploy cohort 1 of apprenticeship for QI (level 5 and 6) across 2022/23.

Theme	Measure	20/21	21/22	22/23
		to this level exploring the use of virtual training and coaching them while they lead improvement projects.	coaching capability.	
1.3 Deliver organisational wide structured Quality Improvement continuous learning programme	Adopt 'Patient Safety Breakthrough Series Collaborative'	Look at lessons learned from the trust wide simulation team teaching and COVID response and offer a virtual breakthrough series.	• Developed e-learning for all new starters. • Continued to offer bite-size training virtually. • Improvement in action teaching and coaching on the clinical leadership programme.	Design a collaborative structure that supports a shared learning approach to improvement of patient and carer experience
1.4 Clinical Excellence Framework	Design and imbed ENHT Exemplar ward programme	Scale and spread quality improvement plans to drive continuous improvement across accreditation pathway pillars.	Supporting all teams that are not achieving their fundamentals of care with improvement plans	Scale and spread reliable compliance of agreed quality fundamentals through supporting all inpatient clinical areas to achieve silver accreditation status and also to start scoping non inpatient areas for the accreditation framework
1.5 Adopt a framework that reflects and values patient co-design	Patient co-design faculty shall be established	Following a 'what matters to you' model ENH QI and Engagement team shall continue to build new ways of working that promote meaningful patient involvement though continuous quality improvement plans.	All improvement programmes have patient representatives and we are encouraging all projects to involve patients with an aim of co-production of all QI projects by 2024.	• Continue monthly shared decision-making council. • Recruit patient and carer partners to ensure diverse and inclusive representation. • Increased numbers of patient and carer partners in projects and programmes

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

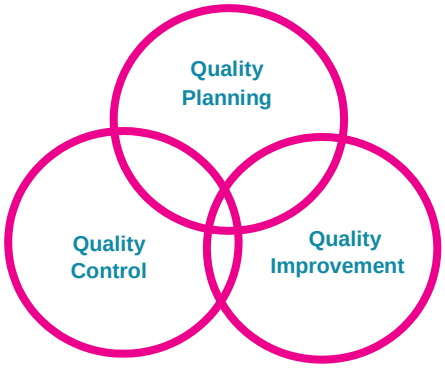
The quality improvement team was set up in September 2019 and restructured in 2020. The team have worked alongside our transformation, education, organisational development and digital teams to develop the East and North Hertfordshire model for a cohesive '7 steps for improvement', known as the 'Here to improve' model (figure 1).

Figure 1.



The Trust is committed to develop skills and knowledge across all workforce groups. By reaching a 'tipping point' over time, through training and coaching people to adopt improvement techniques, this will contribute to the Trust's approach to managing different dimensions of quality (figure 2)

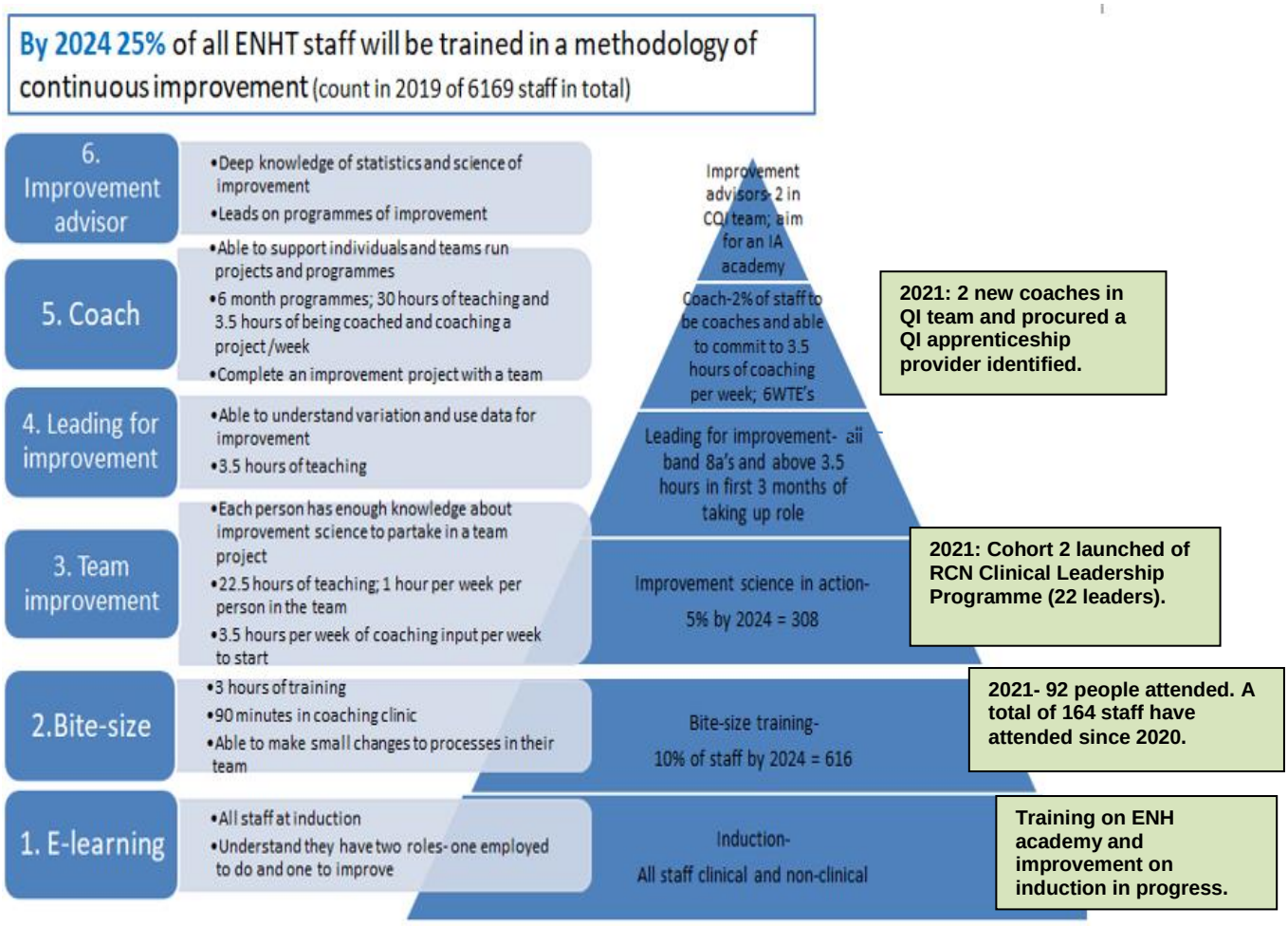
Figure 2



At this 'tipping point' or 'saturation point' the organisation will have a shared language and understanding of how to apply improvement tools and drive change through continuous learning.

Reaching our organisaitonal satuaration point will be achieved through adoption of an evidenced based, tiered dosing formula of skills required at each level of the system. Our progress against each level of skills and knoweldge can be seen in figure 3 below.

Figure 3

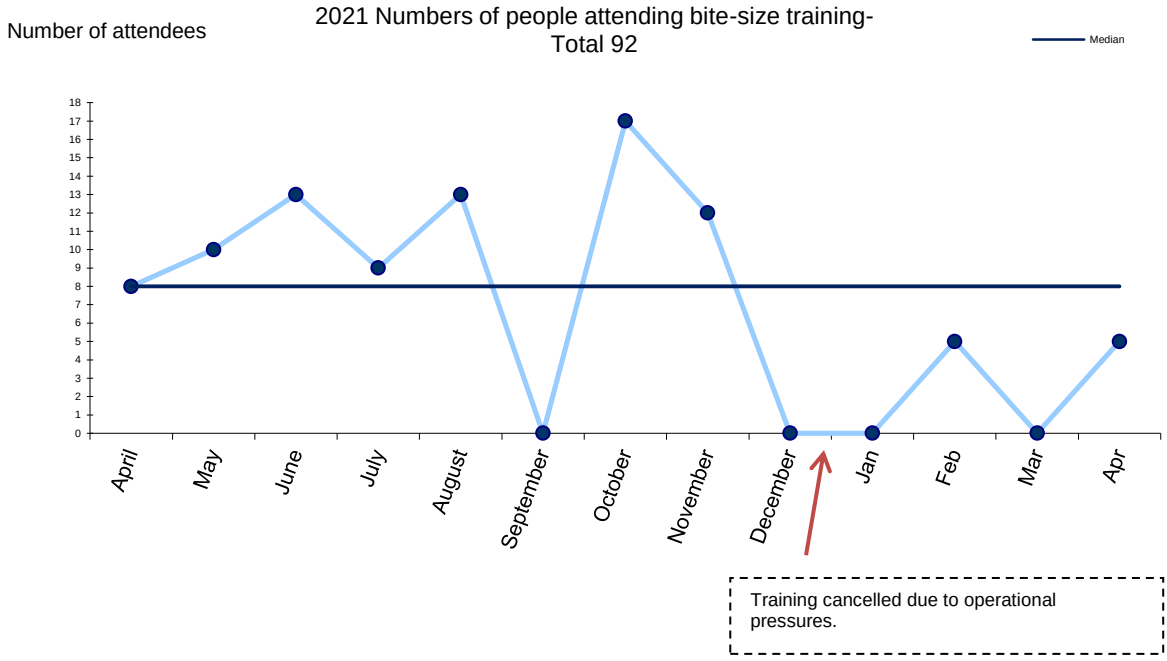


Training shall be designed for different levels to support wider adoption.

- **Level 1** shall target all staff in the Trust to have a basic understanding of key principles to improvement. 'Here to improve' e-learning has been launched on the East and North Hertfordshire Academy and is available to all staff. The quality improvement lead and capability lead are working in partnership to operationalise this. Sessions for new consultants and junior doctors have been initiated.

- **Level 2** has been targeted to staff that have some basic quality improvement knowledge and would like to learn more about specific topics in a little more depth. These sessions have successfully been delivered through the design of virtual teaching sessions. This involves 3 hours of training in the 7 steps for improvement for example how to design an improvement aim, how to analyse data for improvement, how to innovate and test new ideas. In total we have delivered this session to 164 people with 92 in the year April 2021 to March 2022 (figure 4).

Figure 4 Level 2 bite-size training



- **Level 3** has been targeted at 'team' leadership and wider commitment to adoption of quality improvement.
- **Level 4** 2 new coaches in QI team. 2 previous coaches promoted internally within the organisation. One to programme lead and one to the admiral nurse.
- **Level 5** The quality improvement team worked with the education and capability teams to procure level 3, 4, 5 and 6 apprenticeships which are due to start in 2022.

All of our projects are recorded onto LifeQI, a quality improvement project platform, recommended by our regional Academic Health Science Network and NHSE/I. This enables project, programme and portfolio management for the Trust.

Capability and capacity building next steps:

- Apprenticeships will be offered to anyone clinical or non-clinical with a passion for improvement. 15-20 places are available for a year to 18 months that will grow our capability and capacity for improvement in action as well as coaching others to do improvement (level 3 and 5).
- The Trust has committed to a third cohort partnership with the RCN Clinical Leadership programme. A further 20 clinical leaders are enrolled and ready to undertake the programme, due to start June 2022 (level 3).
- Quality improvement will be embedded into inductions so that all people joining the organisation know that they have equal responsibilities within their jobs to commit to continuous improvement efforts.

- The Trust is moving onto a new platform called 'ENHance' to enable oversight of all aspects of the quality management system and improve visibility of parts of the system where increased assurance or overall improvement is required.

Learning through QI programmes:

- All staff attending the deteriorating patient and harm free care programmes are subject matter experts (SME) and have been immersed in carrying out improvement work in clinical areas alongside a coach and a clinical team. Through teaching and coaching these people have learned about delivering improvement and many more aspects of managing change. They are expected to drive an improvement project over a period of time.

- **Discharge quality improvement**: a series of wards were all going through an evaluation of the current state of their use of national discharge policies and procedures to understand the variation in practice following safety incidents related to discharge. The clinical teams on 5 wards participated in projects and were offered workshops in conjunction with the national emergency care improvement support team (ECIST).

- **Patient and carer experience improvement**: the leadership post for the quality assurance side of patient and carer experience was vacant for most of 2021. Assurance and improvement sat under the Head of Quality Improvement until December 2021. This focus on assurance left limited capacity to initiate a series of improvement projects. However the 'what matters to you?' team contributed significantly to patient and carer experience and will be described in the patient and carer experience section of this report.

- **Royal College of Nursing (RCN) leadership programme**: This programme is delivered by the organisational development team and the QI team in partnership with the Royal College of Nursing. 22 leaders from nursing and our allied health professions have been through a year-long leadership development programme including teaching and coaching in QI in order to deliver an improvement project. The celebration event is in June 2022 when the third cohort will begin.

Examples of QI projects are included in Annex 1.

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

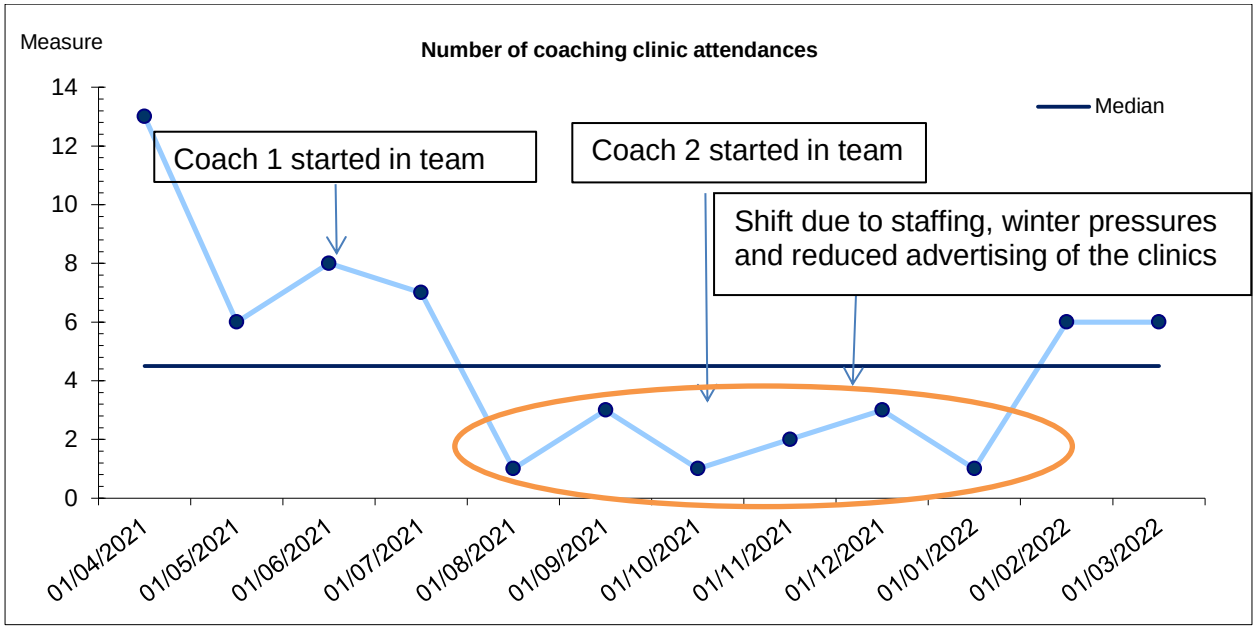
Coaching support for staff is provided from qualified improvement coaches, and the Trust has two full time coaches. Both coaches were recruited from within ENHT. The coaches are supported by the Head of Continuous Quality Improvement and Associate Director for Quality & Safety. Coaching has been provided in clinics and for the projects that feed into the programmes described in section 1.3 and in Annex 1.

Coaching clinics are available twice a week for anyone with an interest in improving any aspect of quality. Staff are encouraged to come along to the clinic and utilise coaching to take the next step in their QI project. Each project is scored and further coaching support is

allocated based on a score. The more aspects that have been considered from the 7 step model the higher the score and the more support the project receives.

Coaching clinic attendance has supported 57 staff in total during the year, compared with 90 the previous year. The reduction is due to a combination of new starters in the team and the operational pressures within the organisation pointing to challenges with capacity for teams to focus on improvement together.

Figure 5

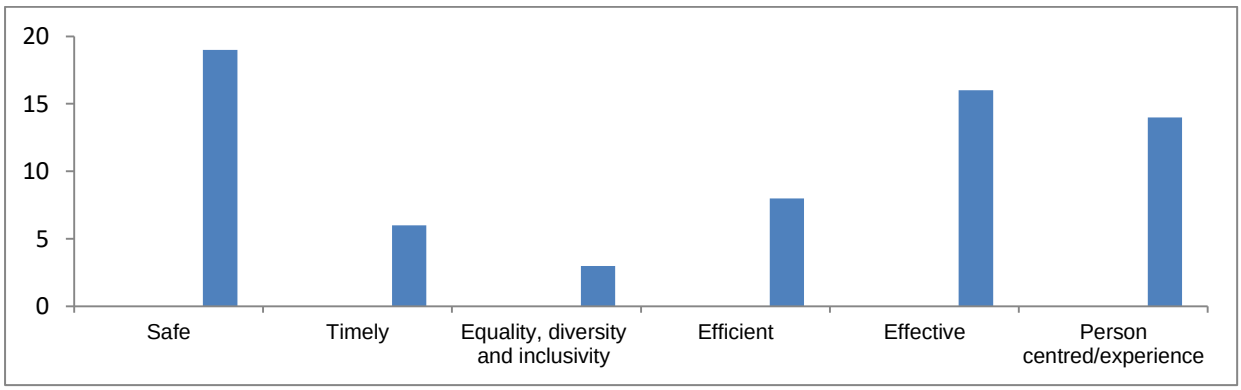


The coaches have supported staff to adopt the recording of their quality improvement projects and programmes on sharing platform LifeQI. There are currently 38 active and 17 completed projects. Each project contributes to a quality priority from the quality strategy and in some cases more than one quality pillar is covered by a project. Safety, efficacy and the experience of our teams and patients appear to be the biggest drivers for change.

Active projects 38; completed projects 17; projects discontinued 13

- Project numbers by division:
- Unplanned care 21
- Planned care 8
- Corporate 5
- Projects not assigned to a division 4

Figure 6 Quality pillars being addressed in projects



1.3 Deliver organisational wide structured Quality Improvement continuous learning programmes

1.3.1 Harm Free Care (HFC) programme

Background: HFC programme is aligned with our Quality Priorities 'Valuing the basics' with an aim to reduce avoidable patient harm from falls, Venous thromboembolism (VTE), Catheter Acquired Urinary Tract Infection (CAUTI), pressure ulcers, nutrition & hydration and medication errors. This is measured through a reduction in overall outcomes for each harm.

How: The HFC work is underpinned by quality improvement methodology that builds an evidence base using our 'Here to Improve Continuous Model for Improvement'. **S**pecific Quality Improvement projects were led by our HFC leads in areas where our quality & safety data highlighted areas of concerns over the last year.

HFC programme driver diagram:

Examples of HFC projects are included in Annex 1.

1.4 Clinical Excellence Accreditation Framework

The Pathway to Excellence® programme is a nursing excellence framework aiming to create a positive practice environment for nursing and midwifery staff that improves nurse and midwife satisfaction and retention. Following a competitive nomination and selection process, the Trust was selected as one of

14 trusts, and one of three in the East of England, to participate in the first national cohort. The Pathway to Excellence® programme is made up of three components which come together to demonstrate different ways to support nurses and midwives to influence and effect change:

1. **The six pathway standards** of shared decision making, leadership, safety, quality, wellbeing and professional development which support the development of a positive practice environment. They focus on transformational leadership and research and innovation, which ultimately influence situations, outcomes and experiences for patients and staff.

2. **Clinical excellence accreditation framework** provides clinical assurance on how our wards and departments are doing. It supports the Trust in maintaining high standards of practice in care through a journey of continuous improvement and giving reward and recognition where positive practices and innovative local initiatives are demonstrated.

3. **Shared decision making** encourages the sharing of best practice and learning from each other. Through the establishment of shared decision making councils, our healthcare professionals are given the platform to work together on local quality improvement initiatives and be part of one professional voice.

Nursing and midwifery excellence – six pathway standards

The six pathway standards are essential to develop a positive practice environment for nursing and midwifery staff:

1. **Shared decision making** creates opportunities for direct care nurses to network, collaborate, share ideas, and be involved in decision-making.
2. **Leadership** supports a shared governance environment by ensuring that leaders are accessible and that they facilitate collaborative decision-making. This standard also emphasizes leadership development, orientation, retention, accountability, and succession planning.
3. **Safety** prioritizes both patient and nurse safety, and fosters a respectful workplace culture free of incivility, bullying, and violence.
4. **Quality** is central to an organization's mission, vision, goals, and values, and is based on person- and family-centred care, evidence-based care, continuous improvement, and improving population health.
5. **Wellbeing** promotes a workplace culture of recognition for the contribution of nurses and the healthcare provider team. Additionally, this standard provides staff with support and resources to promote their physical and mental health.
6. **Professional development** ensures that nurses are competent to provide care and provides them with mentoring, support, and opportunities for lifelong learning.

Our Pathway Standard Leads are supporting with embedding the culture of excellence within the organisation.

Recognising nursing and midwifery excellence:

Recognising and thanking our nursing and midwifery colleagues who go above and beyond is an essential element within a culture of excellence. During the year we have been part of the 'Working with' programme with Cavell Nurses' Trust which gives us access to the Cavell Star Awards. Any nursing or midwifery professional can nominate a colleague who has

shown exceptional care to their colleagues, patients or their patient's families for a Cavell Star Award. Nominations are considered by the trust's Reward and Recognition Shared Decision Making Council. Successful nominees receive a Cavell Star Award medal pack and pin badge along with a framed copy of their nomination and flowers.

To date the following nominations have been awarded; each of these has been celebrated with the person making the nomination and the Chief Nurse either at local events or at the nursing and midwifery quality huddle:

Award Winners	Role	Date
Susan Passfield	Ward Manager 5B	18/02/2021
Eileen Fowler	Nurse Team Lead Children's	18/02/2021
Sarah Collins	Ward Manager Children's Day Services	18/02/2021
Kim Skelton	Lead Pain Management CNS	18/02/2021
Sally Steptoe	Sister, Bluebell Ward	18/02/2021
Alison Baker	Gynaecology CNS	19/02/2021
Catherine Beadle	Clinical Facilitator - Children's	11/03/2021
Lorraine Williams	Lead Infection Prevention and Control Nurse	18/05/2021
Sharon Dudley	Ward Manager	21/05/2021
Vanessa Grinstead	Ward Manager - 11A Respiratory	29/06/2021
June Johnson	Clinical Support Worker phlebotomists	06/07/2021
Nayna Borda	Clinical Support Worker phlebotomists	06/07/2021
Cristina Vinluan	Nurse Team Leader ACU	11/07/2021
Caroline Kirby	Matron AMU	14/07/2021
Clarissa Adupina	Outpatients Team Manager	21/08/2021
Janette Atkins	Team Facilitator & Children's Nurse	01/09/2021
Jericho Almontero	Staff Nurse, Vascular Surgery	06/09/2021
Deloris Brown	Neonatal Services Manager	24/09/2021
Francesca Hogan	Trainee Nursing Associate Swift Ward	03/11/2021
Megan Murthwaite	Clinical Support Worker	18/11/2021
Mandy Simms	Ward Manager 5A	24/11/2021
Sheena Lim	Research Nurse	23/12/2021
Jackie Angello-Gizzi	Clinical Nurse Specialist – Paediatric Diabetes	03/03/2022

Some of our Cavell Star Award winners:

Sue Passfield

Catherine Beadle

Mandy Simms

Lorraine Williams

Local accreditation

Our local accreditation is incorporated within the Clinical Excellence Accreditation Framework (CEAF) introduced in 2019. The CEAF brings together key measures of nursing and midwifery care to enable a comprehensive assessment to be made of the quality of care provided at ward level. The CEAF aligns with the six pillars within the Nursing, Midwifery and AHP Strategy:

Pillar 1: Developing and strengthening leadership
Pillar 2: Optimising pathways
Pillar 3: Valuing people
Pillar 4: Inspiring and innovating through research and quality improvement
Pillar 5: Ensuring quality and safety
Pillar 6: Partnership working

The CEAF Metrics set out a range of standards within each of the 6 pillars and each standard is assessed as either 'not achieved' or achieving bronze, silver, gold or platinum level. Points are awarded for each standard depending on the level met and an overall award made.

The assessment process includes:

- **Baseline/self-assessment** of the standards in the metrics, a staff survey, completing the self-assessment templates and preparing a portfolio of evidence.
- **Independent assessments** against the metrics supported by specialist teams e.g. Infection Prevention and Control, Tissue Viability, Pharmacy, Patient and Carer Experience etc.
- **Time to Shine discussion** which is an opportunity for the multi-disciplinary team to share all that they are proud of.
- Collating the **evidence and clinical assurance** that the fundamental standards are met.
- **Credentialing Award panel** where the final award level is agreed- departments must achieve a minimum of bronze level in all 18 fundamental standards to become or remain an accredited department.
- **Outcome of assessment** shared in a letter from the chief nurse, which provides details of all key areas of achievement and key areas for improvement- departments can begin working on their continuous journey of improvement.

CEAF award levels achieved to March 2022:

Gold	Silver	Ongoing assessment	To be assessed
Neonatal Unit Bluebell Ward Swift Ward AMU-2 Ward 11A/RSU	Ward 5B Ward 6A Ward 6B Ward 7A Ward 9A Ward 9B Ward 10A Ward 10B Pirton Ward Barley Ward Ashwell Ward	MVCC 10/11	Ward 5A Acute Cardiac Unit Critical Care Unit Ward 7B Ward 8A AMU1/SSU

An annual reassessment is undertaken on all wards with a full comprehensive assessment being undertaken every 3 years. The CEAF provides the senior nursing and midwifery team with assurance of the standards being met within each clinical area and enables the trust to reward and recognise excellence in care. The Chief Nurse presents the wards with their award at the nursing and midwifery quality huddle.

6A, 9A and AMU 2 receiving their awards:

Shared decision making

We have developed our pathway of shared decision making through the introduction of shared decision making councils (SDMC). Shared decision making is a collaborative leadership approach, where our point of care staff are given a platform to get involved with decisions that are being made. We encourage all of our colleagues from a variety of professional backgrounds and bands to join and participate. Members of the shared decision making councils are given the opportunity to have their say on what matters to them, to their colleagues and to their patients. They have the opportunity to network with a multi-professional team, develop leadership skills and to share their learning.

Within the Trust we have 3 different types of councils:

- **Ward councils:** Team members from one ward or department create their own local SDMC and develop improvement initiatives for their areas. They have the opportunity to share their learning.
- **Themed councils:** Team members from across the whole Trust create a SDMC focussing on a particular theme such as staff wellbeing and developing improvement initiatives to share with the trust.
- **Specialist councils:** Team members from across the whole Trust create a SDMC representing a specialist area such as research and developing improvement initiatives to share with the Trust.

Current shared decision making councils:

Ward Councils	Themed Councils	Specialist Councils
▪ Neonatal unit	▪ Wellbeing ▪ Reward and Recognition ▪ New Starters	▪ Research ▪ Pharmacy ▪ Leadership

	▪ Communications ▪ Co-production	▪ Dementia – Admiral Nurse

Each shared decision making council nominates a council chair. The council chair is invited to the Trust's Leadership Council where they have the opportunity to share their initiatives and outcomes. The Chief Nurse chairs the Leadership Council and provides support to the councils by connecting them with the right people and helping them overcome obstacles. This enables our point of care staff to share their thoughts, feelings and ideas from the 'shop floor' to board level and informs the board of what really matters to our colleagues.

Some of the projects our SDMC have been working on include:

- **Fluid balance monitoring**: purchased scales, magnets and posters for ward areas.
- **Referral pathway for plastics patients**: streamlining the process for patients to be seen in a plastics dressing clinic.
- **Criteria led discharge for patients having elective joint replacement**: patients can be discharged by a nurse if they meet the criteria.
- **Acupuncture service proposal for staff**: to be delivered by the pain team, Health at Work providing logistical support, trial period due to commence to enable an evaluation period.

To support the development of shared decision making and all council members, the Nursing and Midwifery Excellence Team hold a training session once a month: An introduction to shared decision making. This training provides an overview how shared decision making works and what is looks like, what shared decision making councils are and why the pathway of shared decision making is so important for our Trust. The Nursing and Midwifery Excellence team work alongside the Quality Improvement team and Research team who both offer additional support and training for our shared decision making councils.

Progress with Pathway to Excellence application:

We completed Phase 2, the document submission, for Pathway to Excellence in January 2022. This includes the detailed evidence, known as Elements of Performance, for each of the six pathway standards. Once the outcome of the document submission is shared with the Trust we will move to Phase 3.

Plans for 2022-23:

Nursing and Midwifery Excellence:	
Nursing and midwifery excellence celebration event Launch DAISY Foundation recognition scheme for nurses and midwives	1 April 2022
Survey preparation: sharing communications relating to nursing and midwifery excellence throughout the organisation	April/May 2022
Phase 3: The survey phase where all registered and associate nurses and midwives will be asked to complete the 'pathway survey' to indicate whether the pathway standards have been embedded within the Trust.	May 2022 (estimated)
Phase 4: We receive the results of our PTE submission and survey and, hopefully, PTE recognition.	June/July 2022 (estimated)

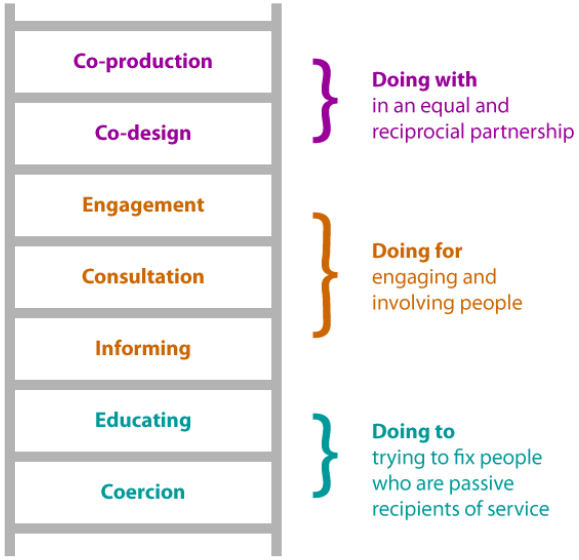
Clinical excellence accreditation: Cohort 7 – 5A, Acute Cardiac Unit, Critical Care Unit Cohort 8 - 7B, 8A, AMU1/SSU (Wards in Cohort 8 have previously received an independent assessment for clinical assurance- self assessments postponed due to clinical demand) Annual reassessments of all wards to continue Develop metrics for Neonatal Unit and Maternity	 March/April 2022 May 2022 Ongoing Ongoing
Shared decision making: Support for existing and development of new shared decision making councils. Council representation at nursing executive committees Development of e-learning training for shared decision making.	 Ongoing Developments

1.5 Service user partnership for co-production

All programmes have patients and carers in the improvement teams. A small percentage of projects have service users in the programmes. We delivered training on the value of co-production in our programmes alongside patient partners.

We have been following the ladder of participation adapted from the Think Local Act Personal website (adapted from Arnstein's model) with an aim of all improvement work being co-designed and co-produced with service users by 2024.

Figure 6



Reference https://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail/what-makes-co-production-different/

The quality improvement team, excellence teams and patient and carer experience teams are supporting the set up and delivery of a shared decision making council for co-production to ensure the engagement, recruitment and remuneration of service user partners in meaningful improvement design and co-production.

Priority two: Keeping our patients safe

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

Link to Quality Strategy: Valuing the Basics and Keeping Our Patients Safe

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 and Safety Committee

Responsible Directors: Chief Nurse

	Theme	Measure	20/21	21/22	22/23
2.1	Medication management	Omissions of critical medications	<4%	<4%	<4%
		Antimicrobial stewardship	>90%	>90%	>90%
		Electronic prescribing / administration	Launch	Launch	Generate digital reports
2.2	Sepsis pathway compliance	Screening for sepsis in ED	>95%	>95%	>95%
		Neutropenic sepsis door to needle time	>95%	>95%	>95%
		Antibiotics in ED within an hour	>95%	>95%	>95%
		Antibiotics on the ward within an hour	>95%	>95%	>95%
2.3	Safer Invasive Procedure Standards	Phased approach to developing and imbedding Local Standards for Invasive Procedures	LocSSIPS for 80% of invasive procedures	LocSSIPS for 80% of invasive procedures	LocSSIPS for 80% of invasive procedures
2.4	Deteriorating patient	Reduce rate of cardiac arrests	<0.8%	<0.8%	<0.8%
		Audit of compliance with timely observations	Variable	Variable	>90% reliability
		Launch escalation module and develop a means of monitoring the escalations	Launch	Launch	Measure reliable escalation following launch
2.5	Safeguarding adults and children	Ensuring reduction of harm of patients with known learning disability	Triangulate incidents, complaints and mortality data	Triangulate incidents, complaints and mortality data	25% reduction in number of incidents of harm to individuals with a LD
2.6	VTE risk assessment	Improved compliance with VTE risk assessment part 1 and part 2	>95%	>95%	>95%

2.1 Medication management

Medicines Management

The past year has required flexibility to safely and effectively manage medicines and new services, including;

- The Covid-19 vaccination programme, where we have administered over 32,000 Covid-19 vaccines to both members of the public and staff since the beginning of December 2020.
- The development of the Covid Medicines Delivery Unit (CMDU). This service was designed to identify and protect the most vulnerable members of our society from admission to hospital with Covid-19. Between December 2021 and March 2022, over 2000 patients were referred into the service. We established a virtual clinic run by pharmacy with wider multi-disciplinary team support to prescribe novel medicines such as sotrovimab and paxlovid®.

Over the last year the pharmacy team has had staffing shortages due to Covid-19 sickness and isolation which created operational challenges. Despite these challenges, the team successfully rolled out electronic Prescribing and Medicines Administration (ePMA), a new electronic prescribing system.

	Target 2021/2022	**Achieved 2021/2022**
Electronic prescribing	Launch	Launched across medical and surgical adult in-patient wards
Omissions and delays to critical medicines	4%	3.6%
Antimicrobial stewardship	>90%	82%
The Trust's Medicines Optimisation Strategy	167	140

Electronic prescribing

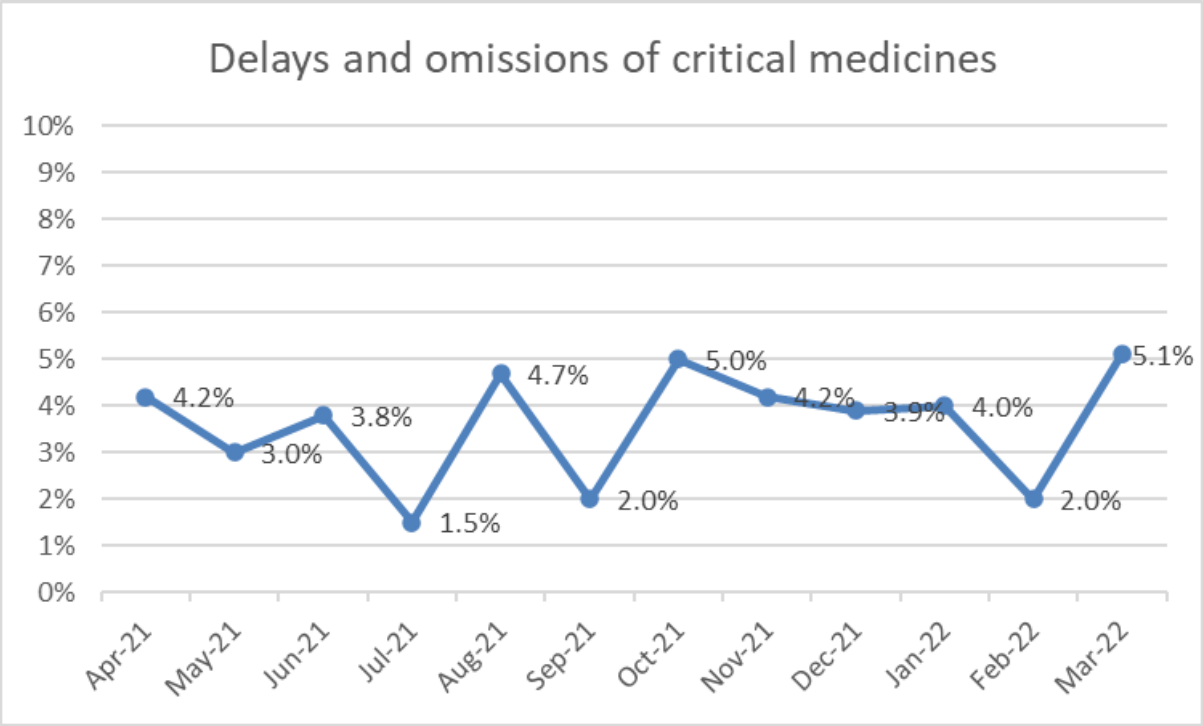
At the beginning of March 2022 Lorenzo® electronic Prescribing and Medicines Administration (ePMA) system was launched across all medical and surgical adult in-patient wards. Roll out was successful and implementation has brought many benefits including improved documentation. The ePMA team are now focusing on embedding the processes into clinical practice; these will be monitored in the ePMA operational group meeting. Over the coming months the focus will move towards benefits realisation of digital prescribing including improvements in patient safety and medicines optimisation.

Critical medicines

The critical medicines audit is conducted across the Trust on a monthly basis. The 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 24hours.

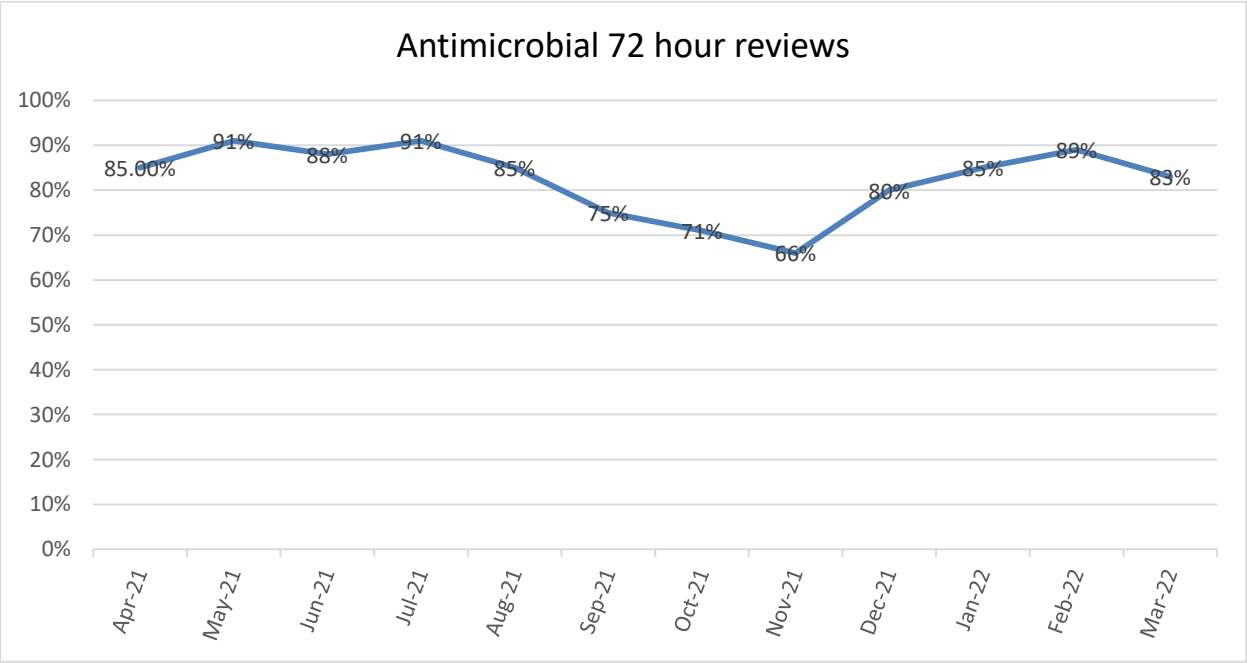
The aim for the Trust is to achieve <4% omissions of critical medications that should not be missed or given late. During 2021/2022 the Trust achieved an average of 3.6%. Between April 2021 and February 2022, the average was 3.4%, this increased in March 2022. This increase could be due to operational pressures, the implementation of ePMA or improved

documentation. The impact of ePMA will be monitored through medication forum and also the ePMA operations group.



Antimicrobial stewardship

Antimicrobial stewardship (AMS) is a coordinated programme to promote the appropriate use of antimicrobials to improve patient outcomes and reduce resistance in the long term. Reviewing the duration of antibiotic usage helps to ensure they are used optimally – long enough to be effective; yet not too long to develop resistance and reduce collateral effects. The aim is to achieve >90% compliance with good governance of antibiotic stewardship.



The graph demonstrates the results of a monthly audit that assesses the antimicrobial reviews for inpatients admitted to the Trust. The 90% target was met between April – July, following which a fall in performance was observed between August –November. Education and training was targeted toward AMS, following this an improvement in compliance was observed between December 2021 - March 2022. The team will focus on education and training and embedding ePMA into AMS.

The Trust's Medicines Optimisation Strategy

The Trust's Medicines Optimisation Strategy 2019-2022 was developed using the NHS Improvement, Hospital Pharmacy and Medicines Optimisation Assessment Framework. The strategy was reviewed and updated in April 2022.

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 Resolution, the Audit Commission, and the Royal Pharmaceutical Society (RPS).

The outcome of the baseline assessment, conducted in February 2019, showed an achievement score of 115 out of a maximum score of 168. The aim was to improve our score over the three years of the strategy to be comparable with the highest achieving Trusts. The score has improved from 123 in November 2019 to 140 in April 2022. The main driver for the improvement over the last year has been the implementation of ePMA.

Other areas of progress have included:

- The Medicinal Products Policy is regularly audited across the Trust; quarterly controlled drugs audits are performed by pharmacy, unlicensed drugs audits, safe and secure medicines audits and drug chart completion audits are all performed on a regular basis.
- The Medicines Optimisation key performance indicators (KPIs) on Qlikview have been presented at Planned Divisional Board, the Nursing Quality Huddle, Medication Forum and Pharmacy Rolling Half Day.
- The Medical Director and the Chief Nurse receive a biweekly report and action plan on Medication Safety and Security from the Pharmacy and Senior Nurse Executive Walk Around.
- Therapeutics Policy Committee and New Drugs and Formulary Group biannual report was presented to the Clinical Effectiveness Committee in January 2022.
- A new Trust-wide formulary was introduced in May 2021. The impact of implementation with regards improvements in compliance against Hertfordshire Medicines Management Committee (HMMC) recommendations, will be audited in 2022/23 following digitalisation of the patient admitted therapy form.

Areas of focus for 2022/23

- Rewrite the Trust's Medicines Optimisation strategy and plan to launch the new strategy in summer 2022.
- Review the Pharmacy and Medicines Management KPI dashboard in terms of reporting, targets and presentation
- Embed all ePMA processes into clinical practice and move towards benefits realisation
- Aim to reduce the number of omitted and delayed doses of critical medicines to achieve a Trust wide average of <3.5%. Critical medicines will be a harm free care priority in 2022/23.
- The antimicrobial stewardship team will focus on achieving the >90% compliance from the 24-72 hour review audit, to achieve this they will focus on education and training and embedding ePMA into AMS.

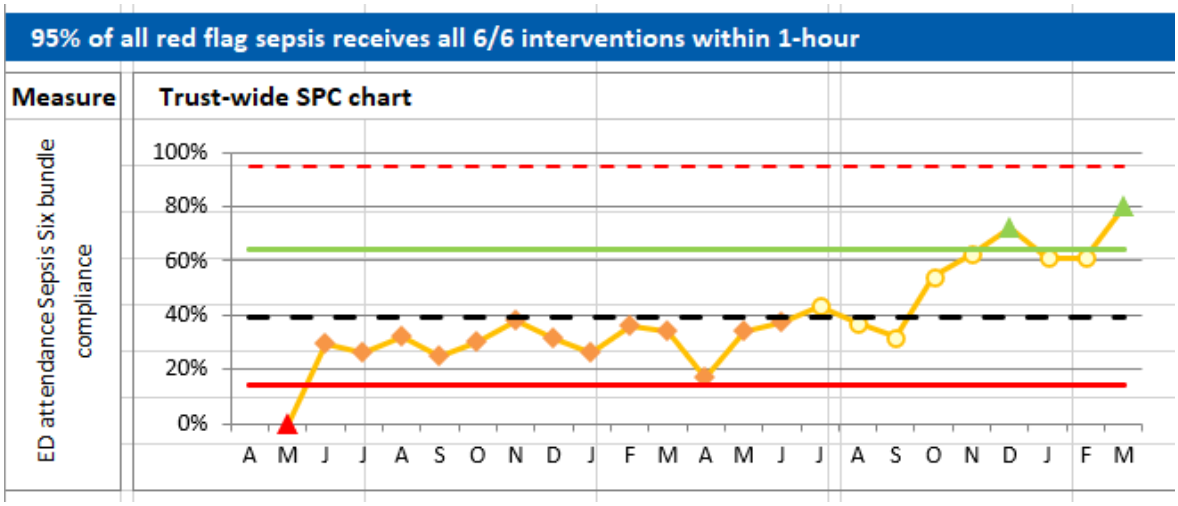
2.2 Sepsis pathway compliance

The Trust continues to prioritise the recognition and management of severe sepsis. Timely administration of intravenous antibiotics remains a key aspect to the whole sepsis 6 treatment bundle. The tracking of improvement compliance is recorded monthly on the quality and safety reporting framework.

	Aim	Achieved
Antibiotics in ED within an hour	> 95%	80%
Antibiotics on the inpatient ward within an hour	> 95%	80%
Neutropenic sepsis door to needle time	> 95%	96%
ED Sepsis six bundle	>95%	49%
IP Sepsis six bundle	>95%	48%

Emergency Department Sepsis Care

While the average compliance remains at 49% for reliability of delivering the sepsis 6 bundle in the emergency department, there has been a sustained improvement trend since October 2021, reaching a compliance of 80% reliability in March 2022.



The sepsis team has been supporting the Emergency Department (ED) by being more clinically visible and available to review the septic patients coming in the department, either via the front door or via ambulance. The team provides support by assessing patients in the back of the ambulance, initiating sepsis treatments when there is a delay in ambulance offload. By doing this, the team ensures that all elements of the Sepsis 6 bundle of care have been carried out within the hour.

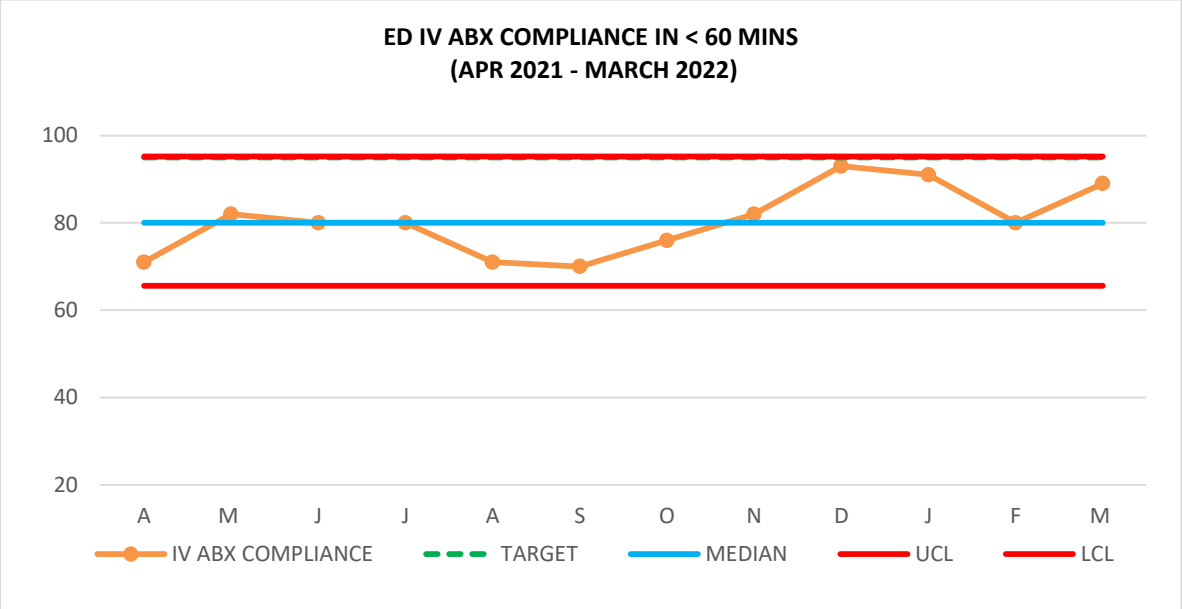
The team has also been very involved in providing virtual sepsis teaching sessions for ED staff, as face-to-face teaching continues to be challenging due to social distancing. The sepsis teaching sessions for ED staff started in September 2021, where the training compliance was 43.1% (72 staff members were trained and 95 staff members required training). The training was provided every week for three months which resulted in an improved compliance rate of 68% (115 staff were trained and only 54 staff require training now).

Emergency Department and In-patient compliance with IV antibiotic administration

Compliance figures have been variable throughout the year. IV antibiotics have been given in the ED within an average of 44 minutes which meets the target of within 60 minutes from trigger. Hence, this has improved their IV antibiotic compliance to 80% compared to 70% from last year.

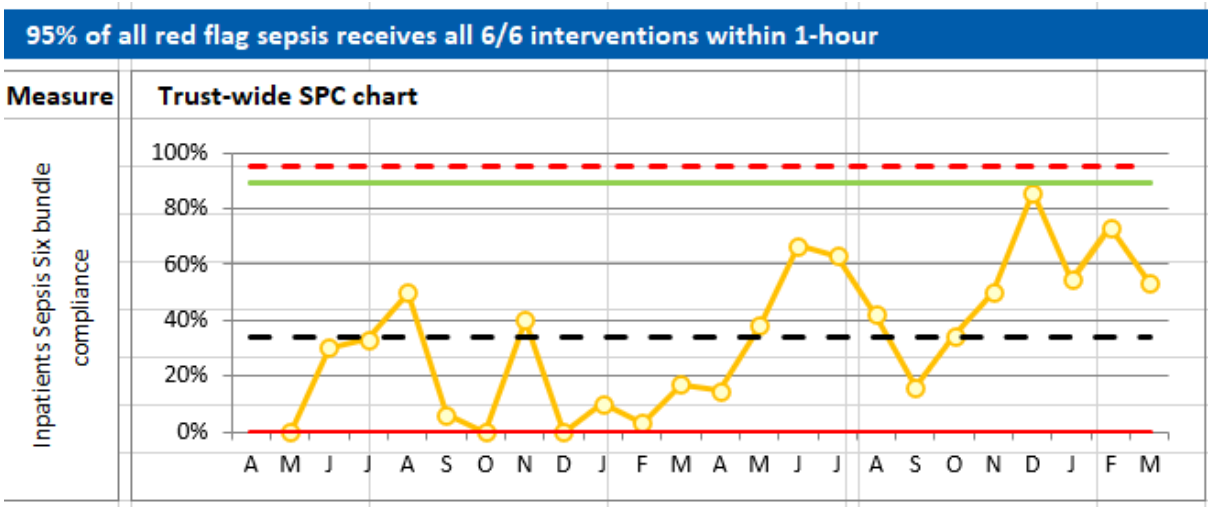
Please refer to Figures 7 and 8 for ED and IP compliance to IV antibiotic administration within 60 minutes. The average time to IV antibiotic can be seen in Figure 7.

Figure 7 (Aim 95%)



Inpatient sepsis care

Administration of IV antibiotics within the 60 minutes time frame in the inpatient area has significantly improved to 80%, compared to 38% from the previous year. The average time to intervention is 33 minutes and the overall trend is improving.



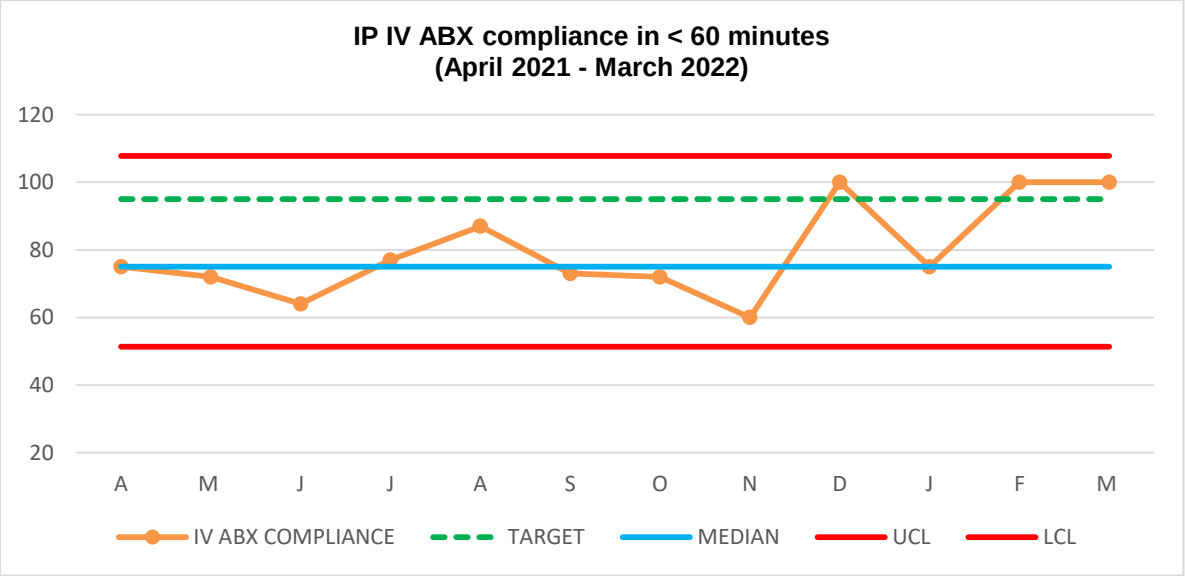
The average time of administration of IV antibiotics within the 60 minute timeframe in the Emergency Department was 82 minutes in April 2021; this is improved to 27 minutes in March 22

Learning themes identified include:

- Adherence to monitoring and recording of urine output in septic patients
- Accurate monitoring and documentation of fluid input and output
- Delay in IV antibiotic and IV fluid administration

- Failure to collect blood cultures
- Failure to collect and measure lactate levels

Figure 8 (Aim 95%)

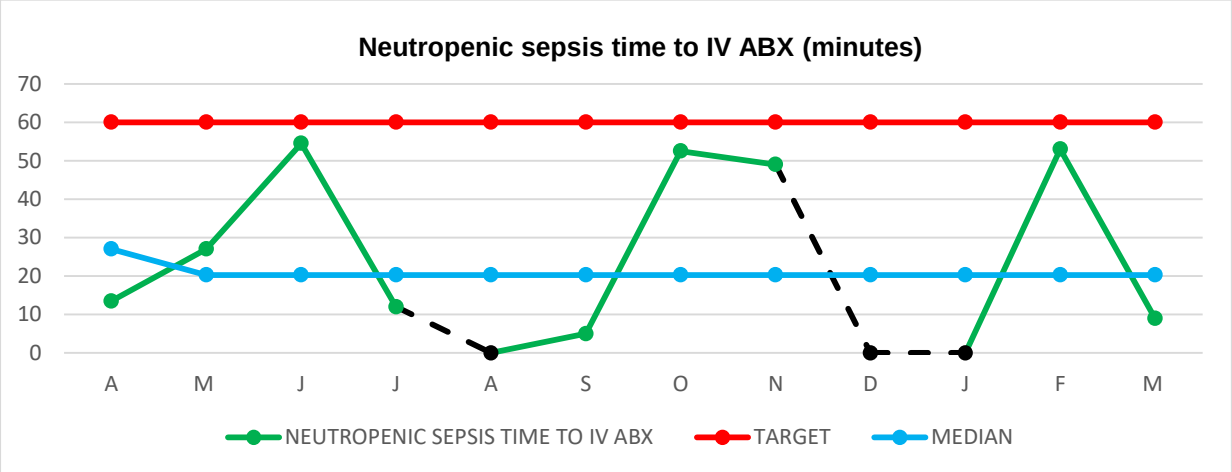


Neutropenic sepsis

A total of 23 patients were audited for neutropenic sepsis between the period of April 2021 to March 2022* across the Emergency Department and Inpatient areas. 91.3% of them received the antibiotics within 60 minutes following sepsis red flag triggers, compared to 83% from the previous year.

The average time to IV antibiotic administration is 30 minutes, which is a significant improvement from 43 minutes of the last year. Please refer to figure 9.

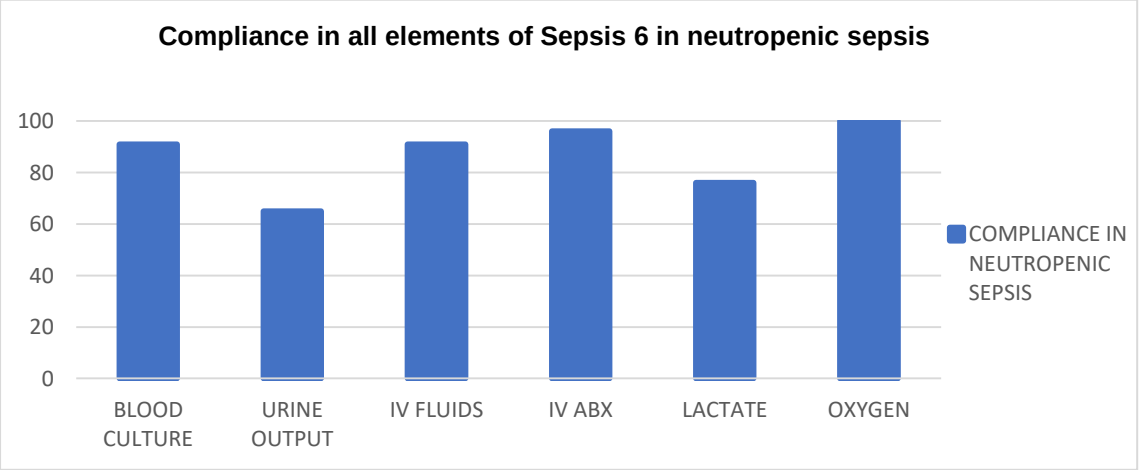
Figure 9



*In August, December and January there were no neutropenic sepsis patients identified for the audit

The compliance for all elements of the Sepsis 6 care bundle to be completed within an hour from trigger is currently 61% (aim was >95%). Please refer to figure 10 to compare the results. All patients who needed oxygen therapy were administered oxygen within an hour from trigger. Reasons for non-compliance are: failure to record and monitor urine output within an hour from trigger (35%), failure to collect and check lactate levels within an hour (24%), neglecting to collect blood cultures within 1 hour from trigger (9%), delay to commence IV fluids within 60 minutes (9%), delay to administer IV antibiotics within 60 mins (4%). Recording and monitoring urine output along with checking lactate levels remain priorities for improvement.

Figure 10



Sepsis 6 bundle

In 2021/2022, the Trust continued to monitor the compliance in initiating and completing all elements of the Sepsis 6 bundle within 60 minutes from triggers, namely:

- Administration of IV antibiotics
- Serum lactate measurement
- Urine output monitoring
- Sample for blood culture
- Administration of IV fluid challenge
- Administration of Oxygen therapy

Over the period of April 2021 to March 2022, the Sepsis 6 compliance has been varying with the lowest recorded compliance of 16% for both ED and IP area. The highest compliance recorded was 80% for ED and 86% for IP. The median for the combined ED and IP compliance is 51.5% which is an improvement on 31% last year. Please refer to figures 11 and 12.

Figure 11 ED attendance Sepsis Six bundle compliance

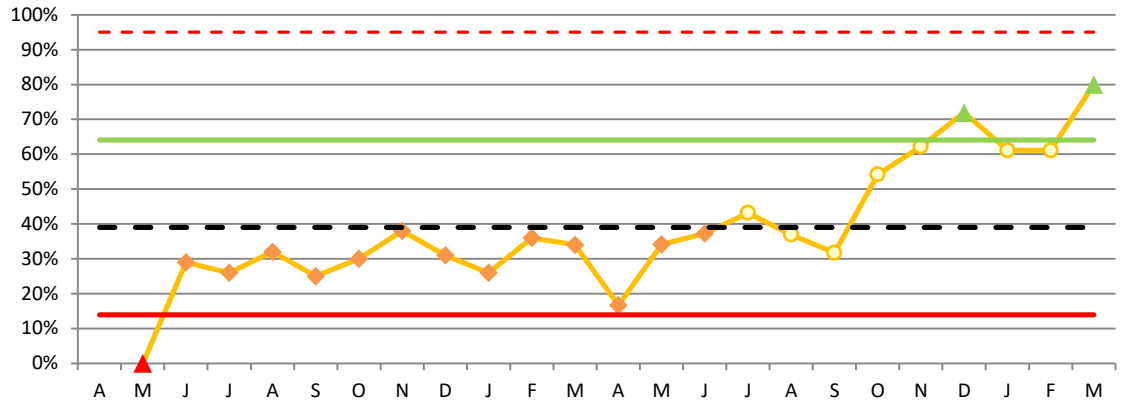
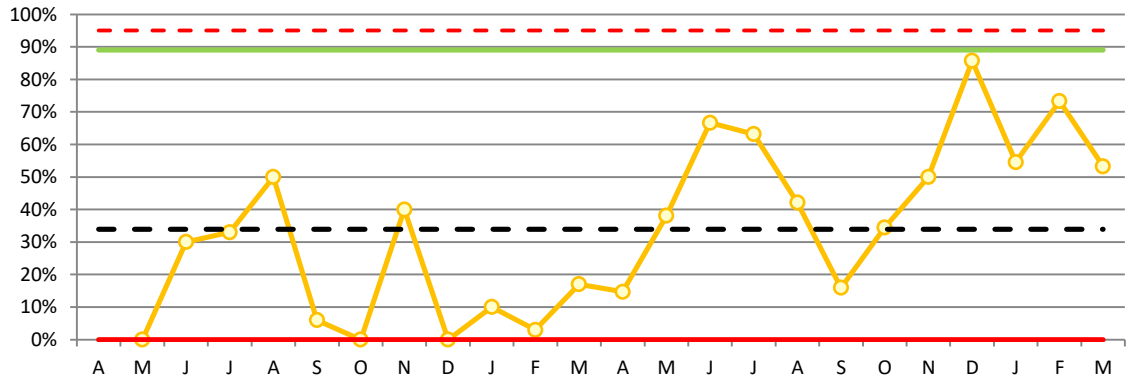


Figure 12 Inpatients Sepsis Six bundle compliance



Managing sepsis remains a quality improvement priority for the Trust-wide Deteriorating Patient Collaborative. Targeted work continues with the acute kidney injury team, critical care outreach team and resuscitation team on escalation using the Situation-Background-Assessment-Recommendation-Decision communication tool (SBARD), fluid balance monitoring, and observations competencies. The Pathway to Excellence programme will continue to drive and help to sustain improvements in managing sepsis.

Quality improvements in 2021/22 include:

- Sepsis and critical care outreach teams have combined to strengthen clinical leadership
- Sepsis team now comprises a mixture of clinical and teaching roles
- The introduction of out of hours emergency cannulation and phlebotomy team
- Implementation of digital fluid balance chart which is embedded in Nervecentre
- Improved awareness and early confirmation of optimum antibiotics, taking account of allergies.
- Sepsis recognition is now included in the scenarios presented in the yearly update of ILS provided by the resuscitation team

- Completion of root causes analysis investigations of all peri-arrest calls, to identify and feedback early sepsis care learning
- The pilot of our electronic medicines prescribing system (ePMA) to facilitate more accurate measurement of doses of antibiotics and intravenous fluid therapies administered

Priorities for 2022/2023 include:

- Improve staff training compliance for ED and IP wards to 90% by October 2023.
- The sepsis team will provide teaching sessions for CSW, OSCE and Pre-registration nurses' induction programmes.
- Empower staff to act on sepsis and commence the "Nursing Actions" elements of Sepsis 6 (Blood culture collection, VBG collection to check urgent lactates, urine output monitoring) and commence IV fluids, IV antibiotics, and administer oxygen once prescribed by the attending doctor.
- Improve and assess staff competency in completing the Sepsis 6 care bundle within 60 minutes from trigger by supervision, training, and encouraging leadership via link nurses. Improvements in compliance should be seen by September 2022.
- Include an e-learning programme (Role Essential Training) for Sepsis in ENH Academy.
- Improve staff competency in recording observations accurately.
- Educate staff in the importance of accurate input and output monitoring as well as proper documentation in the digital fluid balance chart (to be included in the CSW Induction).
- Incorporate the Sepsis Assessment and Sepsis 6 Bundle in Nervecentre.
- Expand the sepsis awareness programme, including recognition of signs and symptoms in paediatric and maternity patients.
- Roll out of ePMA to facilitate more accurate measurement of doses of antibiotics and intravenous fluid therapies administered.

2.3 Safer Invasive Procedure Standards

	Aim	Achieved
Phased approach to developing and embedding Local Standards for Invasive Procedures.	LocSSIPS for 80% of invasive procedures	Approach finalised

A procedure is invasive when a cut is made into the body (or where a body cavity is accessed for example, endoscopy). 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.

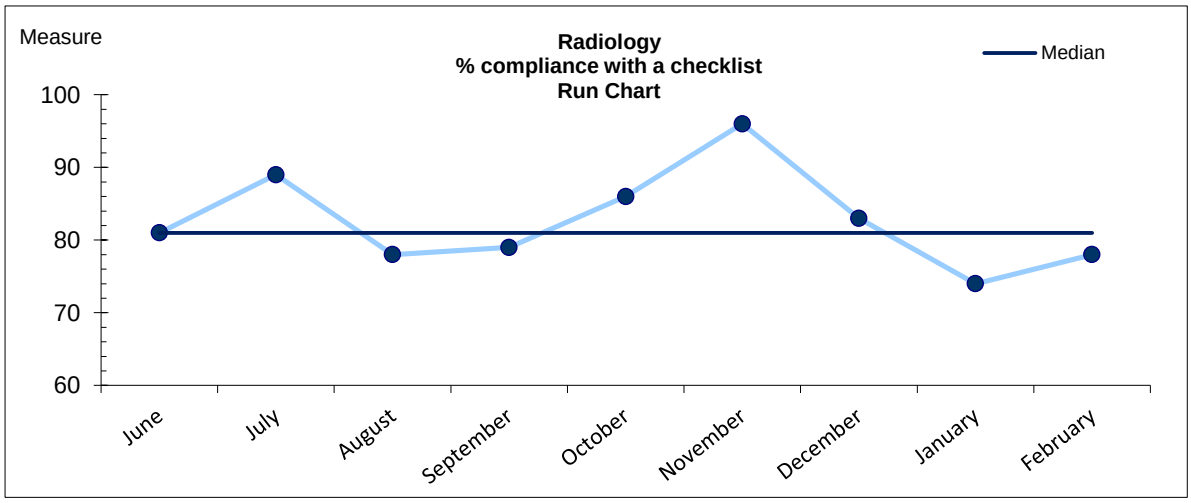
The re-designed LocSSIP paperwork for theatre has now been successfully embedded and is in use in all theatres throughout the Trust (excluding maternity who have separate LocSSIP paperwork). A new audit scheme has been developed for use in theatres and in non-theatre areas which can be uploaded directly to the online IQVIA system. The audit has two sections: one which follows an individual patient through (looking at the handovers, the sign in, time out and sign out), and one which follows the list pathway looking at the huddles and debriefs for the team.

The initial data from theatre shows a median of 74% compliance for the list pathway and 88% for the patient pathway. Previous audit methodology focused on retrospectively auditing notes to assess compliance with LocSSIPS. The new approach is more observational and is designed so staff from neighbouring areas can audit their peers and there can be quality improvement in both directions, as well as demonstrating safety. The audit data will be accessible on-line and can therefore be easily used both corporately for assurance and locally for quality improvement.

A similar audit has been developed for use in non-theatre environments where lists of procedures take place. This has been trialled in radiology and will be introduced in 22/23 to the other clinical areas.

Radiology have moved from auditing 100% of the paperwork to a regular sampling approach. This has shown a median of 80% compliance with completion of the WHO checklist (figure 13). Interventional radiology has made NatSSIPs and the development of their LocSSIPS a focus following the declaration of a Never Event for wrong site treatment.

Figure 13



Endoscopy conducts a large audit of their documentation which includes compliance with completing the WHO checklist. Results have shown showing a mean score of 99% for upper GI endoscopy and 98% for colonoscopy.

LocSSIPS have also been introduced in dermatology, radiology, urology, ophthalmology, critical care and other clinical areas. The focus for 22/23 will be to identify remaining areas which do not use LocSSIPS for their invasive procedures and break down barriers to implementation.

Human factors simulation sessions will be launched in theatres in May 2022, which can then be replicated in other areas throughout the Trust.

2.4 Deteriorating patient and cardiac arrest

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

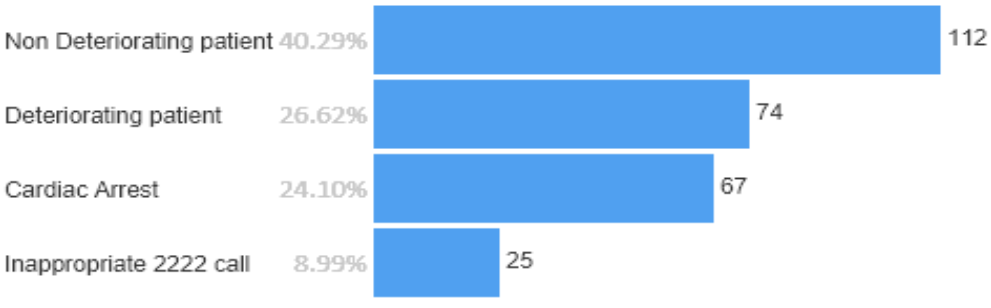
Nationally, more than three quarters of in-hospital cardiac arrests are preceded by a physiological deterioration, indicating an opportunity to recognise, manage and prevent further deterioration and subsequent cardiac arrest.

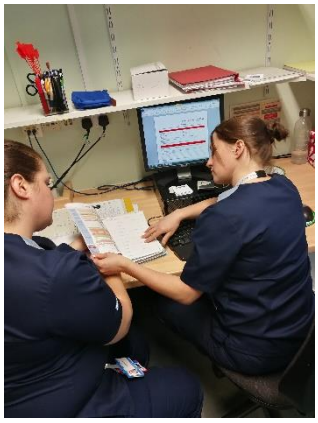
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD 2012) reported that over one third of cardiac arrests were potentially avoidable due to the predictability of the event. National enquiries and datasets highlight the survival rate associated with an in-hospital cardiac arrest is less than 20%. Early recognition and identification of patient deterioration can therefore prevent cardiac arrests and improve patient survival outcomes or allow for a natural transition to end-of-life care if death is inevitable.

During 2021-2022, an average of 0.9 per 1000 patient admissions to Lister Hospital site resulted in physiological deterioration requiring the assistance of the 2222 emergency response team and 0.8 per 1000 patient admissions suffered a cardiac arrest.

27% of all the 2222 team attendances were in response to patients with signs of physiological deterioration, 24% were cardiac arrests and the remainder were sudden collapses with no early warning indicators (40%) and a few unnecessary calls (9%) (figure 14).

Figure 14





Following each cardiac arrest a Rapid Incident Report (RIR) investigation is undertaken to review patient care and any learning is fed back to the teams involved and discussed at the Trust's Serious Incident Review Panel (SIRP).

From that review of cardiac arrests in 2021/2022 we have identified that 60% of all inpatient cardiac arrests (excluding the Emergency Department and cardiac suite) had abnormalities in their physiological national early warning (NEWS) indicators preceding the event. 37% of these patients with early warning signs were identified as having a missed opportunity for optimisation of their treatment plan. An earlier discussion with the patient about their options for care would also allow their wishes to be taken into consideration, including supporting a peaceful natural death without cardio-pulmonary resuscitation (CPR) were this to be the appropriate choice.

Timeliness of Observations and Effective Escalation

Over the past year, the **Deteriorating Patient Committee** has taken the opportunity to reflect on the events of the pandemic and review the priorities for the next year. A key priority remains the timeliness of patient observations and improving escalation. This will require identifying how we support staff to undertake patient observations, within the allocated frame times, to recognise concerns and escalate as needed.

A pilot of targeted improvement work has started on one of our 'planned care' wards, which has identified measures to support improved timeframes for taking observations, and work will continue to embed new processes, which can be then be rolled out Trust-wide for all areas.

There is a Trust-wide drive to support staff training and assess the competency in performance of physiological observations for all clinical staff, including a dedicated neurological competency for registered nurses and nursing associates. These competencies incorporate the new elements of the NEWS2 guidance; the hypercapnic module and new confusion modules. Hypercapnia is a build-up of carbon dioxide in the bloodstream and mainly affects people with Chronic Obstructive Pulmonary disease (COPD), the module allows for adjusting observations for patients with this physiological change.

In order to capture reliable data around our NEWS2 training compliance, the Trust will be re-launching the NEWS2 training module into our e-learning domain. This allows clinical staff to undertake the learning which is then recorded within their learning profile.

For both of these learning priorities we aim to be 95% compliant by December 2022.

Additional classroom learning can be difficult to facilitate since the pandemic. Therefore, to embed the learning from the observation competency assessment and from the NEWS2 e-learning, clinical experts from our Critical Care Outreach Team (CCOT) will be undertaking sessions on the ward, working alongside the staff to support them in their bedside learning. This will include the ABCDE assessment, SBARD communication, performing of observations, fluid balance chart management and education. This will be trialled in the coming months and if successful will become a regular rostered occurrence.

This year the Trust will be launching the Call 4 Concern© initiative. With the reopening of patient visiting, it has been acknowledged that it is not only healthcare professionals that can recognise deterioration in their patients, but also the patients' family and/or carers. Call 4 Concern© will allow members of patients' family/carers to contact our Critical Care Outreach Team if they are concerned about deterioration in the person they are visiting. The aim is to launch in July 2022, and external communications will be provided to our service users, in the weeks building up to the launch.

The Data

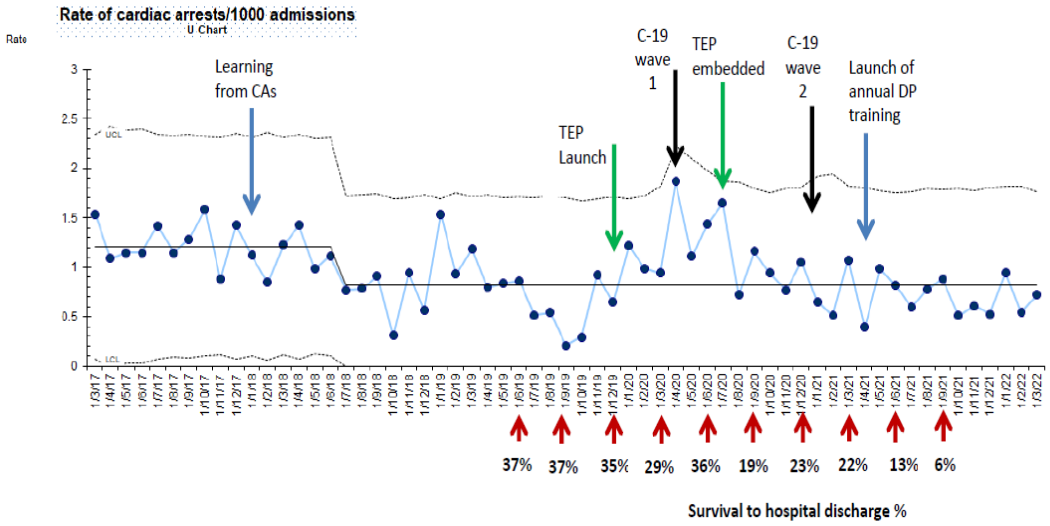
2222 emergency team and cardiac arrest data is routinely submitted to the National Cardiac Arrest Audit (NCAA) database.

Historically the Trust has collected and examined cardiac arrest data. In January 2018 the Trust began deep dive reviews into cardiac arrests and learning was shared following these events. A reduction of 43% was seen within six months and this reduction has been sustained. The chart in figure 15 demonstrates the sustained reduction of in-hospital cardiac arrests to an average rate of 0.8 per 1000 patient admissions (previously 1.2 per 1000 patient admissions).

The reduction in cardiac arrests demonstrated an improvement in the recognition and management of deteriorating patients. In order to further improve and prevent patients from deteriorating, it was recognised that understanding the data was essential. In January 2020, a review of all 2222 calls began, to establish the number of deteriorating patients requiring the 2222 emergency response team. The data can be seen in figure 16

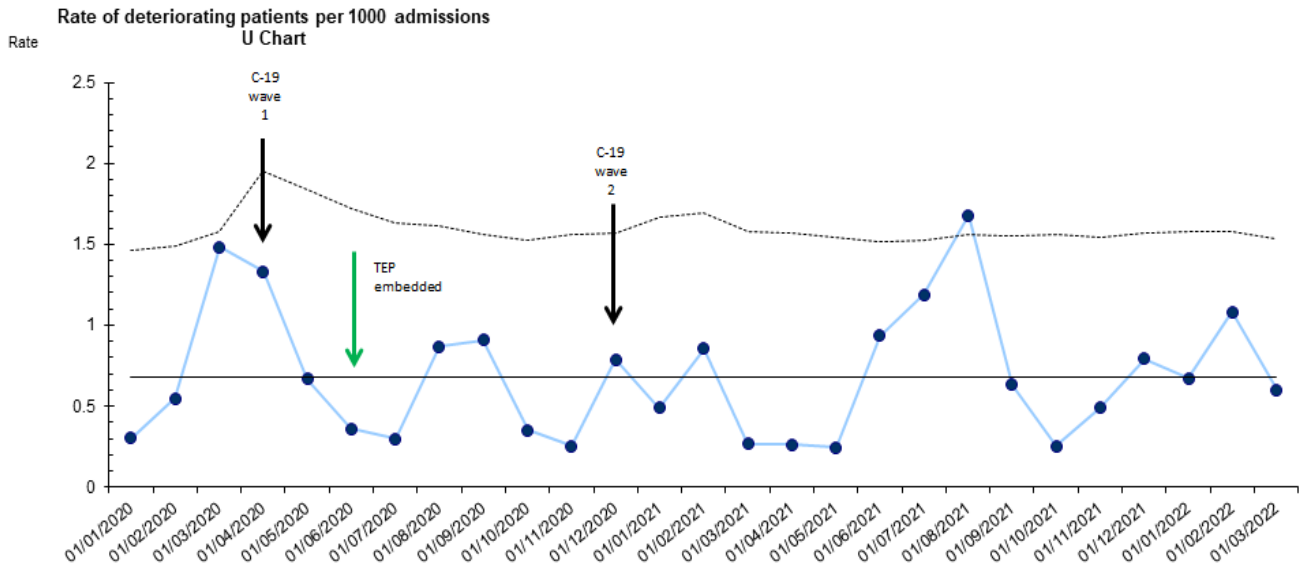
Examination of the data is currently underway to understand changes, peaks and troughs; this will be scrutinised against the acuity levels of in-patients and the number of referrals to the Critical Care Outreach Team (CCOT).

Figure 15



The chart in figure 15 shows the Trust's survival to discharge rate following cardiac arrest, highlighting a lower survival rate since the summer of 2020. Understanding the data can be challenging and further investigation is ongoing. Initial examination of the data reveals that prior to the summer of 2020 less than 50% of all cardiac arrests were either sudden unpredictable events (with no preceding warnings) or appropriate for CPR and with all care in place to try and prevent deterioration. More recently there has been an increase in this category of cardiac arrests, with an average 60% during the first two quarters of 2021/2022.

Figure 16



When cardiac arrests occur suddenly or are appropriate for CPR and with all care in place to try and prevent deterioration, these would be considered unavoidable. The physiological factors causing the cardiac arrest will determine the outcome. If all causes have already been reversed to prevent deterioration, but the heart still stops, the performance of CPR and advanced life support is unlikely to favour a positive outcome.

A patient that suffers a witnessed sudden collapse such as a myocardial infarction (heart attack), with good quality CPR and reversal of the underlying cause (clearing a blocked artery in this example) may favour a positive outcome.

It is certain that early identification of patients for whom advanced CPR would not restart the heart, should be managed with optimal end of life care rather than futile attempts to resuscitate inappropriately. This in turn will impact survival rates.

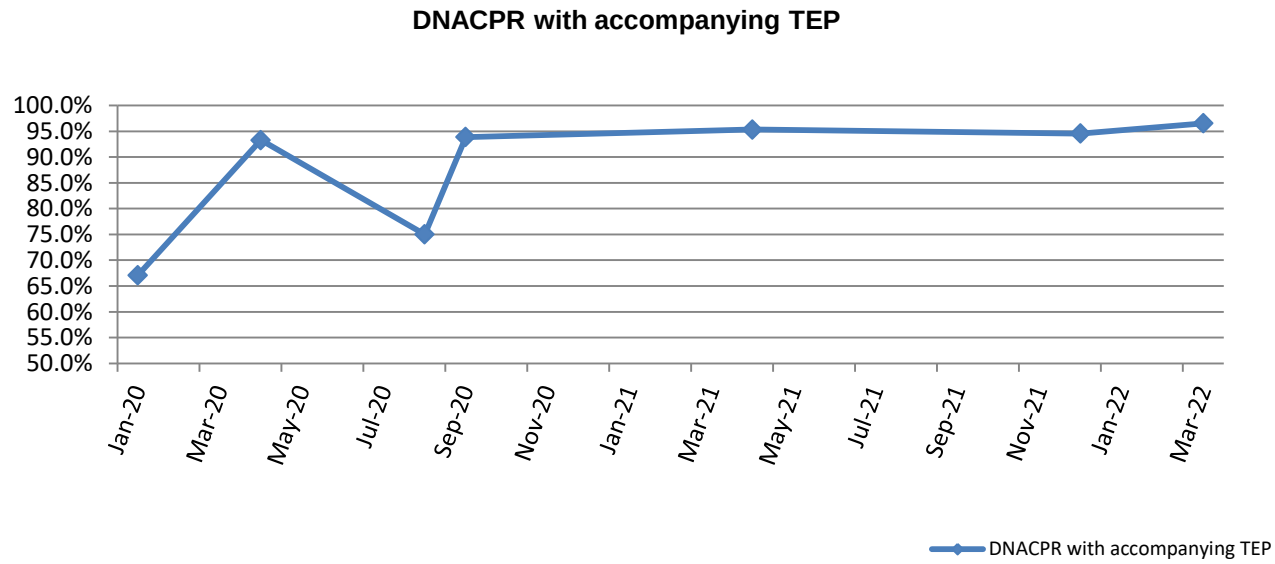
Do not attempt cardio-pulmonary resuscitation (DNACPR) and treatment escalation plans (TEP)

In October 2020 the Department of Health and Social Care (DHSC) requested a review of DNACPR following concerns during the Covid-19 pandemic. Recommendations and actions were set by the Care Quality Commission (CQC) to improve DNACPR decision making process in a report; ‘Protect, Connect, Respect – decisions about living and dying well’ (2021). Universal Principles for Advance Care Planning (ACP) was jointly published by a coalition of partners in response to the CQC report (2022).

The Trust has undertaken a gap analysis against the CQC recommendations following this review and report.

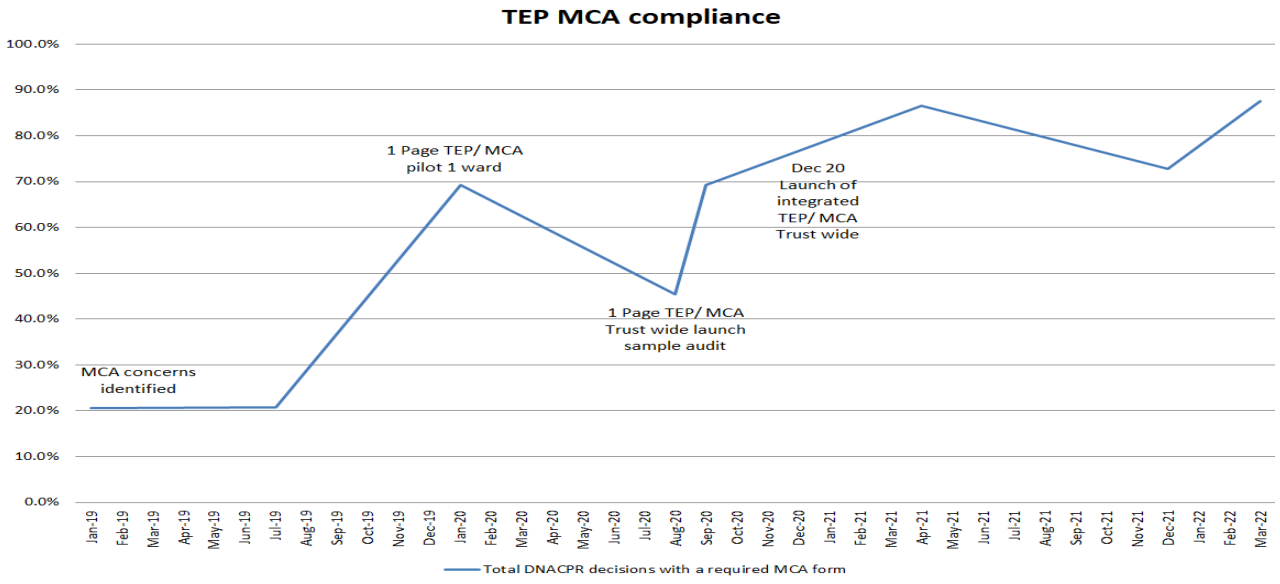
Following the launch of the Trust Treatment Escalation Plan (TEP) in December 2019, the completion of the documentation sits at 97% compliance along with the DNACPR documentation (figure 17).

Figure 17



In January 2020 a pilot of a combined TEP and Mental Capacity Assessment (MCA) document, showed an initial compliance of 69%. In December 2020 the launch of a fully integrated TEP/MCA led to a sustained increase in compliance of 87%; this improvement journey can be seen in figure 18.

Figure 18



People must always be at the centre of their care, including advance care planning and DNACPR decisions (CQC, 2021).

An audit of documented discussions with patients and their loved ones (March 2022), in relation to 'Do Not Attempt Cardio-pulmonary Resuscitation' (DNACPR) decisions, revealed that 97% of decisions were documented as discussed. The content of discussion was clear in 86% of these cases. 89% indicated decisions were discussed with relevant others where the patient was deemed not to have mental capacity to be involved in decisions relating to their care, 71% of these cases had clear documented content recorded in the medical

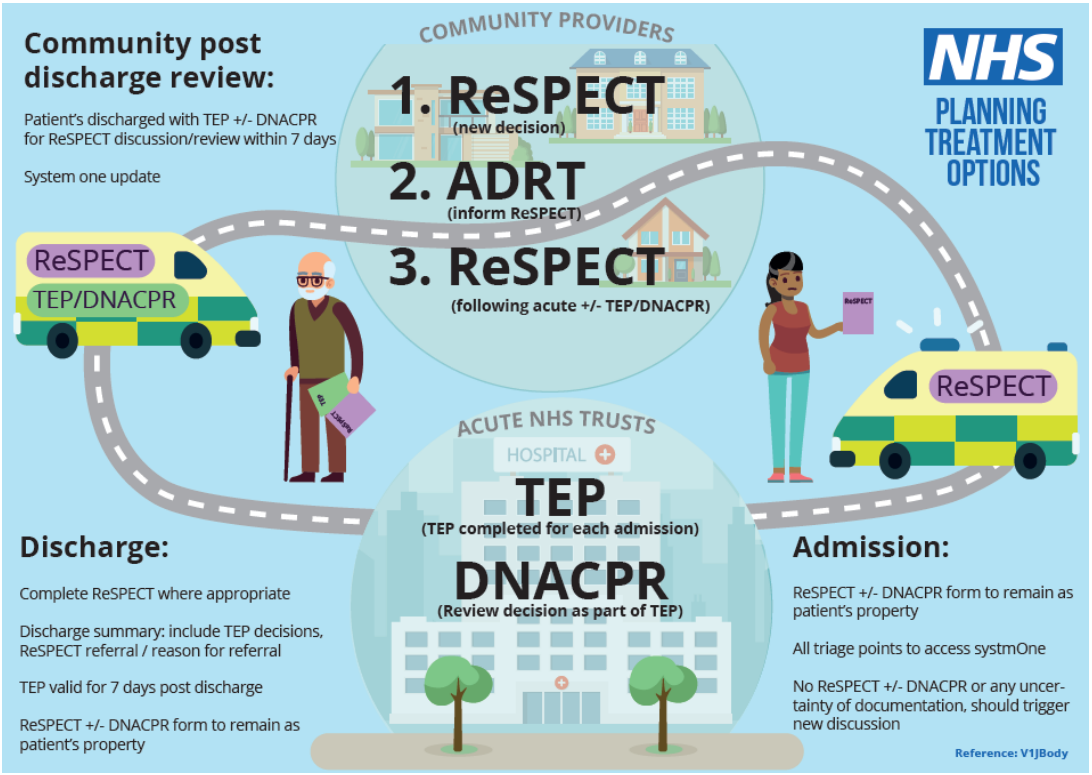
records. Improvement is required to ensure that patients and/or their loved ones are involved and clearly understand the decisions relating to their care.

Improvements and changes during Covid-19 and in 2021/22

TEP / DNACPR

The Trust is currently working alongside the integrated care providers (ICPs) for East and North Herts to launch the national ReSPECT form (Recommended Summary Plan for Emergency Care and Treatment) across the whole region for both hospital and community care.

Figure 19 demonstrates a roadmap for integrating systems, supporting the ICPs improvement.



The ReSPECT form improves upon and replaces the DNACPR and TEP forms and promotes early shared decision making and patient involvement. It considers multifactorial options for patients, including suitability for CPR, and specifically focuses on the wishes of the patient in the event of an emergency. It enables clinicians to better understand the wishes of a patient and to make better decisions relating to the patient's treatment options, particularly in the absence of capacity. The Trust is currently piloting the forms and assessing how they are best used to improve patient care.

Safety and Education

The Covid-19 pandemic required new ways of working to keep patients and staff safe. The National Resuscitation Council (UK) Guidelines changed to protect staff, patients and public from the contraction or spread of the virus.

The biggest change was the need to don personal protective equipment (PPE) prior to commencing any aerosol generating procedure (AGP). These procedures are deemed a risk as they lead to the viral particles being sprayed in the air.

In order to effectively ensure the timely response to a patient's deterioration and the need for PPE during CPR (several interventions with AGP), over 1000 front facing clinical staff were trained within the first four weeks of the pandemic, with approximately 2500 staff subsequently trained in total. To allow for social distancing and lack of face-to-face or classroom sessions, a training video was produced and shared on the ENHT intranet (Knowledge Centre). This video is still used for education in the mandatory training sessions.

In addition, in the past year all clinical staff working with acute inpatients attending their induction or annual resuscitation training receive multi-disciplinary training in the recognition and management of the deteriorating patient. This training includes NEWS2 observation performance & escalation, SBARD communication, the A-E assessment & management, with an additional focus on sepsis and anaphylaxis (emphasis due to increased Covid-19 vaccination), targeted to their job roles.

Improving the knowledge and skill in response to AGPs:

In response to the Resuscitation Council UK (RCUK, 2020) COVID-19 guidance and incident reports highlighting issues relating to incorrect PPE and the deployment of the resuscitation trolleys into contamination zones usage during cardio-pulmonary resuscitation (CPR), further

work was undertaken to improve the staff safety and to ensure the appropriate responses to patient deterioration with AGPs.

In-depth, human factors reviews of care were undertaken, where recommended PPE procedures were breached and key themes highlighted.

Questionnaires were completed by clinical staff across a mix of COVID and non-COVID wards and wards with and without incidents. A quality improvement initiative was implemented to address problems identified.

On-going support on the pilot wards was provided. The learning has been shared in subsequent resuscitation training sessions.

Figure 20

EMERGENCY SHIFT PLAN

Ward: Date:

NHS East and North Hertfordshire NHS Trust

Name	Grade	CPR 1st resp.	Correct FFP3 Avail.	PPE buddy (don/doff aware)	Early	Late	Night

KIT CHECKS	Early	Late	Night
Resus trolley checked and ready for use			
CPR 1st Responder PPE			
Action taken if no staff Fit test passed (Continue overleaf if required)			

WHAT PPE DO I NEED?	Standard PPE	Enhanced PPE
Lay patient flat	✓	✓
Assess patient ABC	✓	✓
Call 2222	✓	✓
Apply defib pads to patient	✓	✓
Shock if appropriate	✓	✓
Apply O2 to patient	✓	✓
Start compressions (CPR responder)	x	✓
BVM (skilled users only)	x	✓
Suctioning	x	✓

ALL PATIENTS, ALL AREAS:

DO NOT START CPR WITHOUT WEARING ENHANCED PPE

NO NOT TAKE RESUS TROLLEY INTO SIDE ROOM OR BAY

RS/2222 Handover/Sept 2020

Improvements can be seen in figures 21, 22 and 23:

Figure 21

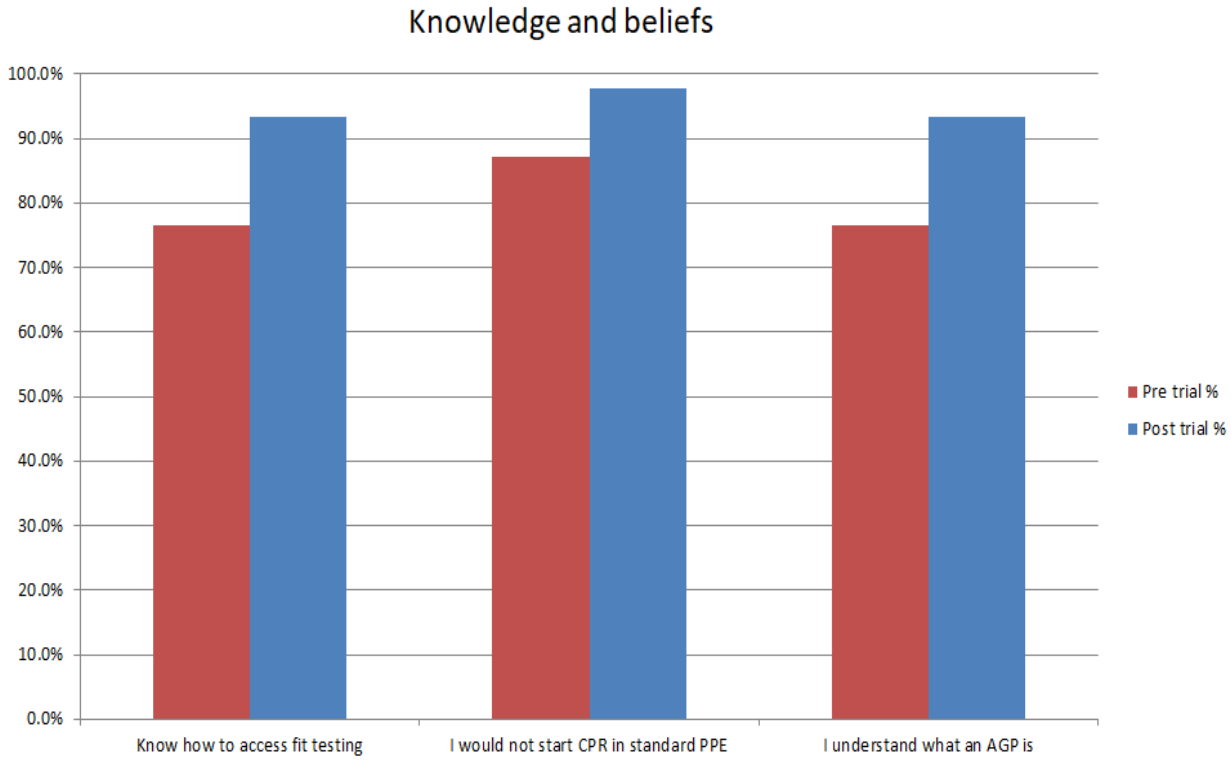


Figure 22

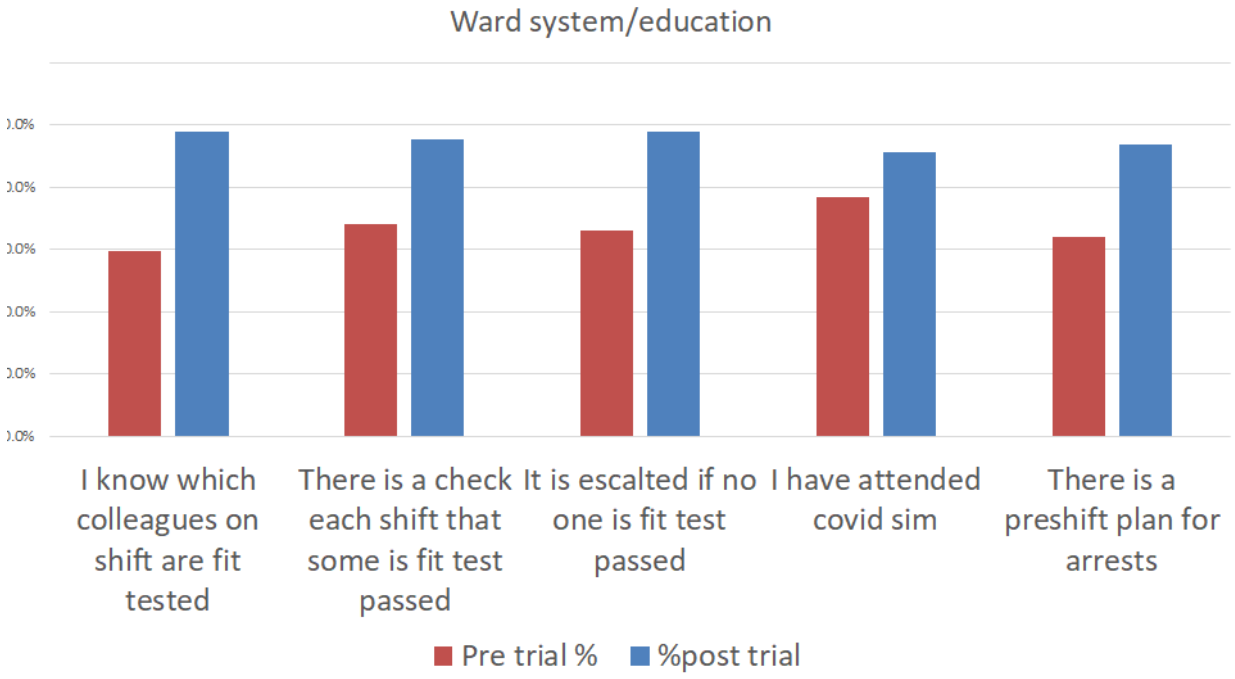
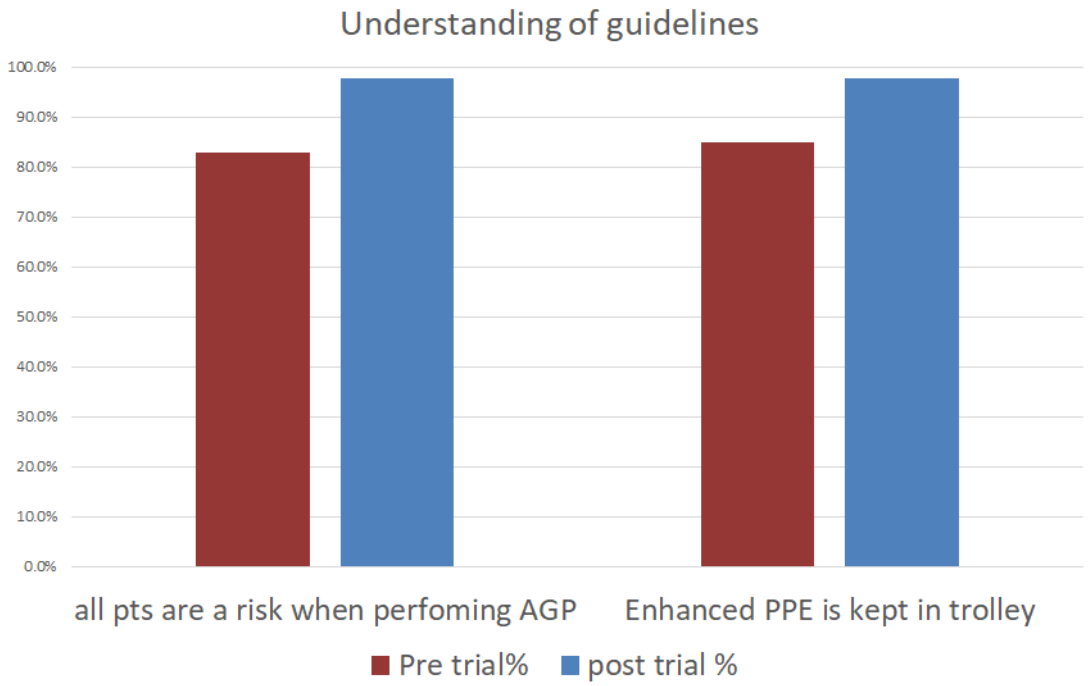


Figure 23



Improvements initiated following trial:

- A new pre-shift emergency plan allocation sheet (figure 20), to establish emergency response procedure, for each shift.
- Poster and first responder PPE kits for top of emergency trolley, to improve response time for responding to patients with correct PPE.
- Development and trial of floor stickers to remind staff of safe distance for emergency trolley, so as not to contaminate kit.
- Meetings with ward leaders/stakeholders to engage and gain buy in, using initial human factor findings for open discussion to enhance safety culture.

Planned quality improvements for 2022/2023:

Understanding response and to clinical deterioration:

We will be performing a human factors framework analysis of antecedent care preceding cardiac arrests, 2222 calls, cases of failure to rescue and inappropriate escalation of care/attempts at DNACPR. This work aims to identify key factors that influence the performance of observations, escalating, the use of structured communication and factors that influence TEP and DNACPR decision making, including communication barriers with patients and families.

Improved education:

We will be launching an inaugural training plan for new clinical support workers (CSWs). This education aims to provide CSWs with the requisite knowledge and skills in performing observations, recognising clinical deterioration, and escalating concerns effectively.

Escalation module and Hospital at Night

In alignment with the Harm Free Care approach to safer systems, the designing of a new hospital at night system and doctors' escalation digital module are now under way. This has involved deployment of new handheld devices, and will be supported through training and escalation awareness to junior doctors. The new hospital at night team structure has been agreed and plans are under way to operationalise in the summer of 2022. This shall be monitored and tracked through both our Harm Free Care & Deteriorating patient collaborative groups.

2.5 Safeguarding Adults and Children

	Aim	Achieved
Ensuring reduction of harm of patients with known learning disability	Triangulate incidents, complaints and mortality data	Yes

Safeguarding adults and children remains an integral priority of patient care within the Trust, and we continue to undertake our duties under the statutory frameworks of the Care Act (2014), Children's Act (1989 and 2004), Working Together to Safeguard Children (2018) and the Mental Capacity Act (2005)

The Chief Nurse is the executive lead for safeguarding in the Trust.

Over the last year, the safeguarding team have taken pride in participating in various local and national campaigns across the Trust, and using social media to highlight the importance of safeguarding and that safeguarding is everyone's business. The following section identifies the activities and how we have worked together with our internal and external stakeholders:

- White Ribbon Campaign and 16 days of Action
    - Progress towards accreditation continues
    - 16 days of promotion for domestic abuse including staff awareness stalls, promoting the practice of recognition and response to domestic abuse for both staff and patients across Trust sites
    - Launch of the joint REFUGE and NHS Domestic abuse training package
- Modern Slavery Day held on 18 October 2021- an opportunity to raise awareness of the Trust strategy and a focus on homelessness and sexual exploitation
- Transitional Safeguarding - hospital youth worker project and voice of the young people

- Mental Health
    - Communication passports to support frequent attenders and transition
    - Care Education and Treatment Reviews to support collaborative working
    - Frequent attenders work and frequent attenders plans includes safeguarding risks
    - Hospital youth worker project
        - Funding extended
        - Development of QR codes to support signposting onto additional services
    - Mental health first aid training
    - Trauma informed care commissioned for unscheduled care settings
    - Tablet devices to support apps and surveys, access to youth programmes, referrals to Beacon for Trauma support
- Multi Agency Risk Assessment Conference (MARAC)– new process implemented to include community services in the MARAC
- Multi Agency Child Exploitation – sharing information for multi-agency risk assessment and safety plans
- Safer Sleep campaign – risk assessment tool, and review of resources available to reduce sudden unexpected death in infancy.
- The Myth of Invisible Fathers – in response to national panel report. Research project into the role of fathers/partners in children's lives
- Medical Neglect – in response to local learning the policy was re-launched with particular focus on 'Was not Brought' ; i.e. children or vulnerable adults who are not brought to hospital appointments as opposed to 'Did Not Attend' (DNA)
- Liberty Protection Safeguards – working group resumed in preparation for launch of national standards
- Independent Sexual Violence Advisor (ISVA) – successful bid and recruitment for a hospital based ISVA. New model developed and introduced successfully.
- Patient Initiated Follow Up (PIFU) - for Ear Nose Throat (ENT) introduced, with those vulnerable identified with clear pathways of care.
- Multi Agency Supervision pilot with Children's social services
- Midwifery and Health Visitor information sharing pathway.

Other team projects and highlights include:

- Safeguarding Champions relaunch – with a focus on visibility
- Frequent attenders – safeguarding representation
- Qlikview data for paediatric liaison service
- Daily learning visits – key areas Children's Emergency Department and Children's Assessment Unit
- Weekly adult Emergency Department training – for doctors and nurses

Activity:

- Supported 675 adults who experienced abuse in the community
- Included in the above number were 184 victims of domestic abuse with the majority of concerns raised to contacts with our Emergency Department.

- Processed and held accountability for 493 Deprivation of Liberty (DoLs) applications made on behalf of inpatients.
- 330 Child protection medical examinations undertaken (18% increase on previous reporting year)
- 677 known children referred to children's social care and 149 unborn babies were referred.

Safeguarding is most effectively delivered through strategic and organisational multi-agency arrangements with key partners working collaboratively to achieve a shared vision. The Trust safeguarding team, along with the Chief Nurse are key members of the Hertfordshire safeguarding boards and partnerships – with work this year looking at task and finish groups for sudden unexpected death in infancy, procedure updates, child protection medicals, consent for medical procedures and Children Looked After (CLA).

Strategies to recognise and respond to Modern Day slavery continue to be developed and implemented into everyday practice at ENHT. Work such as recognising homelessness as a risk factor, and sexual exploitation were a key focus, and on Modern Day Slavery day, work promoting this abhorrent crime reached over 150 staff. The successful appointment of a hospital based Independent Sexual Violence Advisor (ISVA), further strengthens the recognition and support we can provide to victims.

The Trust continues to demonstrate on-going commitment to safeguarding training ensuring all staff receive the required levels under guidance of the intercollegiate documents for children and adults (including FGM). The current safeguarding training is designed to ensure that every member of staff is aware of their safeguarding responsibilities, is able to recognise abuse and knows the response required to act upon the concern. The Safeguarding Training passport for level 3 safeguarding children continues to be embedded in practice, and the adult level 3 passport was launched, offering the same blended learning opportunities to safeguarding practice. Compliance for the uptake of all training modules is monitored via the Safeguarding Committee and reported on a quarterly basis. Due to the pandemic, fluctuations in compliance were seen and this remains a focus for 22/23.

We have continued to provide safeguarding supervision for designated staff groups, however this has been challenging due to the acuity and staffing pressures throughout the year. This is monitored at Joint Safeguarding Committee and continues to be a priority area of focus for 22/23.

Learning from case reviews continued with work around medical neglect, bruising, and professional curiosity. The Trust has continued to receive positive reviews from the Clinical Commissioning Group (CCG) in its annual adult assurance and children's compliance against section 11 of the Children's Act (2004) visit.

Ensuring reduction of harm of patients with known learning disability:

The care of individuals with a learning disability (LD) in the organisation is overseen by the Trust's safeguarding team and the Health Liaisons team who work in tandem with our clinical areas to support service users who have a learning disability during inpatient stays and outpatient service interactions.

The Health Liaisons team consists of learning disabilities nurses who offer specialist advice to clinical areas on the development of reasonable adjustments, which are individualised to meet the needs of each patient.

Our Learning Disability (LD) committee manages the Trust's LD strategy which is based on achieving improvement recommendations set out in 'NHS England's guidance on learning disability improvement standards for NHS trusts', June 2018.
Team projects and clinical highlights in 2021/22 relating to the care of individuals with LD include:

- Robust LD alert flagging system and virtual ward system remains in place.
- Members of the Health Liaisons team continue to support individuals with an LD during hospital stays and at outpatient appointments.
- The Health Liaisons team attend site safety meetings daily and appraise the wider team on actions to be taken relating to individuals with an LD to both improve patient experience and safety.
- Easy read appointment letters for individuals with an LD were introduced in the Trust during 2021.
- 89% of Trust staff have completed the Health Education England's eLearning module on learning disability awareness since its introduction in April 2021.
- The Trust remains active members of LeDeR review groups and improving health care outcomes group.
- The Trust's learning disability and autism policy has been reviewed in 2022 and includes both local and national learning from LeDeR reviews which will improve patient care in the future.
- We offer flexible visiting for inpatients with a learning disability and work in partnership with the carers/ family members of these individuals to enhance patient experience.

2.6 Venous Thromboembolism (VTE) Risk Assessment

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

The stage 1 risk assessment is completed on admission. The stage 2 reassessment is completed at consultant review or within 24 hours after admission and subsequent assessments are performed when the patients' clinical condition changes.

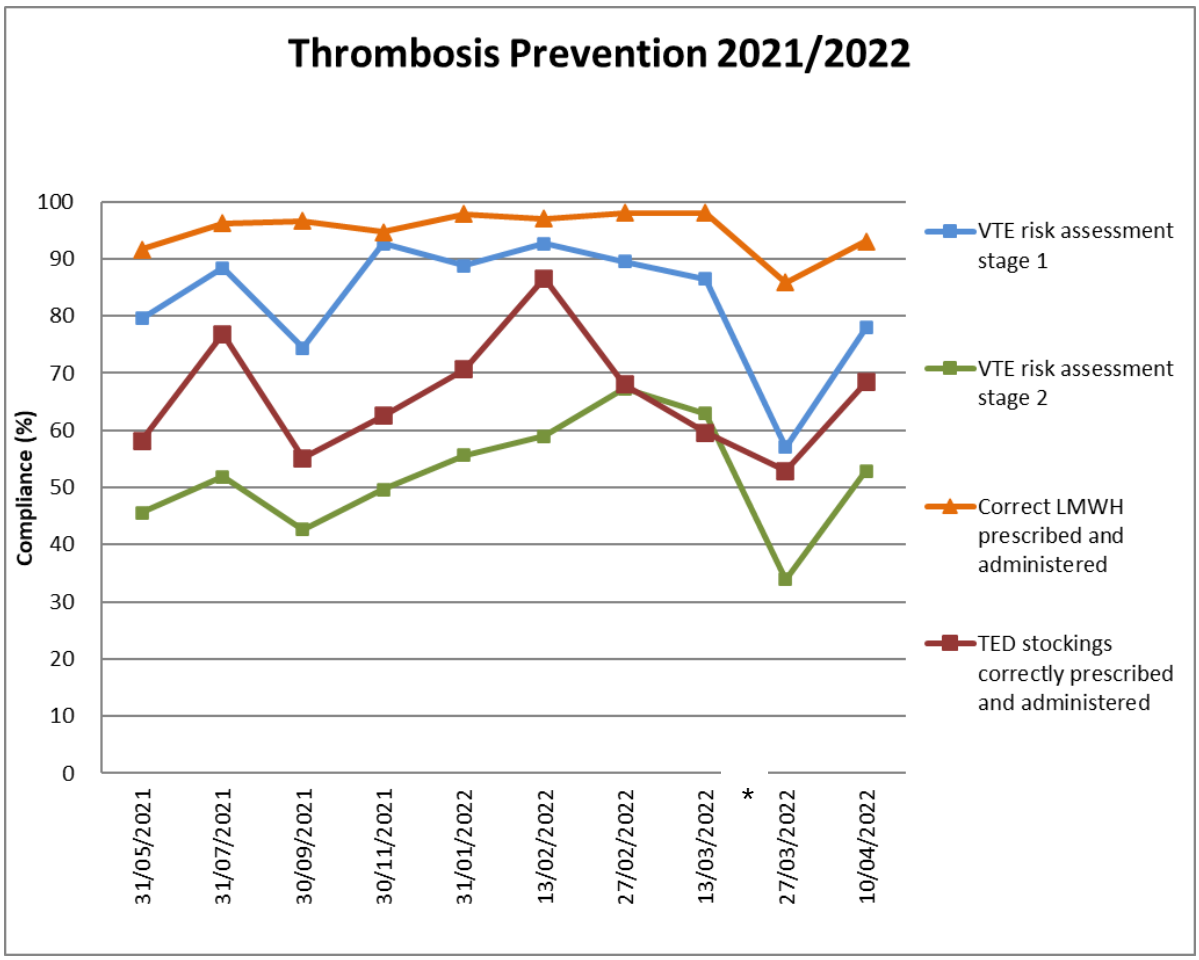
VTE risk assessments are audited regularly by the pharmacy team. The frequency of data collection changed from bi-monthly to alternate weeks at the end of January 2022. The audit is achieved through random sampling in real time in the patient setting, with regular reporting at ward and divisional meetings and at the Trusts Thrombosis Action Group which reports into Patient Safety Forum and subsequently into Quality and Safety Committee. The VTE data forms part of the Trust's quality report which is sent to the Clinical Commissioning Group (CCG), NHSEI and CQC. Results from the audits can be seen below.

Table 1: Aim and results for VTE compliance

	Aim	Mean achieved (April 21-March 22)
Improved compliance with VTE risk assessment stage 1 and stage 2	>95% compliance with stage 1 and stage 2 onwards	Stage 1: 83.5% Stage 2 onwards: 50.8%

The graph below demonstrates the Trust performance against the audit criteria throughout the year.

Figure 24: Audit data of clinical areas' compliance with VTE prevention 2021/2022.



The asterisks (*) on Figure 24 denotes the start of the implementation of ePMA, first full ePMA data set is 27/3/22.

At the beginning of the financial year 2021/22 we achieved 79.6% of stage 1 assessments and 45.6% for stage 2, this slowly increased until February 2022 when we achieved 89.5% for stage 1 and 67.3% for stage 2, however we didn't achieve the 95% target. The results for compliance against stage 1 and 2 assessments then declined in March 2022 due to the roll out of ePMA but have since started to climb again to 77.9% and 52.9% respectively. A similar trend is also seen with the correct prescribing of anti-coagulants such as LMWHs and use of mechanical thrombophylaxis with TEDs where results improved for the correct anti-coagulation prescription from 91.6% to 98% and stockings from 58.2% to 68% both of these also reduced in March 2022 but have started to climb again to 93.1 and 68.4% respectively as the processes are begin to embed into clinical practice.

Root Cause Analysis (RCA) investigations are undertaken when potential hospital associated thrombosis (HAT) cases are identified. There was one serious incident in August 2021 related to hospital acquired thrombosis.

Thematic learning identified from HAT cases has included:

- Importance of accurate documentation of weight to ensure the correct dose of chemical prophylaxis is prescribed.

- Poor documentation for recording if anti-embolism stockings (AES) are being worn and fitted correctly.
- As platelets improve chemical prophylaxis isn't always reviewed and restarted.
- Poor managed on bridging therapy with warfarin when INR is sub-therapeutic.
- Incorrect doses of anticoagulation in patient with acute kidney injury particularly with regards to increasing the dose back as renal function improves.

VTE remains a Trust priority and is a targeted area for improvement and a focus of the Harm Free Care Group and the Trusts Thrombosis Action Group. The aims of the VTE quality improvement work are;

- To reduce serious harm form Hospital Acquired Thrombosis by 50% from 4 per year to 2 by March 2023.
- VTE Risk assessment 1st and 2nd 85% by Dec 2021 and 95% by March 2023.
- TED stockings 85% by Dec 2021 and 95% by March 2023.
- LMWH administration shall be achieved and sustained at 95% by March 2023.

Since the quality improvement work began in July 2021 the following changes and improvements have been made:

- Reviewed and strengthened the VTE/HAT governance structure, this is in line with the Trust priority regarding VTE prevention.
- VTE training became essential training for relevant clinical staff, which is now monitored through ENH Academy and compliance reported at the Thrombosis Action Group meeting.
- VTE has been incorporated into the ward accreditation programme and has been a fundamental standard from August 2021. Wards must achieve the following standard for the initial assessment and the re-assessment for a ward to receive an award; Bronze 65-84.9%, Silver 85-89.9%, Gold 90-94.9%, Platinum > 95%. Since the indication the following wards have been issued accreditations; 10A have been awarded silver, AMU-2 and 11A have been awarded Gold.
- A transformation project was undertaken with support from the transformation team to review the HAT process to establish a more sustainable cycle that supports rapid review of HATs to support investigation and establish any potential harm and identify subsequent learning. This has led to a reduction in the number of outstanding HAT RCAs across the Trust.
- The successful appointment of a VTE lead practitioner.
- The Trusts VTE policy was reviewed, updated and relaunched.
- Increased frequency of data capture for the VTE audit to support the quality improvement project and identification of trends in data.
- Established regular clinical engagement to share VTE data, improvement work and learning from HATs.

The above changes were beginning to show some early signs of improvements in the VTE data as demonstrated in the graph above. In March 2022, the Trust rolled out ePMA which included VTE assessments. The roll out of ePMA was successful and when established will support improvements in VTE such as better documentation of assessments. The team will now focus on embedding the ePMA VTE processes into clinical practice and realising the benefits of a digital system.

Improvement priorities to ensure we meet our aims of > 95% of patients have a stage 1 and stage 2 VTE risk assessment by March 2023 include:

- Understand the impact of ePMA on VTE assessments and embedding the processes into clinical practice. For instance, the utilisation of the ePMA clinical indicator page to identify patients with outstanding VTE assessments.
- Review the VTE digital options appraisal at 3 months to identify the appropriate way forward
- Working with informatics and digital systems to support optimisation of managing thrombosis prevention in clinical areas, e.g. reviewing the possibility of digital Nervecentre flags to prompt VTE assessment completion and establish if retrospective data capture from Lorenzo ePMA is possible for audit purposes.
- Progression towards the appointment of a VTE consultant in 2022/2023 to support the improvement work through strengthened clinical leadership
- Continue to improve patient engagement and review VTE patient information.
- Continue to monitor training figures for VTE and report the results at the Thrombosis Action Group.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.

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

Links to Quality Strategy: Good Governance and Patient Experience

Monitoring: Quality and Safety Committee, Finance, Performance and People Committee

Reporting: Scheduled update to the Quality and Safety Committee

Responsible Directors: Chief Operating Officer

	Theme	Measure	20/21	21/22	22/23
3.1	Improving discharge processes	Reduce number of discharge summaries not sent to GP within 24 hours of discharge	Stabilise	Stabilise	Stabilise
		Patients discharged by midday	>15%	>15%	>15%
		Reduce proportion of beds occupied with length of stay > 14 days	<19%	<19%	<19%
3.2	Improve access	Improve cancer waits from 2018/19 position	Meet all national standards	Meet all national standards	Meet all national standards
		Improve delivery of 7 days services	Agree trajectory and monitor implementation	Agree trajectory and monitor implementation	Agree trajectory and monitor implementation
		Reduce delays in ED 4 hour waiting time	>90%	>90%*	>90%*

*shadow monitor against the proposed new clinical standards for ED

3.1 Improving discharge processes

	Aim	2019/20	2020/21	2021/22
Reduce number of discharge summaries not sent to GP within 24 hours of discharge	90% reduction	28.49%	17.04%	24.52%
Patients discharged by midday	>15%	15.11%	13.14%	13.66%
Reduce proportion of beds occupied with length of stay > 14 days	<19%	4.85%	5.09%	6.02%

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. This has been created into Lorenzo DS bite size learning modules designed to inform doctors on how to complete a DS, including the quality of DS being completed.
- Review of templates standardising format, creation of nurse led summaries
- Daily monitoring through improved data
- Improvement to process, removing unnecessary steps in the discharge process.

The data showed an increase of reliability sending summaries within 24 hours and within 7 days. However, the Trust acknowledged that the required targets had not been met and so this would be a continued focus for 2021/22.

Focus has continued daily with a robust discharge summary team who validate, chase, train and advise all staff involved in outstanding discharge summaries.

An internal discharge summary audit was completed for 2021/22 with actions reviewed from the previous internal audit 2020/21 for various team improvement, not only the reduction in the quantity of outstanding summaries but the quality of how they are written.

The overall assessment on adequate and effective governance, risk and control process shows reasonable assurance.

Whilst the number of outstanding discharge summaries may have reduced, the Trust should continue improvement by addressing the older discharge summaries pre December 2021.

The backlog for 2021/22 is now at 477. For unplanned care - 57 Medicine - validated, 253 Paeds/Bluebell - unvalidated, 167 validated for Planned Care. Please see the breakdown below.

This is a significant decrease in performance over the last year and is mainly due to depleted workforce and the return to 'normal' hospital working post Covid-19.

Overall figures for the Trust 21/22 excluding ED and deceased patients

Mid-day discharges

The number of patients arriving at the Emergency Department (ED) increases during the morning. Some of these will require admission. If inpatient beds are not available then the number of patients waiting within the ED will increase and the flow of patients through the department will be hindered. To maintain an effective and efficient flow of patients within the ED beds need to be made available on the wards to facilitate patient transfers.

Good planning to ensure medication, transport and discharge summaries 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 which supports a better patient experience. On average 13.66% of discharges occurred before midday which is a slight increase from last year.

metric	Apr 2021	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% of discharges before midday	15.0%	15.1%	14.6%	13.8%	14.9%	16.5%	15.0%	15.2%	14.7%	14.1%	14.0%	14.8%

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 6.02 % of beds were occupied by patients where the length of stay was more than 14 days; a slight increase from the previous year.

Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22

Proportion of beds occupied by patients with length of stay over 14 days	16.6%	15.9%	18.5%	19.5%	20.1%	20.1%	20.5%	22.4%	22.9%	22.8%	24.5%	22.9%
Proportion of beds occupied by patients with length of stay over 21 days	8.9%	8.1%	9.6%	9.9%	11.0%	9.8%	10.2%	12.7%	12.5%	12.8%	14.4%	13.0%

ENHT Discharge Programme

An expanded ENHT Discharge Improvement Programme has been established this year to address some of the broader challenges in relation to discharge.

The objective of the ENHT Discharge Improvement Programme is to create improvements in the efficiency of discharge, contributing to improved patient flow, through the creation and implementation of an ENHT discharge policy and processes with standardised, consistent ways of working that align to national guidance. It is key that:

- Every ENHT employee understands their value and contribution to discharge
- Patient outcomes and experience are improved
- Patient flow is optimised to make most efficient use of acute services

The main objectives of the programme are to:

- Support improved flow through hospitals
- Ensure patients do not stay in beds longer than they need to
- Support safe care
- Reduce levels of bed occupancy
- Improve urgent and emergency care pressures
- Contribute to elective care recovery

There are 4 work streams within the Programme:

- **Work stream 1:** Foundations – define and implement the basic administrative and digital processes.
- **Work stream 2:** Ward Processes – Introduce standardised procedures through Trust SOPs which will facilitate and support earlier decision making and empowering teams to make good decisions on discharge
- **Work stream 3**: Interdependent processes – Identify the interdependent services critical to discharge flow and ensure alignment of these to the discharge policy.

- **Work stream 4**: Complex Discharges – work with system partners on those discharges which are more complex, working with partners to influence improvement

The ENHT Discharge Improvement Programme has set the following Key Performance Indicators (KPIs) for 2022/23:

- Proportion of discharges before midday – target 30% (excluding day cases, maternity & paediatrics)
- Proportion of discharges before 3pm – target 60% (excluding day cases, maternity & paediatrics)
- Proportion of discharges before 5pm – target 80% (excluding day cases, maternity & paediatrics)

3.2 Improve access

	Aim	21/22 Achieved
Improve cancer waits from 2018/19 position	National standard	Met 6 of 8 national standards
Improve delivery of 7 days services	Ascertain baseline and agree Trajectory	Partly met
Reduce delays in ED 4 hour waiting time	National standard (95%)	72.78%

Improve cancer performance

Cancer performance was sustained over the course of 2021/22. The 62-day cancer target was achieved for all months, except for January 2022 and March 2022 and our performance against this standard remains one of the best regionally and nationally.

Across all of the cancer standards, the year-end position was compliant with 6 of the 8 standards. Of the 8 standards, the Trust has achieved the two week wait for suspected cancer, the 31-day subsequent Anti-cancer drugs and 31-day subsequent treatment (radiotherapy) standards in every month of 2021/22. Also for the breast symptomatic and 31 day first treatment the Trust has achieved the standards 10 out of 12 months.

The Trust did not comply with the new faster diagnosis standard for 2021/22 on confirming or ruling out diagnosis within 28 days, which was achieved 6 out of 12 months.

Improve delivery of 7-day services

The Trust continues to work towards delivering the national 7-day standards. A consultation with staff involved in providing the consultant general internal medicine rota is planned for summer 2022 when an increase in capacity and hours covered is proposed. The aim is to improve continuity of consultant led review of patients admitted overnight and to ensure all inpatient specialties attend weekday morning handover. A further assessment against the four main standards will be undertaken following the consultation.

An assessment against the four main standards is shown below:

Standard	Requirement	2019/20	2020/21	2021/22	Comment
2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission	Not met	Partly met	Partly met	Full 7-day consultant input not yet delivered on all wards
5	Inpatients must have scheduled 7-day access to diagnostic services	Met	Met	Met	
6	Inpatients must have timely 24-hour access to key consultant-directed interventions	Met	Met	Met	Interventional radiology is provided on an ad hoc basis
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	Not Met	Partly met	Partly met	Full 7-day consultant input not yet delivered on all wards

Reduce delays in Emergency Department 4 hour waiting time

The Emergency Department (ED) has seen a significant increase in the length of stay in the department. This is due to a combination of reasons which the Trust is working hard to address with system partners. Adult emergency activity has returned to and exceeded pre-pandemic levels. This has been replicated nationally with an increase of 28.5% of ED attendances on March 2021 and an increase of 2.1% in emergency admissions.

During the Covid-19 pandemic there was a change in patient behaviours and access to other services. There has been an increase in communication reminding the public about pharmacy support, GP appointments, NHS111 and the Urgent Treatment Centre option. Average length of stay (LOS) in the department for admitted patients has increased due to the current bed pressures, including a high level of patients who do not meet the criteria to reside within the Trust. Due to the increased length of stay of patients within the emergency department, there has been an increase of patients discharged from ED that would ordinarily have been discharged from an assessment ward, impacting on non-admitted performance and Trust activity. Mental health is also a significant contributory factor to the increased length of stay.

This therefore results in a deterioration in the Trust performance against the 4 hour standard. Other factors have been the complex pathways due to Covid-19 e.g. swabbing of patients and time for results, red / yellow segregation of patients and risk assessment of staff which resulted in some staff being able to flex between areas, impact on community provision for ongoing care needs and the capital build work.

Figure 25

Trust performance ED 4 hour standard

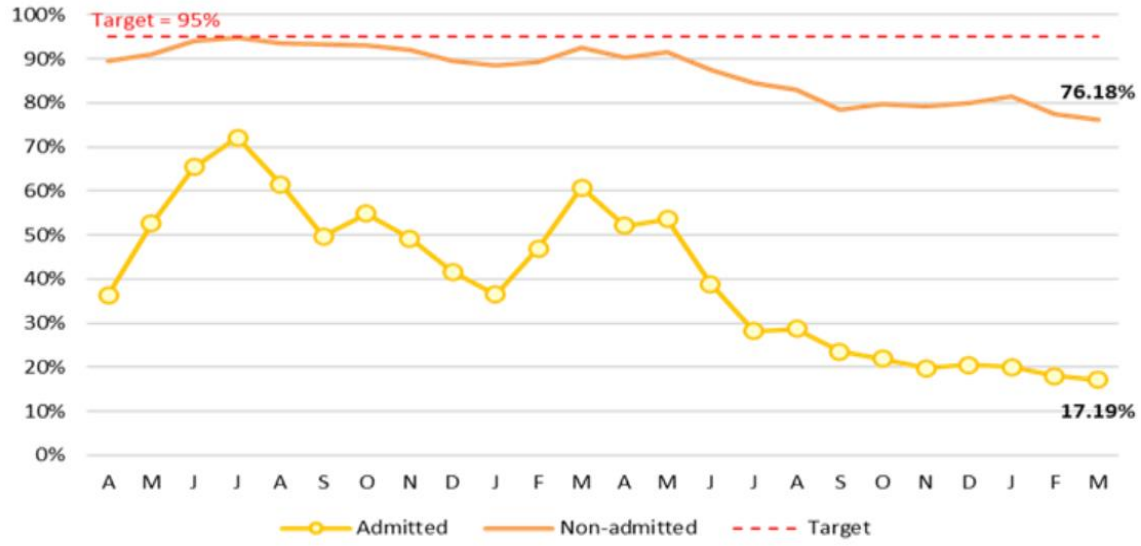
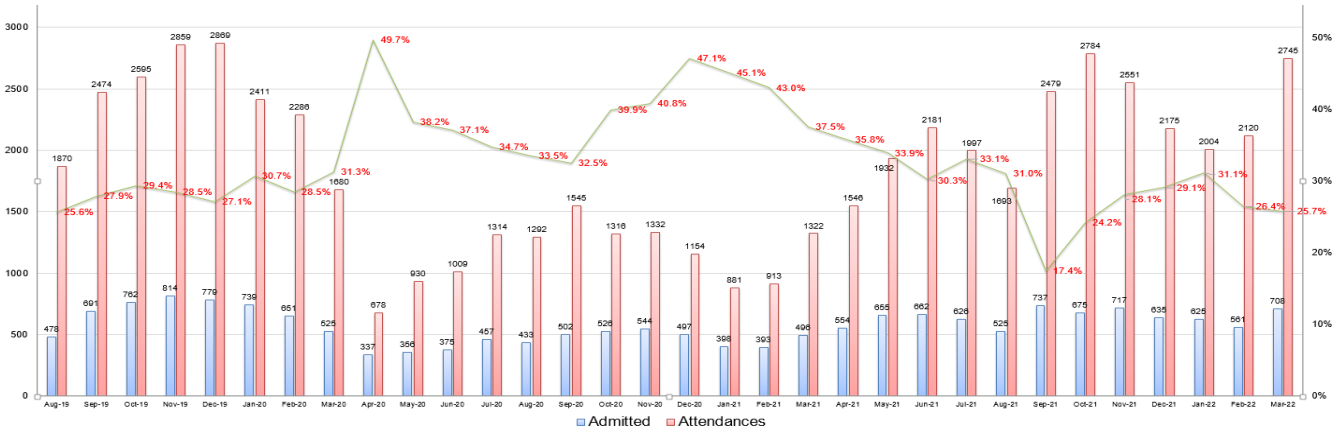


Figure 26

Attendance and Admission Trends in Children's ED: 2019 – 2022

The data below reflects activity in paediatrics compared to pre Covid-19 levels:

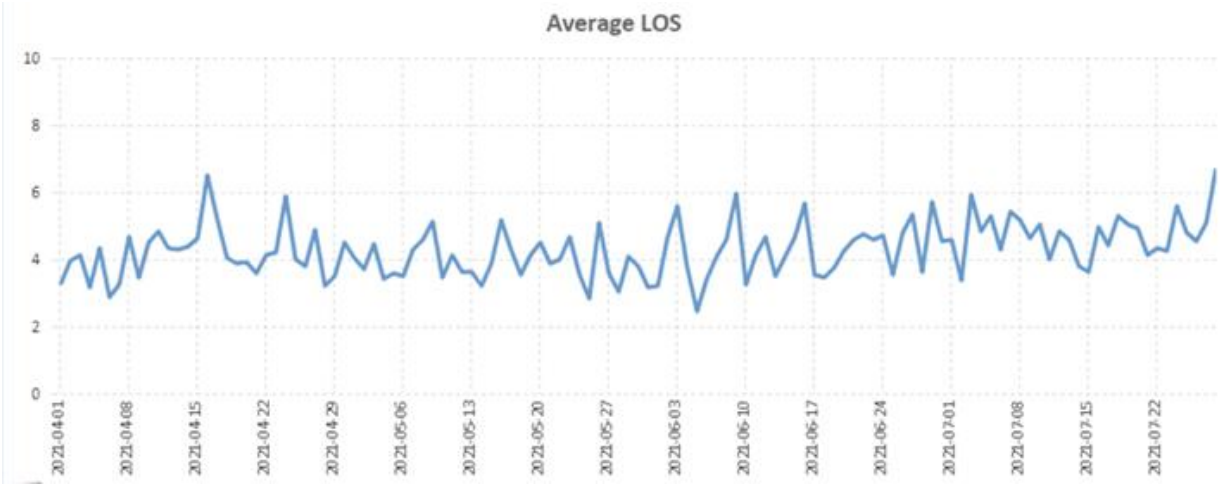


Length of Stay (LOS) emergency

The length of stay has remained fairly constant throughout the year with an average LOS of 4.73 days. Work is ongoing to review and benchmark against the HRGs and work with the ICS partners on prevention of admission, criteria to admit and hospital at home to facilitate earlier discharge and less demand on inpatient beds.

Figure 27

Average Length of Stay (LOS)



Priority four: Patient and 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.

Link to the Quality Strategy: Patient Experience

Monitoring: Patient Experience Committee

Reporting: Scheduled update to the Quality and Safety Committee

Responsible Director: Chief Nurse

	Theme	Measure	20/21 (%)	21/22 (%)	Aim: 22/23
4.1	Patient feedback	Maintain Friends and Family Test scores (average) for inpatients, out-patients, maternity (birth) and emergency department	IP 95.84 OP 97.57 Mat 96.47 ED 94.58	IP 96.69 OP 95.52 Mat 95.90 ED 85.98	IP >95% OP >95% Mat >93% ED >90%
4.2	PALS Responsive ness (new and replaces always events)	PALS response closed within 5 days	79.2%	70.0%	80%
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.	Demonstrable involvement of patients and carers	Demonstrable involvement of patients and carers	Demonstrable involvement of patients and carers
4.4	What matters to you (WMTY) (new)	Measuring the themes of the WMTY conversations	Launch	1945 virtual Visits 2322 messages 2447 photos	Continue to monitor the uptake of this service and ensure if it is accessible to all who require it.

Indicator	Measure	2021/22	Trust previous result 2020/21
Maintain Friends and Family Test scores >90% (average) for inpatients, out-patients, maternity (birth) and emergency department	Patients	IP 96.69% OP 95.52% Mat 95.90% ED 85.98%	IP 95.84% OP 97.57% Mat 96.47% ED 94.58%

*Maternity indicator is a measure relating to birth experiences only

4.1 Patient feedback

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 (>90%) was achieved in all of the survey areas apart from the Emergency Department (ED).

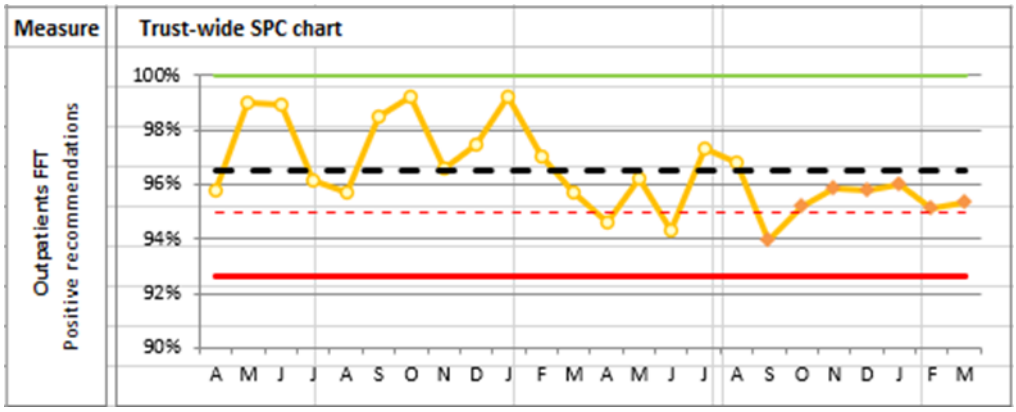
The comments from inpatient/day case patients were mostly positive with patients feeling they were treated with respect and dignity and were given information they could understand. They found staff to be friendly, caring and knowledgeable. Negative comments continue to relate to the environment, food standards and menu choice, noise at night and patients saying they thought there was not always enough staff.

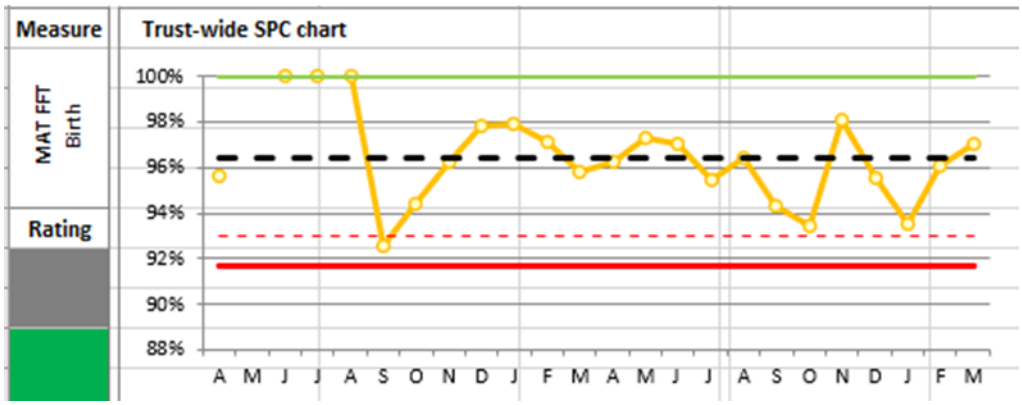
Positive feedback far outweighed the negative comments from patients attending the outpatient department. These included positive comments about the cleanliness of the areas and praise for staff for being kind, helpful and polite. Information about treatment and reasons for it were clear and well explained. Negative feedback concerned waiting times and patients having to wait long past the appointments given. The cost of car parking continues to be frequently mentioned.

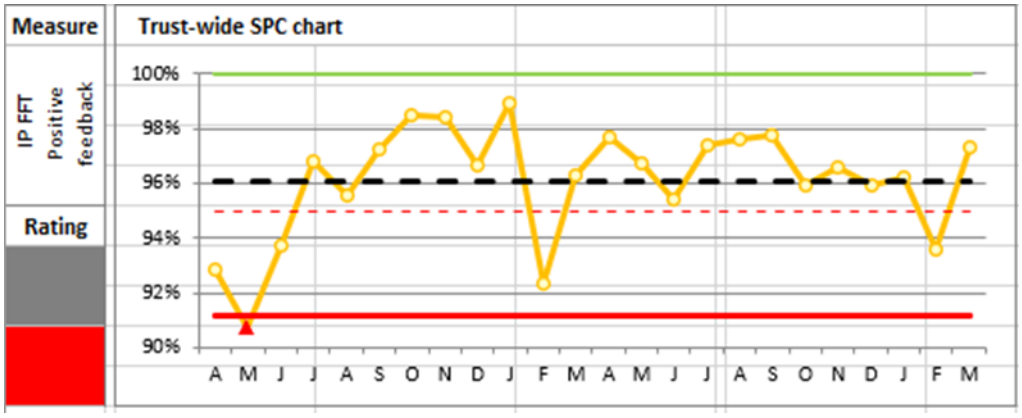
Women were generally positive about their birthing and postnatal experience in the maternity unit, and of the care they received from community midwives. Feedback was given about staff being calm, supportive and reassuring. Many women commented positively about the help and support received from staff with feeding their baby. However, some women found the wards too busy with not enough staff to provide the attention they felt they needed. Women often commented that they would have liked their husband/partner to be able to stay for longer and to have comfortable chairs whilst there.

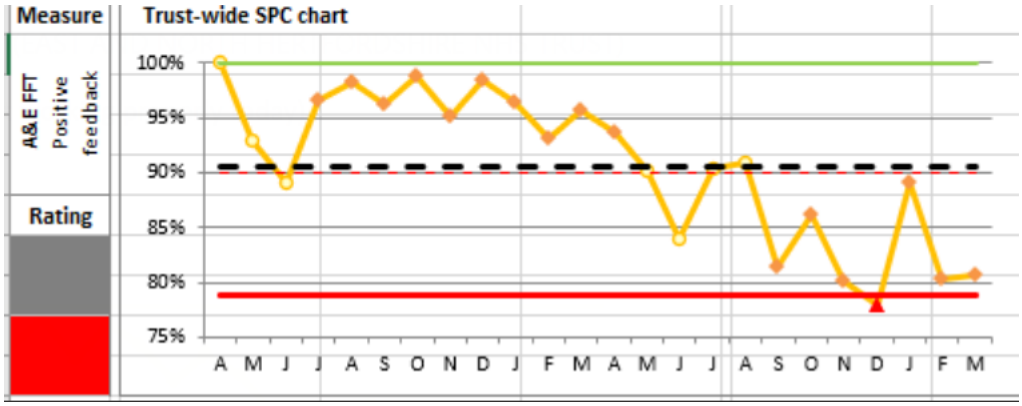
Patients in ED gave mainly positive feedback in relation to staff who were caring and supportive. The communication from staff was also good, particularly with clear explanations regarding treatment. Negative feedback included length of waiting times, the area being crowded with not enough seating, and the lack of refreshments available.

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 charts below.


Measure
Trust-wide SPC chart
Outpatients FFT Positive recommendations
100%
98%
96%
94%
92%
90%
A M J J A S O N D J F M A M J J A S O N D J F M


Measure
Trust-wide SPC chart
MAT FFT Birth
Rating
100%
98%
96%
94%
92%
90%
88%
A M J J A S O N D J F M A M J J A S O N D J F M


Measure
Trust-wide SPC chart
IP FFT Positive feedback
Rating
100%
98%
96%
94%
92%
90%
A M J J A S O N D J F M A M J J A S O N D J F M


Measure
Trust-wide SPC chart
A&E FFT Positive feedback
Rating
100%
95%
90%
85%
80%
75%
A M J J A S O N D J F M A M J J A S O N D J F M

	2019-20	2020-21	2021-22	Aim
Inpatient / Day Case FFT response rate	43.73%	23.34%	23.21%	40%
Maternity response rate (birth)	25.14%	17.71%	12.61%	30%
Emergency department response rate	3.67%	5.75%	0.95%	10%

The Trust considers that this data is as described, as it is based on data submitted directly by patients to the national surveys programme. The Trust 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.

Data submission and publication for the Friends and Family Test (FFT) restarted for acute and community providers from December 2020, following the pause during the response to Covid-19.

Data from December 2020 onwards reflects feedback collected during the Covid-19 pandemic, while also implementing the new guidance after a long period of suspension of FFT data submission. The number of responses collected is, therefore, likely to have been affected. Some services may have collected fewer FFT responses, or been unable to collect responses at all, because of arrangements in place to care for Covid-19 patients.

4.2 PALS Responsiveness (new and replaces always events)

This is detailed with Complaints in the section below in performance measures

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 (due to Covid-19 pandemic)

A Trust wide involvement register is being developed to ensure a diverse range of service users and carers are invited to work with the Trust in sharing their experiences and knowledge to develop and improve the services we provide.

A co-production shared decision making council is being set up. The Council plans to measure the number of projects and programmes that involve service users as part of the project delivery group.

The ‘keeping in touch’ team have worked relentlessly over the last year to provide families and friends the opportunity to virtual visit and send messages and pictures to their loved ones during Covid-19 when visiting has been restricted. In the last year 1945 virtual calls have been facilitated in 26 clinical areas with global reach to 18 countries outside of England. The team also delivered 2322 messages and 2447 photos to patients from families and friends.

Volunteer’s services have continued to support patients across the hospital during this year, with 101 registered response volunteers. During this time there have been many roles that the response volunteers have been involved in such as:

- Befriending services
- Assisting contacting loved ones
- Mealtime help
- Restocking supplies
- Pharmacy and laboratory runs

The response volunteers have also supported in delivering the Staying in Touch letters to patients and have provided continuous interaction with patients during the last year by taking out the activity trollies around the wards. Volunteers will approach each patient asking if they would be interested in participating with some of the activities that we provide such colouring, crosswords, Sudokus or word searches. There are also creative activities such as making greetings cards from one of our specially made kits, or simply enjoying some company and a chat.

4.4 What Matters To You (WMTY)

The WMTY initiative encourages all Trust staff to have meaningful conversations, to understand what is most important for patients, their families and carers whilst they are in hospital. From March 2021 the PACE team have been visiting the inpatient wards and asking the WMTY question.

Due to restrictions of the pandemic the 2020 WMTY day focussed on Staff conversations and embedding WMTY into our bite size QI and coaching programme and all our Quality Improvement initiatives.

WMTY day shall be celebrated on 9 June 2022 and the PACE team and our volunteers will be visiting the wards and having WMTY conversations, promoting and role modelling how to ask WMTY. The Trust charity funded a 12 month fixed term post for the “what matters to you” volunteers’ coordinator, who was appointed at the beginning of May 2021.

2.2 Statements of assurance from the Board

Review of services

During 2020/21, the East and North Hertfordshire NHS Trust (ENHT) provided and/or subcontracted 27 relevant health services. The ENHT has reviewed all the data available to them on the quality of care in 27 of these relevant health services. The Trust operated under the revised financial framework in the NHS last year. For further details please refer to the Trust Annual Report.

Participation in clinical audits

During 2021/22 there were 57 national clinical audits and 7 national confidential enquiries covering relevant health services that ENHT provides.

During that period ENHT participated in 96% of the national clinical audits and 100% of the 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 2021/22
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2021/22, and for which data collection was completed during 2021/22, 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 Project Name	**Participated**	**% Cases Submitted by March 22**
Case Mix Programme (CMP)	Yes	Continuous data collection
Chronic Kidney Disease Registry	Yes	Continuous data collection
Elective Surgery (National PROMs Programme)	No	
Emergency Medicine QIPs - Pain in Children (Care in emergency departments)	Yes	22 cases
Falls and Fragility Fracture Audit Programme (FFFAP) - National Audit of Inpatient Falls	Yes	Continuous data collection
Falls and Fragility Fracture Audit Programme (FFFAP) - National Hip Fracture Database (NHFD)	Yes	Continuous data collection
Inflammatory Bowel Disease (IBD) Audit - Biological Therapies Audit	Yes	Continuous data collection

LeDeR - Learning Disabilities Mortality Review collection	Yes	Continuous data collection
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Yes	Continuous data collection
National Adult Diabetes Audit (NDA) - National Diabetes Foot Care Audit	Yes	Continuous data collection
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	Yes	Continuous data collection
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Audit Harms (NaDIA-Harms)	Yes	Continuous data collection
National Asthma and COPD Audit Programme (NACAP) - Adult asthma secondary care	Yes	Continuous data collection
National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Continuous data collection
National Asthma and COPD Audit Programme (NACAP) - Paediatric - Children and young people asthma secondary care	No	
National Audit of Breast Cancer in Older People (NABCOP)	TBC	Continuous data collection
National Audit of Cardiac Rehabilitation	Yes	Continuous data collection
National Audit of Care at the End of Life (NACEL)	Yes	40 cases
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) - Clinical Audit	Yes	Continuous data collection
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) - Organisational Audit	Yes	Continuous data collection
National Cardiac Arrest Audit (NCAA)	Yes	Continuous data collection
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Yes	Continuous data collection
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management Devices and Ablation	TBC	Continuous data collection
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty	Yes	Continuous data collection
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	TBC	Continuous data collection

National Comparative Audit of Blood Transfusion - Audit of Blood Transfusion against NICE Guidelines	Yes	Continuous data collection
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Continuous data collection
National Emergency Laparotomy Audit (NELA)	Yes	Continuous data collection
National Gastro-intestinal Cancer Audit Programme (GICAP) - National Bowel Cancer Audit (NBOCA)	Yes	Continuous data collection
National Gastro-intestinal Cancer Audit Programme (GICAP) - National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Continuous data collection
National Joint Registry - Ankle replacement	Yes	Continuous data collection
National Joint Registry - Elbow replacement	Yes	Continuous data collection
National Joint Registry - Hip replacement	Yes	Continuous data collection
National Joint Registry - Hospital performance	Yes	Continuous data collection
National Joint Registry - Implant performance	Yes	Continuous data collection
National Joint Registry - Knee replacement	Yes	Continuous data collection
National Joint Registry - Shoulder replacement	Yes	Continuous data collection
National Joint Registry - Surgeon performance	Yes	Continuous data collection
National Lung Cancer Audit Programme	Yes	Continuous data collection
National Maternity and Perinatal Audit (NMPA)	Yes	Continuous data collection
National Neonatal Audit Programme (NNAP)	Yes	Continuous data collection
National Paediatric Diabetes Audit (NPDA)	Yes	Continuous data collection
National Perinatal Mortality Review Tool	Yes	Continuous data collection

National Prostate Cancer Audit (NPCA)	Yes	Continuous data collection
National Vascular Registry - Carotid Endarterectomy	Yes	Continuous data collection
National Vascular Registry - Elective AAA Repair	Yes	Continuous data collection
National Vascular Registry - Lower Limb Angioplasty/Stent	Yes	Continuous data collection
National Vascular Registry - Lower Limb Bypass	Yes	Continuous data collection
National Vascular Registry - Lower Limb Major Amputation	Yes	Continuous data collection
Respiratory Audits - National Outpatient Management of Pulmonary Embolisms Audit	Yes	100%
Respiratory Audits - National Smoking Cessation Audit	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP	Yes	Continuous data collection
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Continuous data collection
Society for Acute Medicine Benchmarking Audit	Yes	100%
Transurethral Resection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.	Yes	TBC
Trauma Audit & Research Network	Yes	Continuous data collection
Urology Audits - Management of the Lower Ureter in Nephroureterectomy Audit	Yes	Continuous data collection

National Confidential Enquiries Project Name	**Participated**	**% Cases submitted**
Child Health Clinical Outcome Review Programme - Transition from child to adult health services (NCEPOD)	Yes	7 (70%) 3 in progress
MBRRACE Maternal mortality surveillance and confidential enquiry (Maternal, Newborn and Infant Clinical Outcome Review Programme)	Yes	Continuous data collection
MBRRACE Perinatal confidential enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	Yes	TBC
MBRRACE Perinatal mortality surveillance (Maternal, Newborn and Infant Clinical Outcome Review Programme)	Yes	Continuous data collection

Medical and Surgical Clinical Outcome Review Programme - Crohns disease (NCEPOD)	Yes	No audit cases received as yet
Medical and Surgical Clinical Outcome Review Programme- Epilepsy study (NCEPOD)	Yes	6 (100%)
NCEPOD - Alcohol Related Liver Disease (Organisational) (Medical and Surgical Clinical Outcome Review Programme)	Yes	1 (100%)

The reports of national and local clinical audits were reviewed by the provider in 2021/22 and ENHT has outlined intended actions to improve the quality of healthcare provided in Annex 2.

Research and development

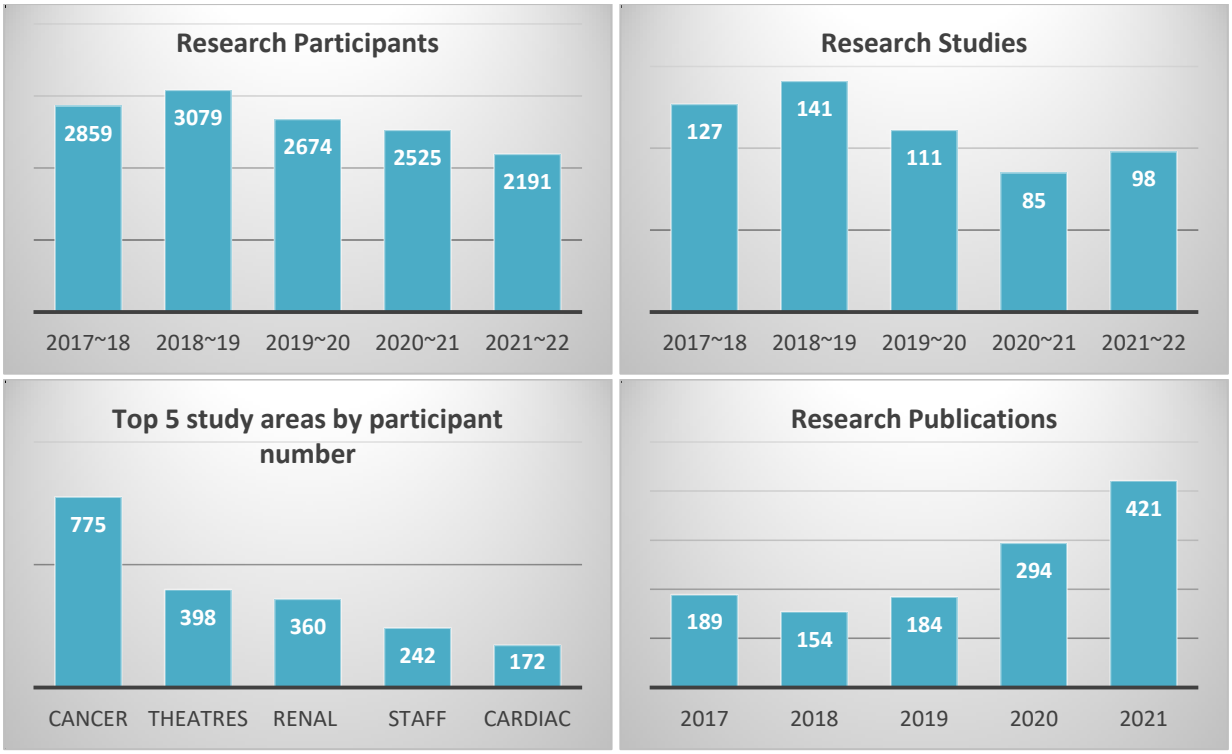
In 2021/22 2350 patients were recruited to participate in research at ENHT. All research at ENHT is approved by a designated NHS research ethics committee. These 2350 patients received relevant research-related health services, provided by or sub-contracted by ENHT during 2021/22

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 and 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.

The Trust is proud to be part of the National Institute for Health and Care Research (NIHR) which has a national vision ***"to improve the health and wealth of the nation through research***".

The research activity in 2021/22 relating to studies adopted to the NIHR Portfolio can be summarised in the graphs below (please note that this is less than the total research activity as not all research studies are adopted). The number of studies we could open and the number of participants taking part in research was less than recent years due to the impact of Covid-19. The top 5 areas of highest research activity are shown below with cancer having the greatest number of participants (775). It is worth noting the increase in research publications over the last two years and to acknowledge that 42 of these in 2020 were jointly written with the University of Hertfordshire – a great sign of partnership working.



Helping address the Covid-19 challenge

Covid-19 research at the Trust has directly led to treatment innovations, such as GenoMICC, a large UK-wide study examining genetic susceptibility in critical care patients with Covid-19. GenoMICC has now found 23 genetic associations and identified a causal role for coagulation factors and platelet activation in critical Covid-19, providing answers for why some people with Covid-19 suffer blood clots. We have also innovated by developing new studies around treating hearing loss as a result of Covid-19.

In addition to research directly on Covid-19, we also created novel approaches to dealing with the Covid-19 related backlog of patients requiring treatment. DELTA - integrate**D** diagnostic solution for **E**ar**L**y de**T**ection of oesophageal c**A**ncer is a project s based on the use of the innovative Cytosponge approach - a '*Sponge on a string'* test that samples cells from the oesophagus without the need for gastroscopy. The use of Cytosponge can help with early detection and treatment of oesophageal cancer with improved health outcomes and cost savings. It also offers a much quicker and patient-friendly approach when compared to gastroscopy (a tube into the stomach and previous standard of care). This benefits patients in terms of their experience and health outcome around oesophageal adenocarcinoma (OAC) diagnostics, as it can be nurse-led, is quick to do (which means cost-savings as fewer expensive gastroscopies are performed), and backlogs can be quickly cleared.

Public involvement and research participation

Our Patient and Public Involvement in Research Panel have continued to meet online three times a year since the start of the pandemic and will resume in-person meetings in May this year. This group of around 15 patient and public members have provided input into a range of Trust-sponsored research, and also received training about ongoing research (including both methodology and scientific training) that encompasses a range of Covid-19 and non-

Covid studies at ENHT. We have shared our research activity across a range of fora within and outside the Trust to foster engagement.

We were also delighted to welcome the former CEO of the Health Research Authority, Teresa Allen, to join our Research and Development Board as a public representative; she brings a wealth of experience and provides a public voice to contribute to our activities.

Results from our 2021/22 Participant in Research Experience (national) Survey (PRES), continue to demonstrate that patients had a good or very good experience taking part in research, with 107/135 reporting positive experiences. The main areas for improvement related to; provision of blood test results and information, more information about the study (especially for Covid-19 studies) during participation and after, and less repetition of asking for the same the information.

Examples of qualitative feedback from research participants:

- I was hopeful that the trial would give me time and keep me as fit as possible to enjoy the things that matter to me. I felt I was contributing to the advancement of treatment for the disease. The team were always polite, helpful and supportive. Can't fault the care
- Dedicated, professional research nurse X. Always courteous and contactable. Research staff have kept me informed of process thoroughly. During COVID 19 I have felt well looked after and safe
- Throughout my research experience I felt valued and cared for. The staff were very courteous and welcoming and I felt relaxed and informed when tests were taking place. Contact has been maintained between myself and the staff and I have been happy to contribute.
- The blood samples are taken at the same time I am in hospital receiving my Infliximab infusion so its convenient and doesn't take up any extra time. The surveys I complete are well written and designed and don't take too long to complete. All in all, a very easy study to take part in.
- X has always been kind and professional especially as part of the experience was during COVID. Her manner is lovely and communicates well. All COVID precautions have been kept. Telephone prior to appointments to ensure I feel ok to attend
- I was always treated with kindness and respect. Have nothing but respect for everyone involved with my care and treatment.

Commissioner's contractual requirements (CQUIN)

A proportion of the ENHT's annual income is usually 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.

There have been no CQUINs in place during 2021/22 as they were nationally suspended due to the pandemic.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is '**requires improvement**'. We are rated as '**good'** for caring and effectiveness and '**requires improvement'** for safe, responsiveness and well led. We are rated as '**requires improvement'** for use of resources.

The Trust is not fully compliant with the registration requirements of the Care Quality Commission. The CQC has not taken enforcement action against the Trust during 2021/22. The following conditions remain on the Trust's registration following the 2019 Inspection:

- 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

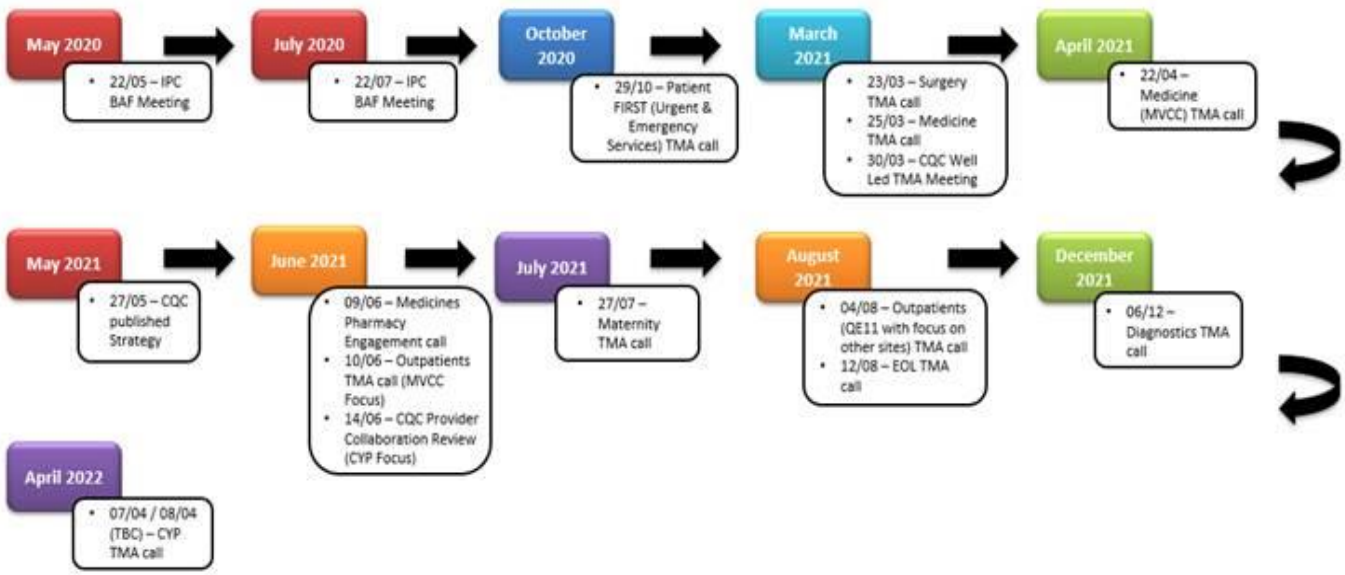
The Trust has participated in special reviews or investigations by the CQC during 2021/22 relating to the following areas; the system wide Children and Young People Provider Collaborative Review and a speciality investigation which was closed without any action following CQC's review of the Trust's information.

Since the last inspection undertaken by the Care Quality Commission in 2019, the Trust has not received an on-site inspection. During the COVID-19 pandemic, the CQC changed and evolved their approach to regulating. This new approach has ensured the CQC has had oversight of our Trust and services. The Direct Monitoring Approach focused on safety, how effectively a service is led and how easily people can access the service.

In 2021/2022 the CQC held the following virtual reviews:

- Under the Transition Monitoring Approach:
  - Medicine Core Service (MVCC), April 2021
  - Outpatients Core Service (MVCC), June 2021
  - Maternity Core Service (Lister), July 2021
  - Outpatients Core Service (Lister and QEII), August 2021
  - End of Life Core Service, August 2021

Transitional Monitoring Approach Timeline:



All the reviews were positively received, and no follow up information was requested.

To support these reviews with the Care Quality Commission each core service developed a gap analysis against the streamlined key lines of enquiry, including any gaps and mitigating actions.

An action plan was 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 and Risk Framework has been developed and approved by the Quality and Safety Committee.

During 2021/22 we continued to adapt our compliance framework. This has five compliance pillars which are: Intelligence Monitoring, Communication & Engagement, Departmental Visit Programme, Proactive and Not Reactive. We have continued a streamlined programme of audits and reviews to support monitoring of compliance against standards, including retesting our previous actions from inspection. In April 2021 we formally recommenced our internal unannounced inspections to the clinical areas. These are held jointly with our Clinical Commissioning Group (CCG). In addition, the pathways to excellence programme support providing assurance on the continued progress against the fundamental standards in ward areas.

Data quality

East and North Hertfordshire NHS Trust submitted records during 2021/22 to the Secondary User Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The tables below provide an update of how the Trust has performed against a few of the data items presented in the data quality reports.

Reporting Period - April 2021 to February 2022 (up to Month 11) - extracted on the 17 March 2022, published 5 April 2022.

The information is intended to support data quality improvements by organisations delivering NHS services.

	Valid NHS Number	Valid General Medical Practice Code
Admitted patient care	99.9%	98.9%
Out-patient care	99.9%	100%

Patient Pathway	Provider % Valid	Region % Valid	National % Valid
Admitted patient care	54.6%	59.7%	68.5%
Outpatient care	47.7%	58.6%	67.0%

Ethnic Category	Provider % Valid	Region % Valid	National % Valid
Admitted patient care	95.3%	94.6%	95.4%
Outpatient care	90.4%	92.8%	93.3%

During the year 21/22:

The data quality (DQ) team have undertaken several on-going data quality improvement related programmes across the Trust to progress and improve patient experience, service delivery and patient flow, including accuracy of data recording.

The DQ team have worked on the following during this year:

- Continued to promote awareness of the importance of Data Quality (DQ) and set out expectations of staff responsibility, provide training and support.
- The monthly Data Quality Steering Group meetings were reinstated with attendance from all the divisions, supplemented with bi-weekly DQ surgeries.
- Published data quality training modules on the Trust's ENH Academy
- During the summer, the Ethnicity Dashboard was developed and is monitored at the Divisional Performance Review Meetings.
- Following the dashboard, the Ethnicity Leaflet was developed and distributed to all outpatient areas.

- Managed the recording of all insourcing / outsourcing.
- Led on correcting the data recording of the Trust's pre-operative assessment clinics.
- Set up a Trust wide Super User Group focussing on training and correction.
- Launched the Trust's Data Quality Dashboard- Phase 1.
- Started the monthly DQ Audits, which are presented to the Trusts' Audit Committee.

The DQ team will be taking the following actions to improve data quality across the Trust.

Plans for 22/23:

- Develop a suite of online training 5minute courses on the most common DQ corrections for ENHT Academy
- Running bi-weekly meetings inviting the services to manage their performance against the DQ Dashboard, ensuring accurate and appropriate recording of activity
- Floorwalking outpatient clinics to ensure key demographics i.e. Ethnicity are captured for Population Health Management
- Developing Phase 2 of the Trust's Data Quality Dashboard
- Continue the development of the monthly DQ Audits with a report / application on QlikView.
- Review the Trust's Data Quality Strategy and Policy by July 2022.

Information governance / Data security

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 GDPR.

The Trust declared a fully compliant 'standards met' position of the Data Security and Protection Toolkit 2020/ 2021 in June 2021. This was audited by the Internal Auditor and rated as 'substantial' assurance.

Progress with completion of the DSPT for 2021/22 is underway to meet the June 2022 submission and is monitored at the Trust's Information Governance Steering Group meetings which are held quarterly.

During 2021/22 we have not declared any incidents classified as Level 2 or that meet the requirements to report to the Information Commissioner's Office (ICO). 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

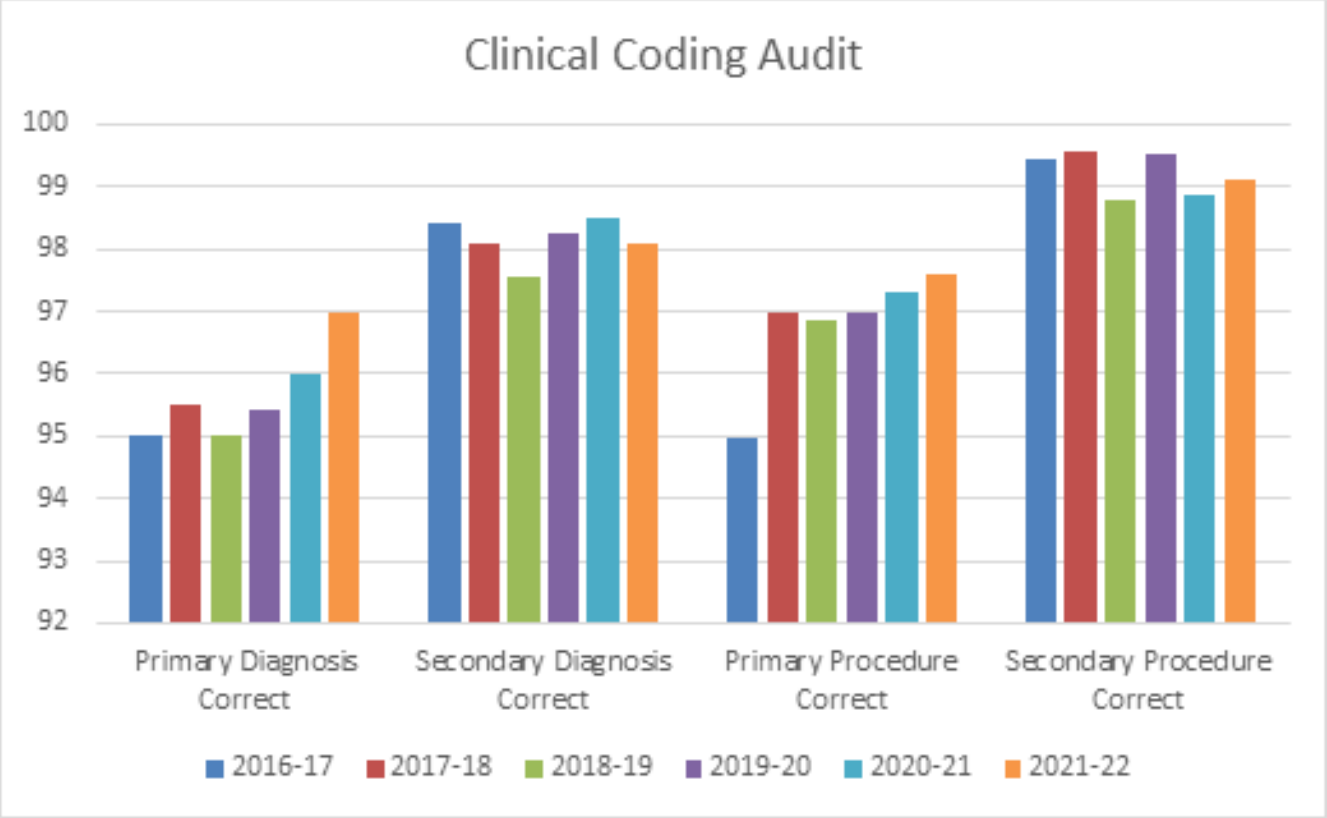
Clinical Coding is compliant with the Data Security and Protection Toolkit [DSPT] for the following standards:

- Data Security Standard 1 – Personal Confidential Data
- Clinical Coding Audit and Data Security Standard 3 – Staff Training

The Trust undertook a clinical coding audit in 2021/22 based on 200 consultant episodes. The Trust maintains its Level 3 outcome (highest level) and the comparative results are as follows:

Year	Primary Diagnosis Correct	Secondary Diagnosis Correct	Primary Procedure Correct	Secondary Procedure Correct	Level
2019-20	95.41	98.25	96.97	99.51	3
2020-21	96	98.5	97.3	98.89	3
2021-22	97	98.1	97.6	99.1	3

Figure 28 Clinical Coding Audit



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.

The Trust is committed to continuously seeking ways to strengthen our governance and quality improvement initiatives to support our learning from deaths framework.

While our mortality rates have remained strong, it is increasingly recognised that while monitoring these rates has a role to play in mortality governance, there is limited correlation between them and the quality of care provided by organisations.

In order to learn from deaths and improve the quality of our care, we recognise that it is vital that we have a robust process for reviewing the care received by our patients at the end of their life. We have reviewed our current processes and are currently introducing a number of reforms which we believe will build on the solid mortality review processes already embedded at the Trust, enabling us to further improve our learning framework and subsequently the quality of the care we provide.

Central to this work is the adoption of the Structured Judgement Review Plus format for review, developed by the “Better Tomorrow” team. “Better Tomorrow” is a new collaborative initiative hosted on the FutureNHS platform, whose aim is “To support effective learning from deaths in order to improve care for the living”. Additionally, it’s reporting approach has been designed in collaboration with NHSE’s Making Data Counts team and aligns with wider Trust data reporting initiatives. While the COVID-19 pandemic slowed the pace of reform, the project is now well under way, with adoption of the new process schedule for summer 2022.

Currently learning from our mortality review process, whether specific cases or themes, is shared across the Trust with clinical staff via clinical governance forums such as Rolling Half Days and is also shared with relevant working groups such as those focussing on Deteriorating Patient and End of Life Care. This is in addition to the direct learning and actions taken within specialties where a concern has been raised and discussed. As we implement the new SJR+ format for mortality review and reform associated systems and processes, part of our focus is on developing our mortality reporting and communications framework. Our aim is to build on our existing processes to make our learning even more accessible to the staff who can make a difference.

Mortality review process

1. Stage 1 is undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It is a structured, evidence-based review format comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections.
2. 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.
3. 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 RCP methodology). Scores of ≤3 (more than 50% likelihood that the death was avoidable) have been used to answer this question. Quality of Care rating is now also agreed using the scale adopted from the PRISM methodology.

As part of the mortality review process where areas of concerns are identified, these are themed to provide an at-a-glance summary. Learning themes are shared with wider Quality Improvement initiatives such as Deteriorating Patient Collaborative and End of Life Care, where they are captured as key drivers for change ideas.

The figure (29) below provides outline detail drawn from areas of concern considered in the first three quarters of the year.

Figure 29

2021-22: Q1-Q3: ACON Key Themes

Communication

Poor communication between:

- Geriatrics and Surgery regarding shared care of elderly patient with a perforated bowel
- Specialty asked to comment on care of patient 18 months after the event
- Poor communication and documentation regarding discussions with family regarding end of life care and advanced care planning. Some discussions were not communicated
- Lack of ownership and effective shared care of complex patient between Gastro and Cardiology
- Decision for invasive ventilation later overruled by on-call team without discussion with senior consultant
- Complex patient with non-gastro primary problem transferred to Gastro, when arguably should have gone to Cardiology

Clinical management

- EOL: Failure to identify that the patient was approaching end of life, with active care continuing rather than consideration as to whether palliation would have been more appropriate
- Lack of recognition of urosepsis in elderly patient
- Missed fractured neck of femur by radiology
- Failure to identify deteriorating patient with marked drop in sats (when NEWS not elevated)
- High risk patient (for potential emergency laparotomy) not discussed at senior level
- Planned NGT was not inserted in ED as per plan prior to surgery for obstructed bowel
- Inertia between ward round clinical decision and action based on post ward round blood results
- LD Patient was not reviewed and was discharged without being diagnosed and without a robust plan of care in the community

Review & Escalation

- Lack of observation/escalation of patient with high NEWS score
- Missed opportunity for repeat CTPA which would have identified pulmonary embolism
- CDU patient not reviewed by medics until transfer to ward
- Delayed referral to MVCC for palliative radiotherapy which in a different case may have had significant adverse consequences
- Delayed review of patient by medical team
- In early stage of pandemic, failure to recognise how seriously ill COVID patient was, based on increasing oxygen requirements, requiring more frequent observations
- Delay in making decision to escalate the complex patient to ITU or to set ceiling of care
- Patient spent several days out of therapeutic INR range prior to having a stroke
- Ward round notes do not evidence consideration of infection despite significantly raised CRP and neutrophil counts
- Delay in making decision to escalate the complex patient to ITU or to set ceiling of care

2021-22: Q1-Q3: ACON Key Themes

Process & Policy

Poor adherence to policy/guidelines:

- Failure to adhere to PPI precautions when dealing with a COVID cardiac arrest
- Trust HAT process was not followed for patient who developed a DVT & for patient over weekend

Process issues included:

- TEP not in place for patient who subsequently arrested
- Patient requiring shared care was not seen by the appropriate specialist in a timely manner
- Multiple transfers of COVID patient in short period of time
- Multiple ward moves for extremely sick, complex patient
- Frequent change of juniors/lack of continuity of care has a negative impact on quality of care

Documentation

- Conversation where patient declined surgery and requested only to be made comfortable was not clearly documented
- Failure to make clear, appropriate, timely entries in the patient notes during the night
- Failure to record patient review in notes
- Failure to files notes in an appropriate, correct order
- Prior to cardiac arrest failure to document need for escalation despite elevated NEWS
- Slight discrepancy of documentation of neuro-observations for an LD patient
- Unclear treatment plan in post take ward round compounded by poor hand-written notes
- Failure to record detail of abnormalities of ABG result; CCOT review; or handover of care to the evening team
- The fact that LMWH was withheld due to low platelets was not documented in the notes for patient who developed DVT

Operational/competency

- Patient was inappropriately taken off oxygen in order to give a nebuliser
- Consultants cross covering wards due to AL can lead to over-stretch and negative impact on communication and documentation
- Handover day shift/night shift – opportunity missed for early family discussion/TEP which delayed the decision regarding active treatment
- Lack of medical review of complex, frail patient in the evening/overnight
- Rationale for DNACPR initially stated as Learning Disability – with subsequent correction
- Patient discharged with incorrect TTO
- IV fluids not prescribed following transfusion
- Decision that patient for ward-based care only reversed to 'for active management' resulted in missed opportunity to provide the best end of life care

The content and format of the learning from deaths information below has been provided in accordance with the statutory instrument 2017 No 744 'The National Health Service (Quality Accounts) (Amendment) Regulations 2017.

Statutory Ref	Prescribed information	2021-22 Response (using prescribed wording)
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2021-22, 1341 of ENHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 311 in the first quarter; 345 in the second quarter; 341 in the third quarter; 344 in the fourth quarter.

27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 31 March 2022, 809 case record reviews and 54 investigations have been carried out in relation to 1341 of the deaths included in item 27.1. In 48 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: 176 in the first quarter; 190 in the second quarter; 237 in the third quarter; 206 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter. [Note: this does not mean that no 2021-22 deaths will be identified within the item 27.3 definition, but that by 31 March 2022 no concluded ACON investigations 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. Stage 1 is undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It is a structured, evidence-based review format comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections. Potential areas of concern found by reviewers trigger a Stage 2 review by the relevant Specialty with discussion and identification of learning/actions points at their Clinical Governance Forum. 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 an avoidability of death score is agreed (using the scoring criteria adopted from the RCP methodology). Scores of ≤3 have been used to answer this question (Death probably avoidable, more than 50-50). Quality of Care rating is now also agreed using the scale adopted from the PRISM methodology.

27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	0: 2021-22 deaths have 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 2022. [Refer to note in 27.3]
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	0: 2021-22 deaths have 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 2022. [Refer to note in 27.3]
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	0: 2021-22 deaths have 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 2022. [Refer to note in 27.3]
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	82 case record reviews and 15 ACON investigations completed after 1 April 2021 which related to inpatient deaths which took place before the start of the reporting period.

27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0 *[of the 15 investigations reported in 27.7 above]* representing 0% of the patient deaths before the reporting period *[ie 2020-21]* 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	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	1 representing 0.6% of the patient deaths during 2020-21 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

Performance against national core indicators

The Summary Hospital-level Mortality Indicator (SHMI) is expressed as a ratio of observed to expected deaths so that a number smaller than '1' represents a 'better than expected' outcome. The Trust's SHMI for the twelve months to October 2021 is **0.88**, positioned within the 'lower than expected' Band 3 category. SHMI is generally available 6/12 in arrears.

Following significant improvements in SHMI, there has now been a sustained period of stability. Our position relative to our national peers currently stands at 12th out of all acute non-specialist trusts (122).

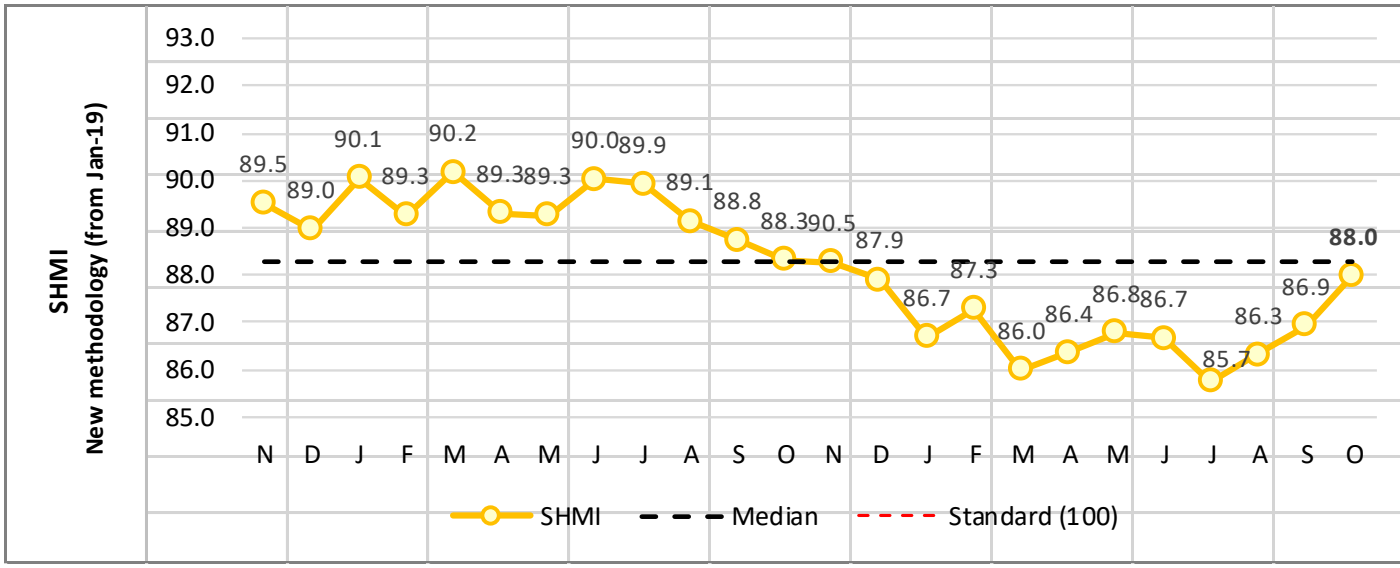
NHS Digital has excluded COVID-19 activity from the SHMI metric. Of note is that the fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, which provides some assurance that our response to COVID-19 has not generally resulted in a disproportionate increase in deaths within 30 days of discharge.

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	0.8719	Dec 20-Nov 21	0.8791	0.7161	1.1949	0.99
	Banding	3 – Lower than expected		3 – Lower than expected	-	-	N/A
% deaths with palliative care code	N/A	38		33	11	64	N/A

*NHS Digital, published 14 April 2022

Rolling 12-month SHMI: November 2019 – October 2021

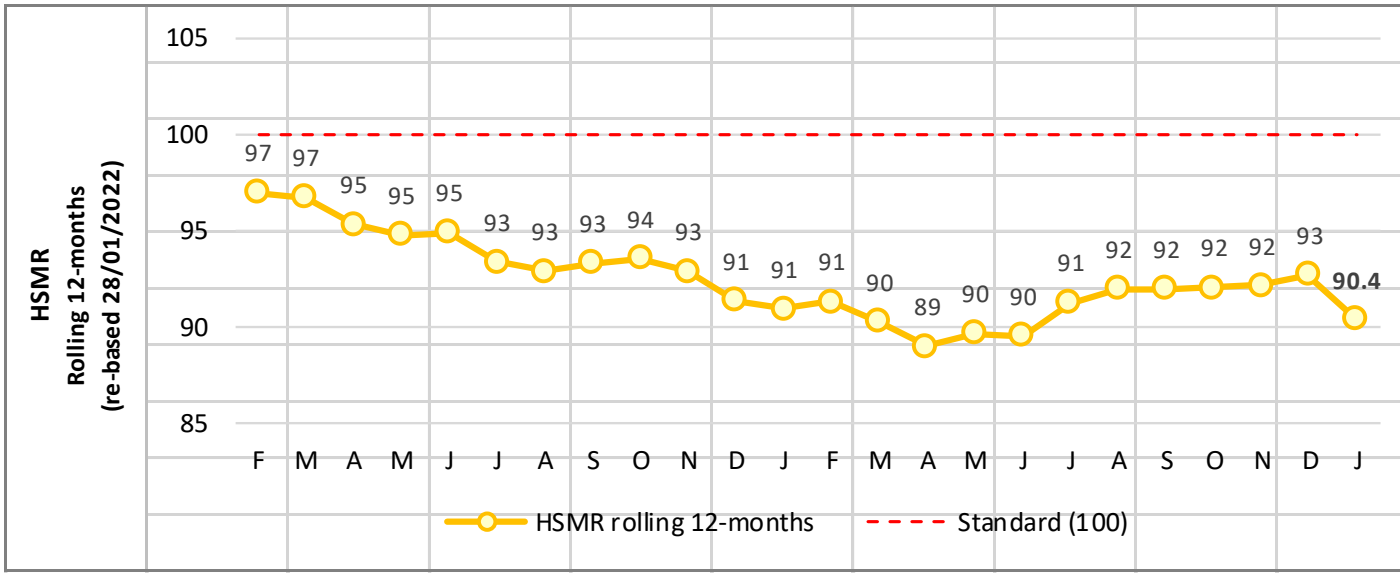


Note: In the chart above the observed to expected deaths have been multiplied by 100 (comparable to HSMR methodology) so that '100' and is comparable to the '1' as described above, where the number of observed deaths exactly matches the number of expected deaths.

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, for example, demographics.

In this metric the observed to expected deaths ratio is multiplied by 100 so that when observed deaths match expected deaths the rate stands at 100 (blue line in the graph below). Again, this means that a figure below 100 indicates a 'lower than expected' number of deaths. Performance has remained consistent in the first quartile of Acute Trusts. HSMR is generally available 3 months in arrears and the latest HSMR for the rolling 12 months to January 2022 is 90.4 placing the Trust in the best performing quartile of Trusts i.e. the Trust has lower mortality numbers compared to 75% of peer hospital Trusts. The figure appears higher than last year's reported figure due to a long awaited rebase by our provider, CHKS, which generally shifted rates upwards. The Trust is currently still within the first quartile of acute trusts.

Rolling 12-month HSMR: February 2020 – January 2022

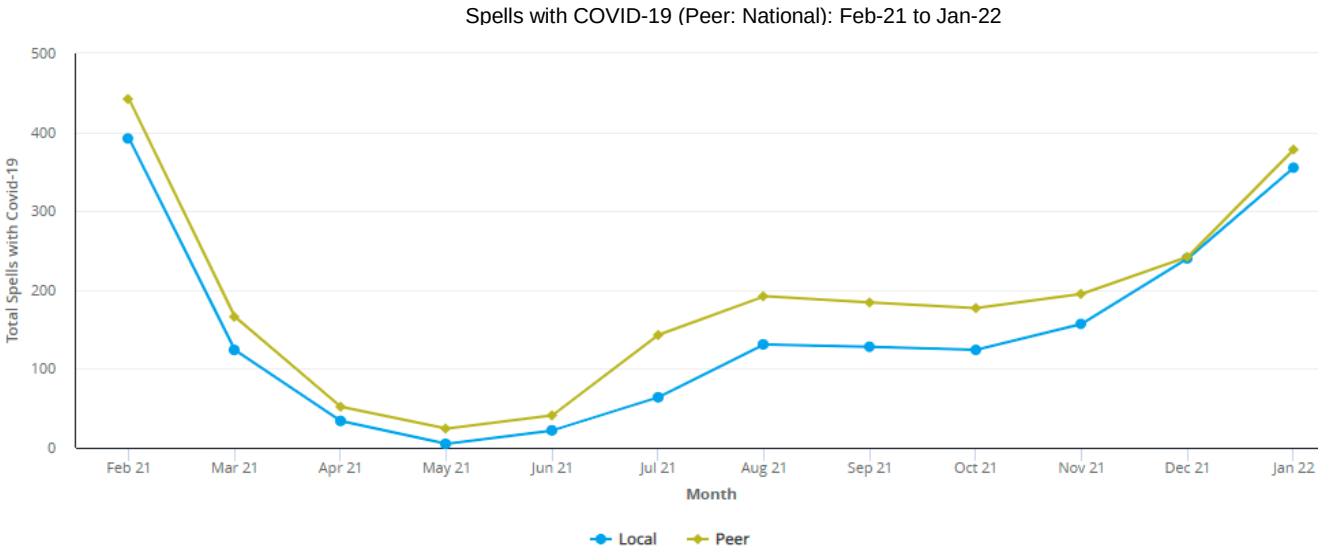


Covid-19

The multi-layered effects of the Covid-19 pandemic have made meaningful analysis and comparisons regarding mortality data challenging. For example, in-patient numbers and case-mix have varied during the pandemic.

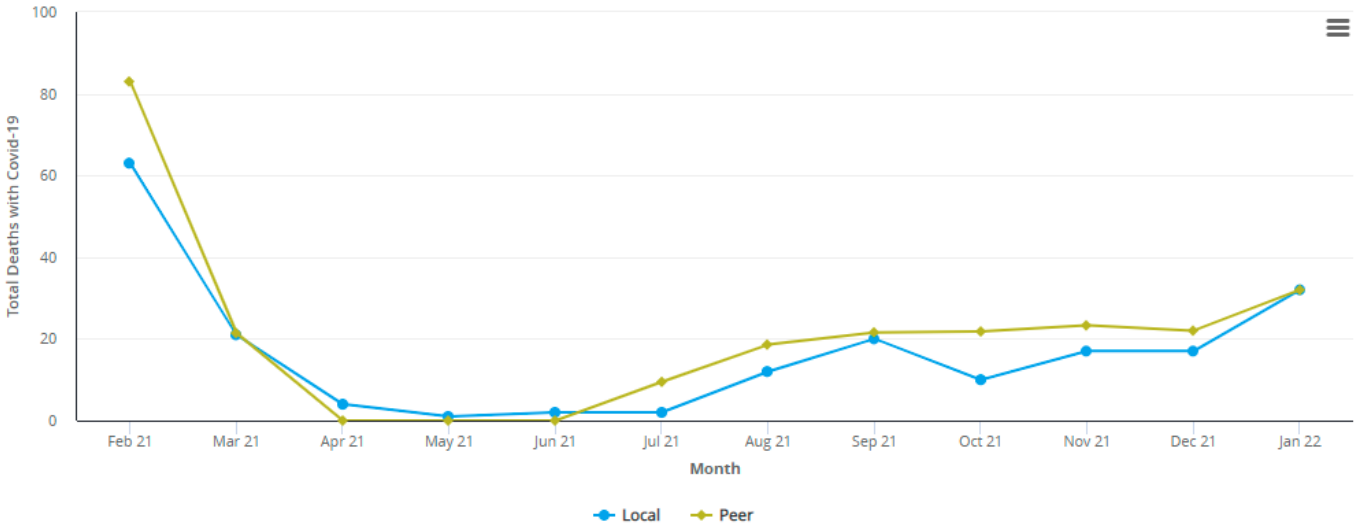
At the same time, the following observations can be made.

The Trust's position has been closely aligned with national peers for both spells and deaths reported with Covid-19, as demonstrated by the following charts:



Source: CHKS

Deaths with COVID-19 (Peer: National): Feb-21 to Jan-22



Source: CHKS

Our reported number of deaths for the year 2021-22 are as follows:

Covid deaths 1 Apr 2021 to 31 Mar 2022	**Definition**
160	Patients who had a positive test or were clinically coded as COVID. These deaths are reported to NHS Digital so underpin our publicly reported mortality rates.
139	Patients who had a laboratory-confirmed positive COVID-19 test and died within 28 days of the first positive specimen date. This is the Public Health England national reporting definition.

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 processes in place and takes on-going action to improve these scores, and consequently the quality of its services, including 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 a case-by-case level.

Patient Reported Outcome Measures (PROMs)

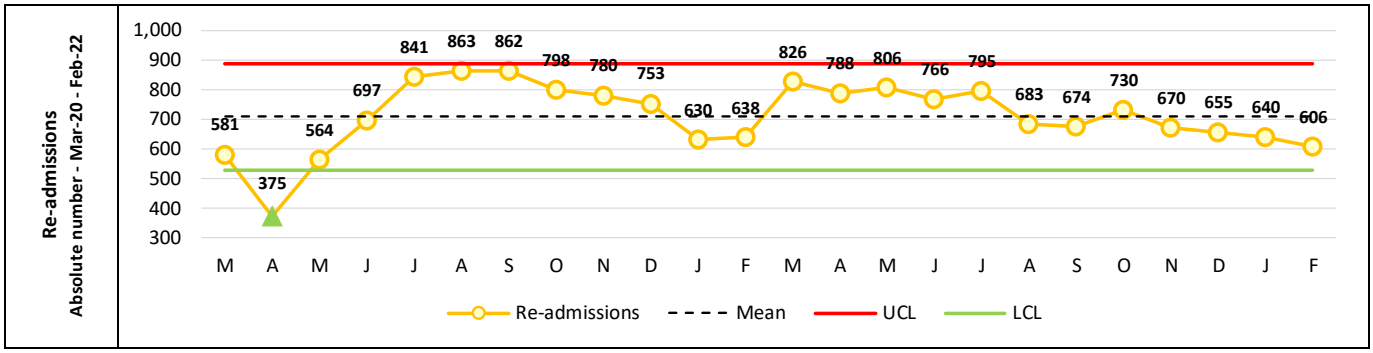
There is no national data available at the time of publication.

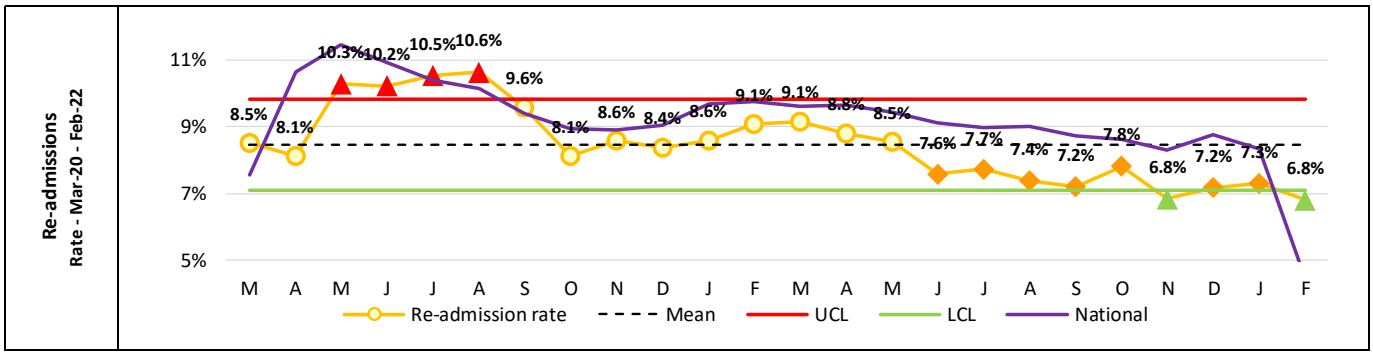
Emergency readmissions

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

The Trust's re-admission rate has generally been consistent with the national performance. with the Trust tracking just below the national average Since September 2020. This has stayed consistent since then. The significant changes in overall admissions and the change

in case mix during this period make interpretation of this data challenging but the Trust's position will continue to be monitored.





Responsiveness to patient needs

The CQC Adult Inpatient survey asked the views of adults who had stayed overnight as an inpatient, and people who were discharged from an NHS acute hospital in November 2020. This year, for the first time, participants of the survey were offered the choice of responding online or via paper-based questionnaires. The sampling month also moved from July to November. As a result, the 2020 survey results are not comparable to previous years. (The CQC Inpatient Survey for 2021 was paused due to the Covid-19 pandemic).

581 patients responded to the ENHT survey, a considerably improved response rate of 50% (compared to 41.4% in the 2019 survey). Our Trust response rate was better than the average response rate for all Trusts at 46%.

Inpatients were asked what they thought about different aspects of the care and treatment they received. Based on their responses, the CQC gave the Trust a score out of 10 for each question (the higher the score the better). Each Trust is assigned a category showing whether their score is 'better', 'about the same' or 'worse' than most other Trusts for each section and question.

Overall, the Trust scored **about the same**, reporting a similar performance to most other Trusts that took part in the survey. Out of the 45 questions, 43 were scored **about the same** (96%), and 2 were scored **somewhat worse than expected** (4%).

Top patient experience scores:

These are the five results for our Trust that are highest compared with the average of all Trusts. These were calculated by comparing our Trust's results to the average of all Trusts:

Question	Trust Score	Average score of other Trusts
Were you ever prevented from sleeping at night by noise from other patients?	6.8	6.2
How did you feel about the length of time you were on the waiting list before your admission to hospital?	8.1	7.7
During your hospital stay, were you ever asked to give your views on the quality of your care?	1.6	1.3
Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	7.2	7.1
Were you ever prevented from sleeping at night by noise from staff?	8.1	8.0

Lowest patient experience scores:

These are the five results for our Trust that are lowest compared with the average of all Trusts. These were calculated by comparing our Trust's results to the average of all Trusts:

Question	Trust Score	Average score of other Trusts
How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	6.9	7.5
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.4	7.8
Were you given enough notice about when you were going to leave hospital?	6.8	7.2
Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?	6.9	7.3
How clean was the hospital room or ward that you were in?	8.8	9.2

The Trust considers that this data is as described, and it is based on data submitted directly by patients to the national survey. The Trust 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 Group.

CQC Maternity Survey:

This year's survey shows results have declined in many areas nationally, likely reflecting the impact that the Covid-19 pandemic has had on services and staff. Results show that areas particularly affected were; involvement of partners, choice, information provision and staff availability. Despite the pressures of the pandemic, the majority of women continued to report positive experiences of maternity care, particularly during their labour and birth.

Statistically significant improvements since 2019 have been seen in questions asking about continuity of carer. 41% of women said they saw or spoke to the same midwife every time

during their antenatal check-ups, up from 37% in 2021. Postnatally, 30% said they saw or spoke to the same midwife every time, up from 28% in 2019.

351	351	60%	54%	41%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (210)	Average response rate for similar organisations	Your previous response rate

The majority of women continued to report positive experiences about their interactions with staff. For example, 86% of women said they were 'always' spoken to in a way they could understand during their antenatal care; 85% said that they were 'always' treated with respect and dignity during labour and birth and 71% said that they were 'always' treated with kindness and understanding while in hospital after the birth.

69% of women said that during their antenatal check-ups, the midwife asked them about their mental health. Postnatally, 95% said that the midwife or health visitor asked them about their mental health. Most women (83%) said that if they needed this, they were given enough support for their mental health during their pregnancy.

Most improved scores	Trust 2021	Trust 2019
B16. Provided with relevant information about feeding their baby	76%	70%
D2. Discharged without delay	59%	55%
B13. Given the help needed by midwives (antenatal)	96%	92%
C22. Involved enough in decisions about their care (during labour and birth)	97%	93%
C13. Had skin to skin contact with baby shortly after birth	91%	90%

Most declined scores	Trust 2021	Trust 2019
B5. Given enough information about where to have baby	68%	82%
F17. Received suppport or advice about feeding their baby during evenings, nights or weekends	67%	80%
B7. Felt midwives or doctor aware of medical history (antenatal)	77%	88%
F6. Saw the midwife as much as they wanted (postnatal)	67%	78%
F14. Told who to contact for advice about mental health after having baby	75%	85%

The Trust will be focussing on improving these key areas; information provided, support and advice given to mothers and families.

CQC Cancer Survey

This year's survey was voluntary and we were one of only 55 trusts in the country to participate. This means that scores have not been compared nationally this year and that we are unable to split the results between trust sites.

Overall (statistically) the results are static. Patients' average overall rating of care was good which shows that despite the pandemic, cancer patients continued to receive care and treatment.

Statistically significant improvements are evident in questions about communication, with an increase in the number of positive responses where patients felt hospital staff didn't talk about them as if they were not there (an increase of 10% from the previous survey in 2019). Additionally,79% of patients felt there were enough staff on duty to care for them, which is an increase of 21% from 2019 and may be attributed to the significant work on safer staffing within the Trust. There was an increase in the numbers of patients who felt waiting times in clinic were appropriate. This is likely related to the increased use of virtual consultations and changes to patient pathways due to the pandemic.

	Question	2019	2020
Q30	Hospital staff didn't talk in front of patient as if patient wasn't there	78%	88%
Q34	Patient thought there were always or nearly always enough nurses on duty to care for	58%	79%
Q59	Patient felt length of time for attending clinics and appointments for cancer was about	45%	68%

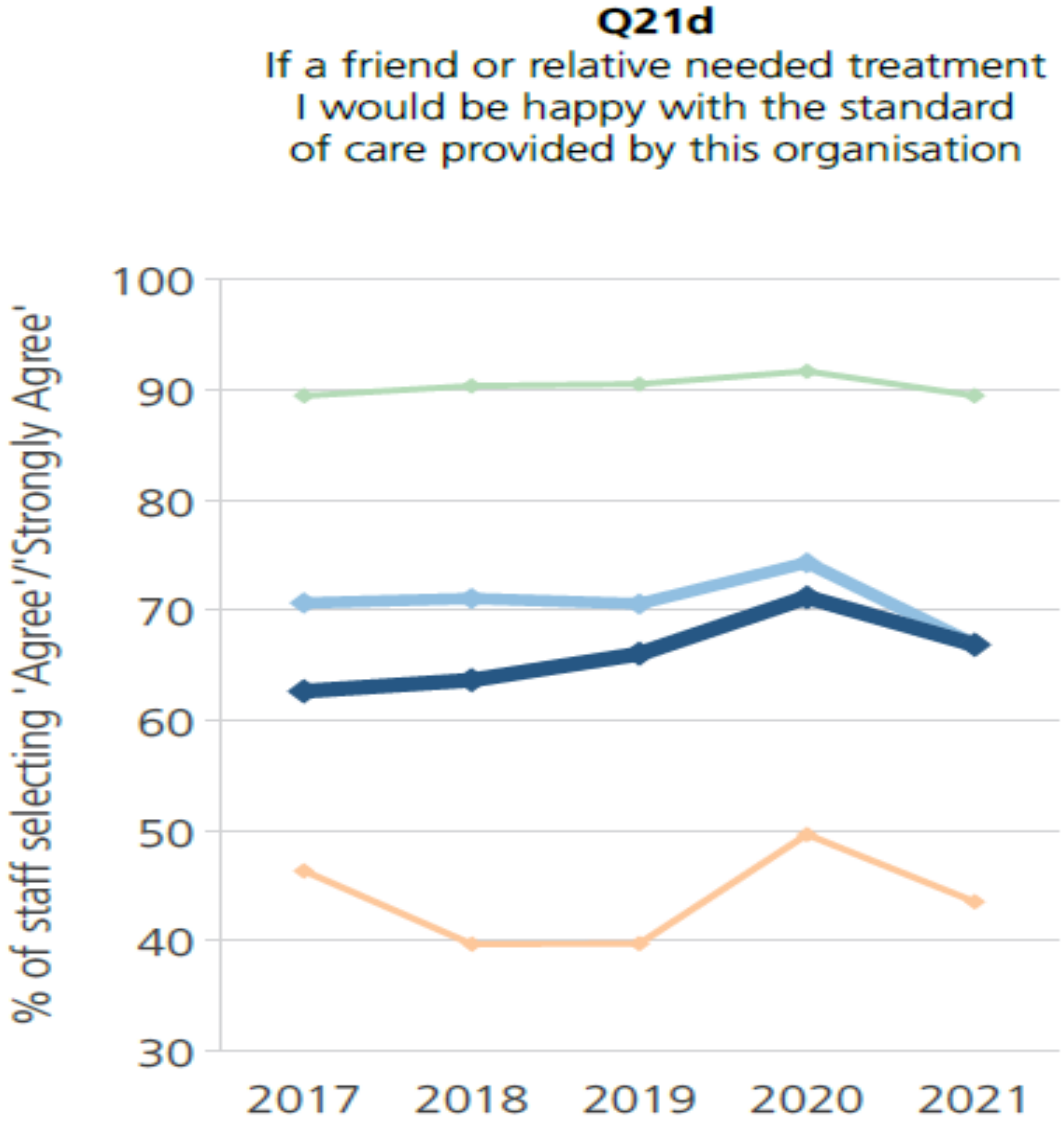
The only statistical reductions noted were in questions about clinical trials, in that trials were not discussed with patients. However, the majority of clinical trials were suspended during the time period of this survey. Another area that scored lower than the previous survey related to patients not feeling as supported by their General Practitioner, which was down to 35% from 41% the year before.

The key areas the Trust will be focusing on going forward is the information and support provided to cancer patients along all stages of their cancer journey. We will continue to work with the numerous teams who care for these patients as well as involving patients themselves so we can improve services.

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	66.9%	2021/22 Q2	71.2%	89.5%	43.6%	66.9%%

2647 staff completed the NHS national staff survey in 2021 representing a 42% response rate. Of those surveyed, 66.9% of staff state they would recommend the organisation as a place to receive treatment. This represents a slight decline this year, which is representative of the picture across the NHS as a whole and our score this year is also in line with the national average.



Best	89.5%	90.4%	90.5%	91.7%	89.5%
Your org	62.7%	63.7%	66.0%	71.2%	66.9%
Average	70.7%	71.1%	70.6%	74.3%	66.9%
Worst	46.4%	39.7%	39.8%	49.7%	43.6%

Throughout the survey there are again mixed scores with a higher proportion of questions showing no changes from 2020 results. When benchmarked by the national average score, we are however in line with the national average score for our sector for most themes apart from two themes where we are 0.1 points below average, namely, compassion and inclusion: and 'each voice counts'. However, we are above the national average score by 0.1 points for 'flexible working'

Going forward it is now our priority to increase on improving staff experience in the areas identified with a focus on areas such as safe and healthy workplaces, working flexibly, recognition and reward and we are always learning.

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 94% A/E 80% Mat 96%* OP 95%	Feb 2022	IP 97% A/E 94% Mat 94% OP 96%	100% 100% 100% 100%	77% 29% 67% 81%	94% 77% 94% 93%

*Maternity indicator is a measure relating to birth experiences only

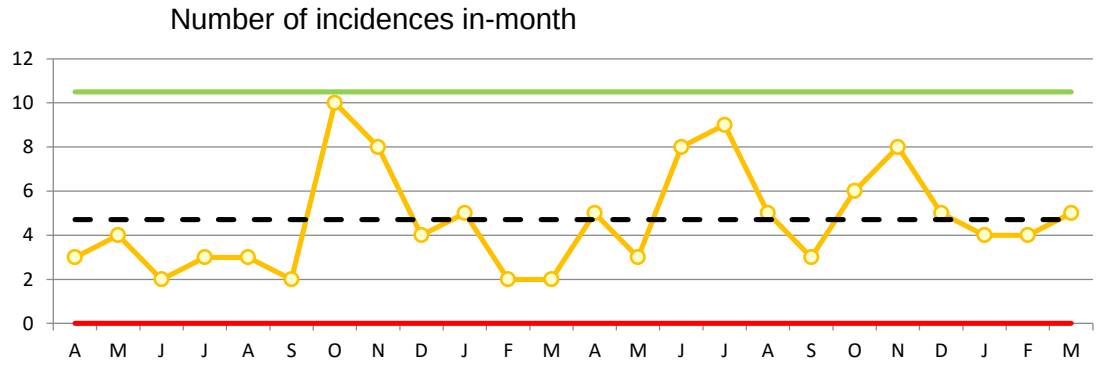
The Trust considers that this data is as described, as it is based on data submitted directly by patients to the national surveys programme. The Trust has taken the following actions to improve uptake and score; promotion of the survey within the inpatient and outpatient services, working with the inpatient services towards the accreditation within the pathway to excellence programme and adding QR codes to access the survey in and around the Trust. The feedback received is continually reviewed to identify themes and trends to produce improvement initiatives alongside our quick responses which are displayed monthly on our "you said, we did" boards.

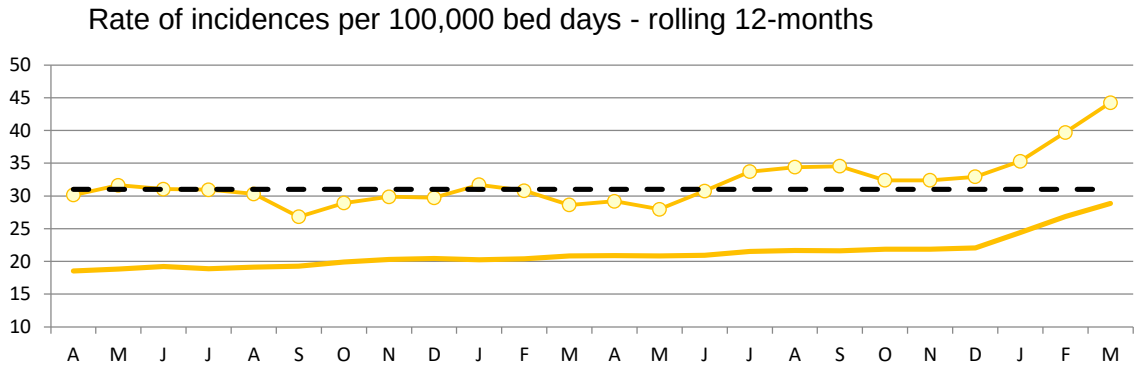
Venous Thromboembolism (VTE)

The national bench making data collection continues to be paused and therefore is not currently available.

Clostridium difficile

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





When more than one Clostridium difficile Infection (CDI) is identified in the same location and within a certain time period, ribotyping is requested: and continues to demonstrate that there has been no cross transmission thus far.

The Trust reported a total of 59 healthcare-associated infections (HCAIs) for April 2021- March 2022. This is above the Trust ceiling target of 52 HCAIs for April 2021- March 2022. All cases are usually 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.

The Trust will carry out a representative proportion of post infection reviews (PIRs), as agreed with the CCG, in order to identify any inadequate areas of practice. The MDT rounds should restart in May 2022 to provide support for the wards where CDIs have occurred. The current Trust position for April 2021- March 2022 is 59 HCAIs with total of 10 further appeal cases to be presented. This is likely to bring us in line with our ceiling. The Trust has a continued focus on Infection Prevention and Control; please refer to the MRSA section for further details.

Patient safety incidents

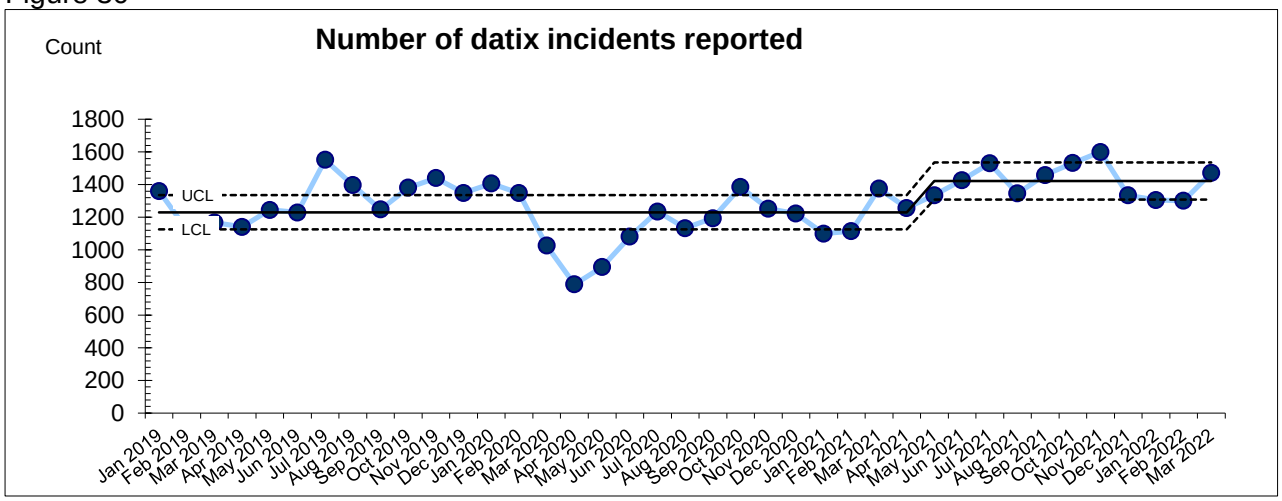
Incidents are reported on the electronic reporting system, Datix. The patient safety incident data is uploaded into a national system where incident reporting patterns, types of incidents can be analysed. The rate of incidents is the number reported per 1,000 bed days.

Between 1 April 2021 – 31 March 2022 the Trust reported a total of 13,543 patient safety incidents. This can be seen in figure 30.

Prior to COVID-19, there was an average of **1230** incidents reported each month. Nationally, there was a reduction in incident reporting seen at the beginning of the pandemic between March 2020 – June 2020. This was reflected locally; our incident reporting at the beginning of the pandemic (March 2020) noted a statistically significant decrease to our monthly reporting, with April 2020 showing the lowest number of incidents reported for a month at 789. As the pandemic progressed through the second wave there was only a marginal decline in incident reporting. As the graph below (figure 30) demonstrates, incident reporting levels have been gradually increasing since then and on average, they have sustained an increased reporting trend since May 2021, compared to pre-pandemic average of 1303 per month to a current average of **1406** incidents per month.

Of note over the last six months there has been a steadily improving trajectory of reporting and in April 2021 we saw a step change. It is recognised that the biggest driver to improvement in reporting is feedback; the ways in which we can improve our feedback are being explored. Teams are being encouraged to ensure incidents are part of local discussions at quality huddles and team meetings.

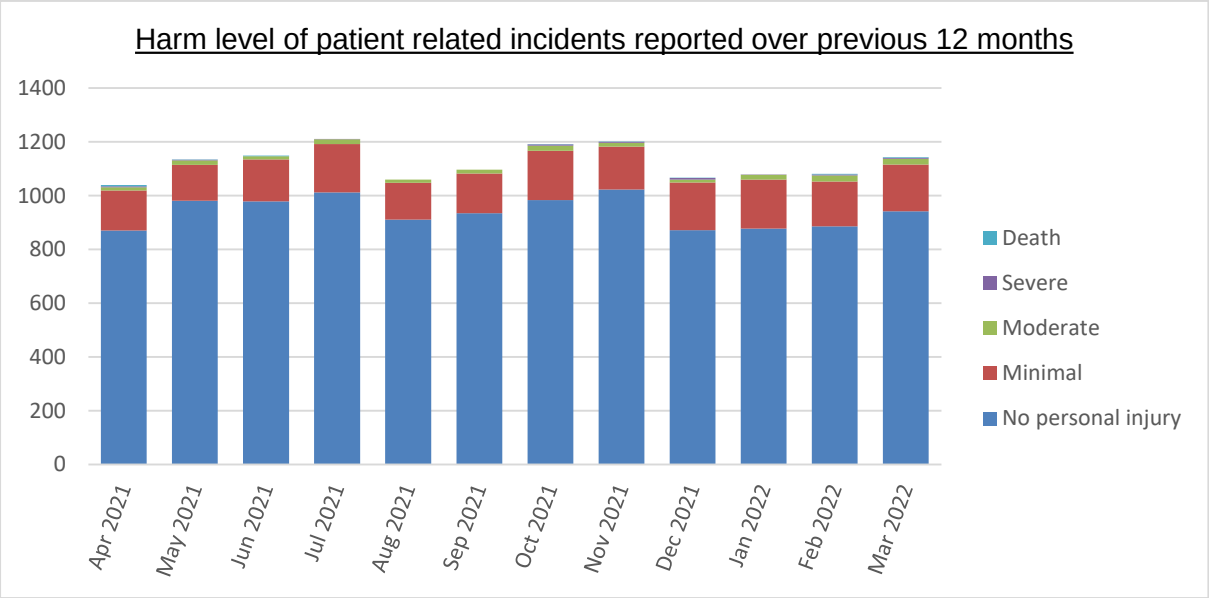
Figure 30



Of the total incidents reported in 2021/22 financial year (13,543) 80% relate to patient safety incidents and 12% relate to staff. Within staffing incidents, the top 3 themes are violence and aggression, staffing and health and safety / security incidents.

Between 1 April 2021 and 31 March 2022, 98% of patient safety incidents reported (n=13215) resulted in no or minimum harm.

Figure 31



Part 3

3.1 Review against selected metrics

Patient safety

Indicator	19/20	**20/21**	**21/22**	**Aim 22/23**
Never events	3	3	**5**	0
MRSA Bacteraemia (post 48 hours)	6	0	**0**	0
Number of inpatient falls	816	652	**672**	10% reduction
Number of inpatient falls resulting in serious harm	14	11	**19**	25% reduction
Number of preventable hospital acquired pressure ulcers	151 (0.62 PU per 1000 bed days) 2 cat 4	235 (1.21 PU per 1000 bed days) 1 cat 4	**205** **(1.05 per 1000 bed days)** **1 cat 4**	0.85 PU per 1000 bed days Zero cat 4

Never events

Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations are in place. The table below indicates the number of never events reported in the Trust during the last three years.

	2019/2020	**2020/21**	**2021/22**
Wrong site surgery	1	2	4
Retained object	1	0	1
Oxygen tubing to air	1	1	0
Total	3	3	5

There were 3 Never Events declared relating to Invasive Procedures in this period, two relating to wrong site treatment and one to retained dressing following surgery. The wrong site treatments occurred in radiology, plastic surgery and in ophthalmology outpatients. All areas have conducted a significant review and implemented changes to their procedures and LocSSIPS (and department inductions about LocSSIPS) following these events. In addition, areas are exploring suitable de-briefing tools, updating staff awareness of the WHO checklist, reminder of appropriate escalation when patient safety incident occurs and ensure learning is cascaded across the surgical and theatre teams. The retained dressing was erroneously thought to be an absorbable dressing and there was no handover or plan for its removal.

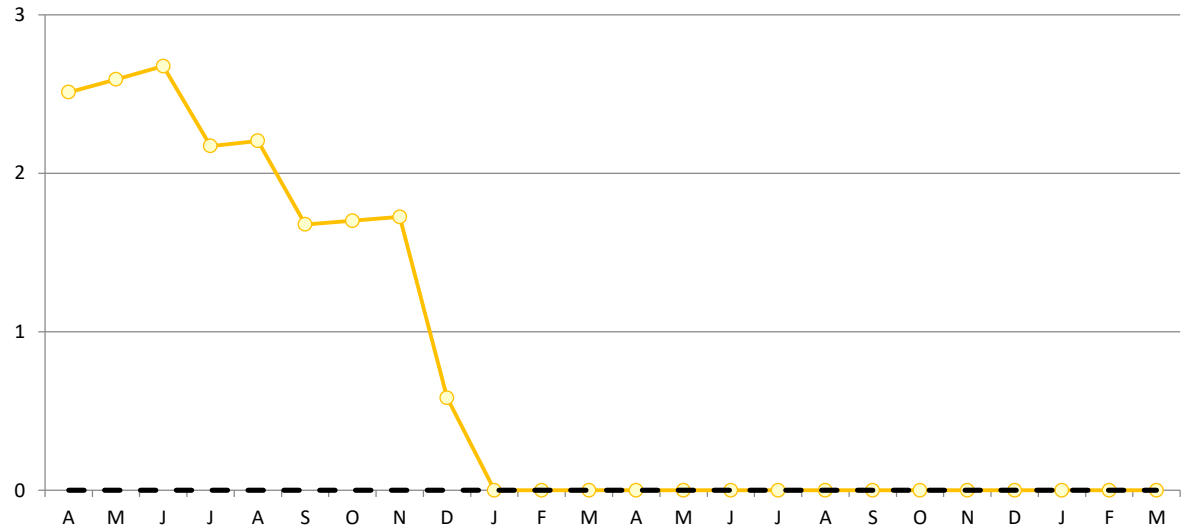
Within Planned Care, a programme of simulation training across theatres is planned in recognition of the Human Factors elements influencing of Never Events that have occurred within the Trust. These will be monthly live sessions focussing on debriefs, the WHO checklist and situational awareness. In addition a survey has been sent out to all staff working across theatres exploring psychological safety. The results will be incorporated into the monthly situational awareness training sessions and a further survey will be undertaken in six months' time to review the progress that has been made and to identify any further areas that need improvement. Plans are also in progress for a Patient Safety day on 23 September 2022; this is currently being led by the Planned Care team. It is anticipated this will include external speakers from both healthcare and the airline industry, a patient story from someone who has been the subject of a Never Event and a member of Trust staff who has been directly involved in a Never Event. The day will focus on patient safety culture and behavioural culture of staff.

Across Trusts in the Eastern region, wrong site surgery has consistently been the most common Never Event declared over the previous 3 years with 59 being declared. The second most common theme is that of retained foreign object, of which 32 were declared. The Healthcare Safety Investigation Branch (HSIB) undertook a national learning report about Never Events, looking at the strength of barriers and hierarchy of controls. The HSIB noted that the Covid-19 pandemic had exacerbated the risks surrounding Never Events. They made three recommendations; national review of the Never Event list, find strong and systemic barriers where barriers are not currently possible or strong enough and review of NATSIPS. NHSE/I are currently undertaking a Never Event review, which includes specific focus groups looking at the barriers that are in place to prevent them occurring and are intending to review and revise the Never Event policy and framework later this year.

MRSA Bacteraemia (post 48 hours)

MRSA bacteraemias are classified as Hospital Onset if the sample is taken later than the day following admission. The Trust reported a total of 0 MRSA bacteraemias for April 2021-March 2022 for the second time since 2015/16 and it in line with the Trust ceiling target of 0.

Rate of incidences per 100,000 bed days - rolling 12-months



The Trust reported a total of 0 MRSA bacteraemias for April 2021- March 2022, for the second year running. This sustained improvement is as a result of collaborative efforts to identify areas of learning regarding Aseptic Non-Touch Technique (ANTT) practice and vascular access. Involvement in national improvement work has also positively impacted Trust bacteraemias.

The work needed to develop a Trust wide ANTT competency was largely stopped due to Covid-19 pressures. However, an ANTT competency, which is owned and facilitated by Medical and Nurse Education and supported by the IV access leads and IPC, is still required.

The Trust will focus on devising and implementing a robust ANTT competency alongside other vascular access training.

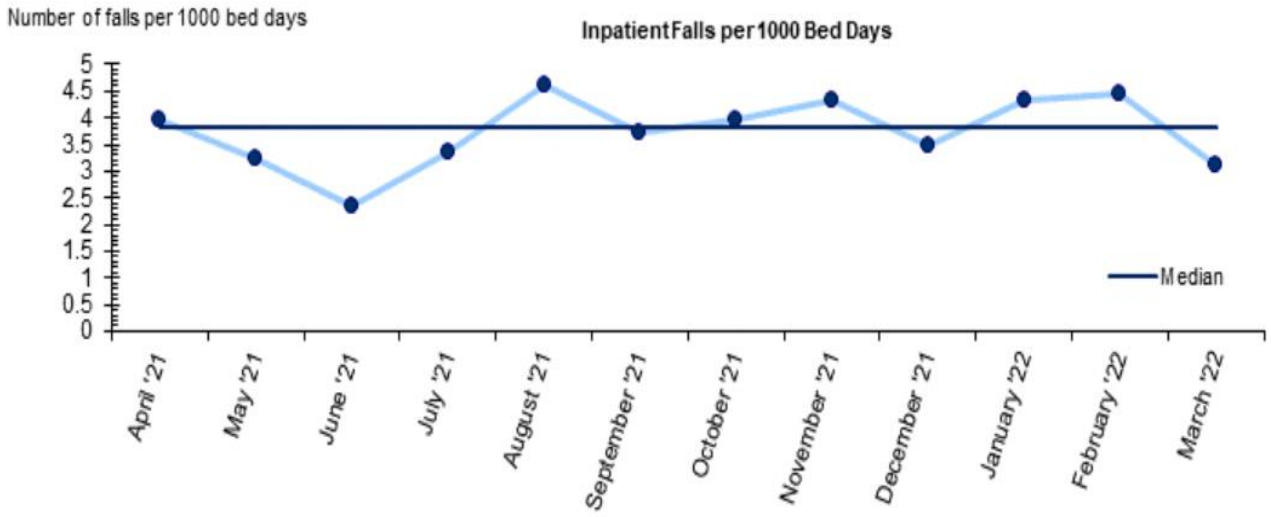
Key priorities for 2022/23 include:

- Devising and embedding 'Living with COVID-19' Trust IPC principles.
- Refocussing Trust IPC practice on standard infection control precautions and transmission-based precautions to appropriately prepare for seasonal changes.
- Embedding the newly released national IPC manual
- Continuing and escalating the post infection review (PIR) process for Hospital-acquired E.coli BSIs with rationalised PIRs for Hospital-acquired C.difficile
- Supporting surgical site infection quality improvement within the Planned Care Division

Inpatient falls

The Trust has sustained an average falls rate of 3.78 per 1000 bed days which is lower than the previous year (4.30). This represents a 12.01% reduction from the previous year. We are still recording a lower falls rate compared to the national average of 6.6 (NHSI).

Figure 32 Rate of Falls per 1000 bed day



During 2021/22 there were 672 inpatient falls. This represents a 3.07% increase when compared to 2020/21. We have also seen an increase of 18.71% occupied bed days compared to the previous year.

Number of inpatient falls resulting in serious harm

Learning from incidents

The Trust has a number of measures in place aimed at minimising the risk of falling. These include risk assessments on admission and mitigation actions such as the use of bed rails, low rise beds and high observation interventions such as Baywatch or 1:1 nurse ratio.

When falls resulting in serious harm have occurred, a safety investigation learning review is undertaken which is called a 'round table'. These reviews are attended by nursing, medical, therapy and pharmacy staff to identify learning themes to prevent future harm.
Learning identified during 2021/22 includes:

- Unwarranted variation in the reliability of timely completion of falls risk assessment,
- Challenges in providing reliable compliance with Baywatch interventions
- Sometimes delays to medical review following the occurrence of inpatient fall
- The quality of documentation related to completion of MCA and DOLS

Financial Year	# IP Falls	Reduction year on	% trend	Falls with Serious Harm
2019-2020	747			14
2020-2021	652	95	12.72% ↓	11
2021-2022	672	+20	3.07% ↑	19

We have been working closely with the Trust's Harm Free Care collaborative to improve our compliance with falls training and education. This will include the medical workforce, post falls escalation and management, and developing escalation tools to support all staff to communicate safety critical information through ward channels such as huddles and board rounds. We are also working closely with the safeguarding team to ensure staff are aware and supported with MCA/DoLS completion through practical competency-based learning and simulation, including when patients have fluctuating capacity.

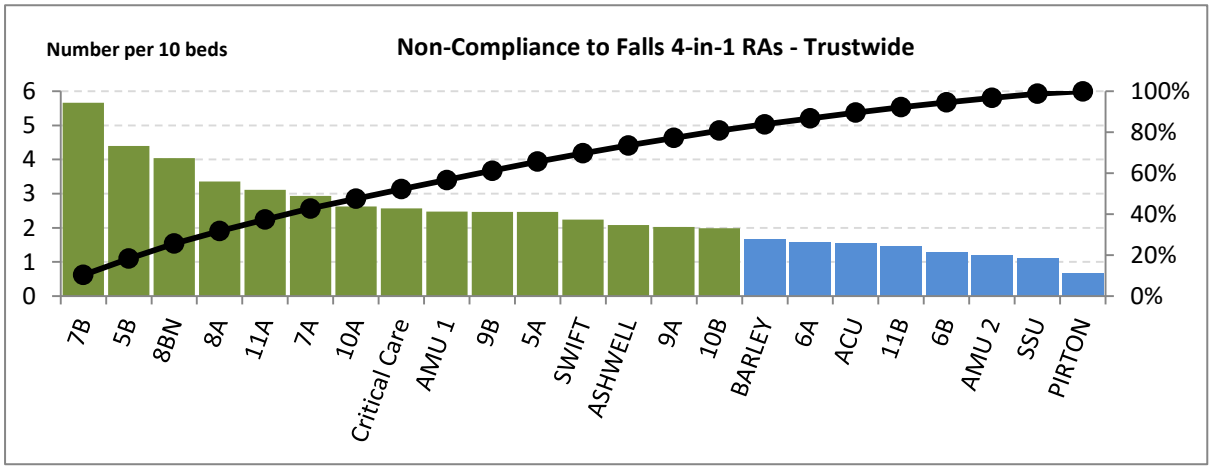
Work underway:

Harm Free Care Falls Priority Aim:

- **Falls Risk Assessment**

  Priority Theme 1: Falls risk assessment should be done within 4 hours of admission as per NICE Falls guidance. In quarter three of 2021, we launched falls risk assessment as part of digital nursing 4-1 falls risk assessment, KOPS programme. Timely assessment of inpatients falls risk remains a challenge and the

pareto chart below shows significant variation in compliance up to 50% on most inpatient wards.



All wards 'green' are demonstrating a reduction in new digital falls risk assessment compliance.

Work Underway: This is ongoing Trust-wide improvement work aiming to improve compliance and digital adoption by engaging staff in completing falls risk assessment in a timely manner. We will also be looking at launching falls care plans as part of the KOPS programme in the coming months.

- **Assessment Areas (AMU 1)**
  - **Priority Theme 2:** Assessment areas have a quick turnaround of patients admitted from different specialties. This poses a challenge in managing patients with different needs. AMU set an aim of reducing serious harms from falls by 50% and achieved this goal for 2022/21
  - **Work Underway**: Falls posters aiming at informing and educating patients, are going to be trialled in the area using PDSA tools as part of their quality improvement journey.
- **Baywatch**
  - **Priority Theme 4**: Compliance with Baywatch has been an ongoing challenge which has a negative impact in managing high risk falls patients.
  - **Work Underway:** Falls prevention training is now live on ENH academy which includes Baywatch education. We will provide bespoke Baywatch training for areas with poor Baywatch compliance

Achievements: The quality improvement project on ward 8A was successful in achieving a reduction of falls over the past year. We have also successfully tested and implemented the alcohol withdrawal proforma which will improve the timely prescription and administration of appropriate medication for patients withdrawing from alcohol, thus reducing the risk of falls for this group of patients.

Next steps: Quality Improvement work for falls this year will focus on the aim of reducing Trust-wide falls with serious harm by 25% by April 2023. The overarching goals will be to improve communication amongst ward staff, compliance with Baywatch and involve service users in co-designing the falls improvement work.

Inpatient pressure ulcers

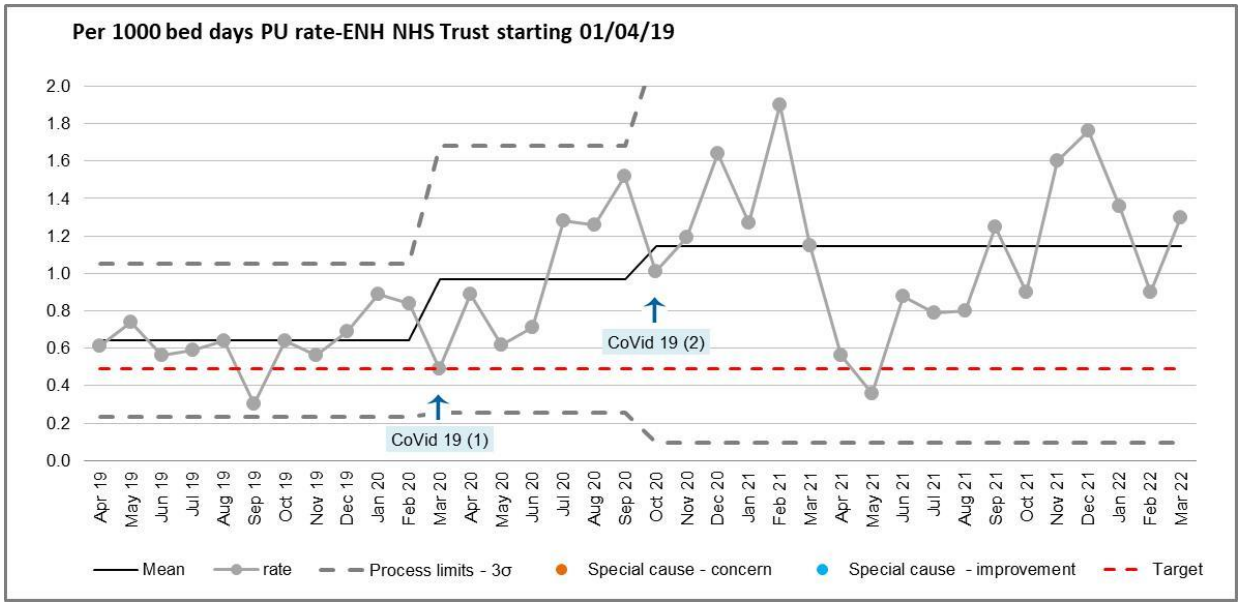
The Trust is committed to the prevention of harm caused to patients whilst in hospital, particularly from Hospital Acquired Pressure Ulcers (HAPU). All HAPU are investigated via a root cause analysis (RCA) investigation to capture any learning.

HAPU identified by ward staff are reported to the Tissue Viability Team (TVT) via our incident reporting system Datix. These incidents are then triaged by a Tissue Viability Nurse (TVN) and the skin damage is validated to ensure accurate reporting of harm and expert wound care planning to enable wound healing.

The Trust has reported 205 HAPU for 2021-22 which is a 12.7% reduction on our previous year's data.

	2019/20	2020/21	2021/22
Number of patients with reportable HAPU	151	235	205

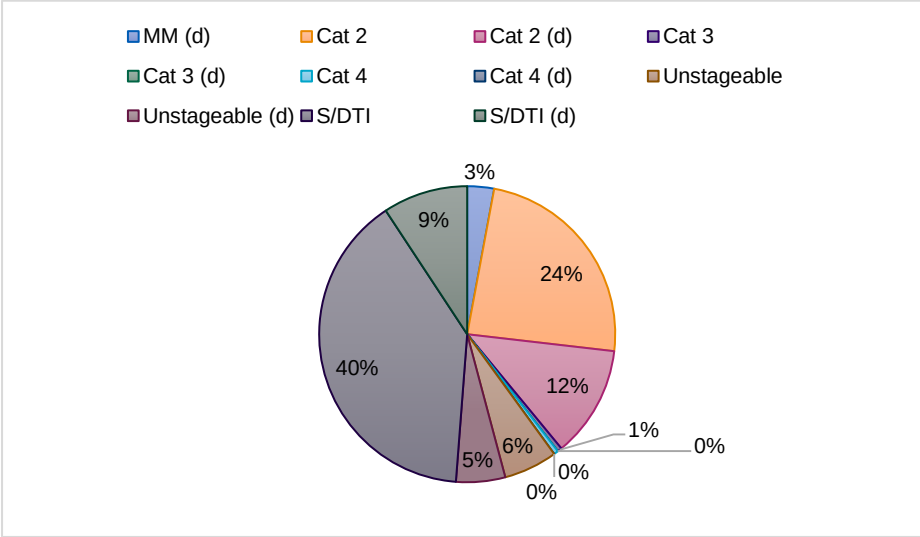
In the chart below, time series data demonstrates the rate of pressure ulcers (PU) per 1000 bed days. Due to the 2018 NHS Improvement pressure ulcer reporting changes, 2019-20 has become our new baseline year as the number of PU categories we are required to report on, has increased.



PU Categories

The most prevalent category for 2021-22 has been suspected deep tissue injury (SDTI) accounting for 48.8% of total reportable pressure ulcers. 22% of these SDTI were directly related to the use of a medical device. All other categories and prevalence can be seen in figure 33 below.

Figure 33



Category	Total number
MM (D)	6
Cat 2	49
Cat 2 (D)	25
Cat 3	1
Cat 3 (D)	0
Cat 4	1
Cat 4 (D)	0
SDTI	81
SDTI (D)	19
US	12
US (D)	11
Total	205

**(D) = Medical Device Related; MM = moisture membrane; SDTI=suspected deep tissue injury; US=unstageable*

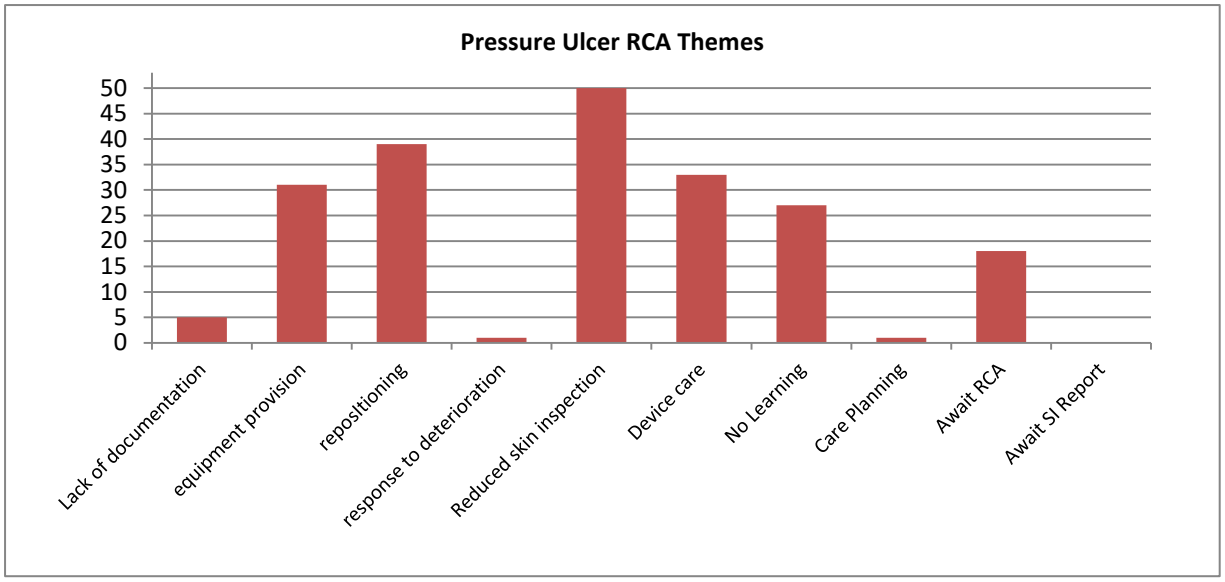
PU Learning

Every HAPU is investigated by a Tissue Viability Nurse (TVN) to enable identification of gaps in care so that learning can be identified and improvements delivered. A Root Cause Analysis (RCA) investigation is performed at the time of validation and outcomes are fed back directly to ward staff. Category 3 and 4 PUs are escalated via the Serious Incident Review Panel for consideration and possible Serious Incident investigation. The diagram below details the themes associated with this year's PU data. Our most prevalent themes are reduced skin inspection (24.4%) and repositioning (19%). One category 4 PU was escalated for Serious Incident investigation in 2021/22.

In compliance with the NHSI PU recommendations, the terms 'unavoidable' and 'avoidable' are no longer used. In 27 ulcers (13%) we were unable to determine any learning for ward staff as all care was delivered and documented in line with trust standards and best practice.

The Trust has seen a reduction of medical device related pressure ulcers within critical care, from 56 in 2020/21 and to 37 in 2021/22, as a result of the quality improvement projects and increased awareness of QI methodology.

	Total pressure ulcers within critical care	Medical device related pressure ulcers within critical care
2020/21	75	56
2021/22	43	37



Harm Free Care priority aim

Through the Trust Harm free Care Collaborative, the Tissue Viability Team will continue to work alongside the quality improvement team and apply QI methodology to drive continuous improvements. The Tissue Viability Team have identified 3 priorities for improvement work over the coming year.

1. To sustain the reduction in reducing medical device related pressure ulcers within critical care
2. To improve the quality of repositioning care on general wards in collaboration with the clinical practice team
3. To improve the quality of SSKIN care documentation to facilitate delivery of care across the Trust. (This was paused during 2021/22 due to the impending implementation of a new digital care planning system)

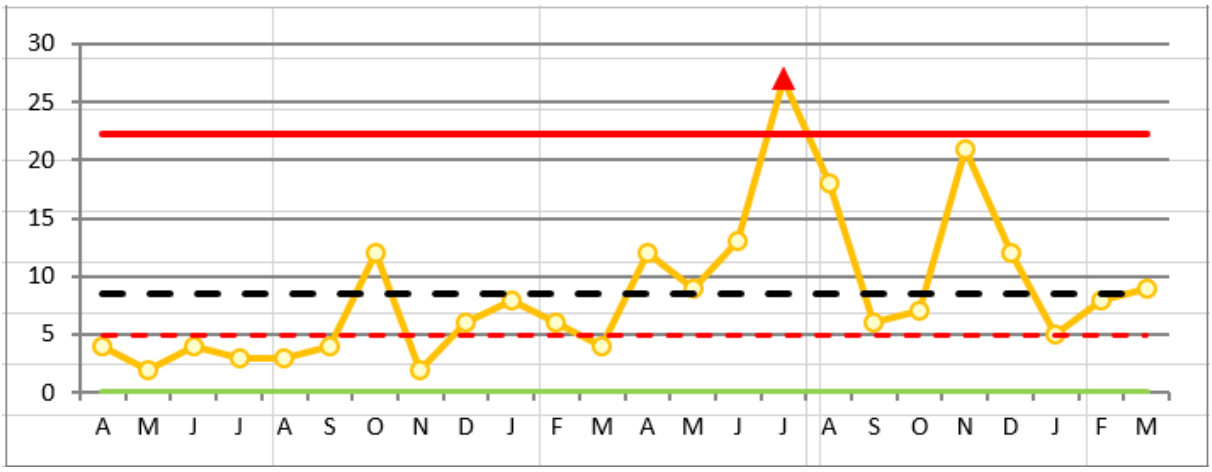
Serious incidents

When an incident occurs that might fulfil the criteria for a serious incident an initial investigation is undertaken and any immediate safety actions are identified and put into place. A short rapid incident review is completed by the relevant clinical team and discussed at the Serious Incident Review Panel that meets twice weekly, chaired by either the Chief Nurse or Medical Director. The panel consider whether any 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 and the

investigation undertaken by the Patient Safety team with input from subject matter experts and relevant clinicians.

During 2021-22, the Trust formally declared 147 Serious Incidents (SIs). The chart below (figure 34) shows the average number of serious incidents reported each month is eight, with common cause variation of SIs reported each month in Q3 and Q4.

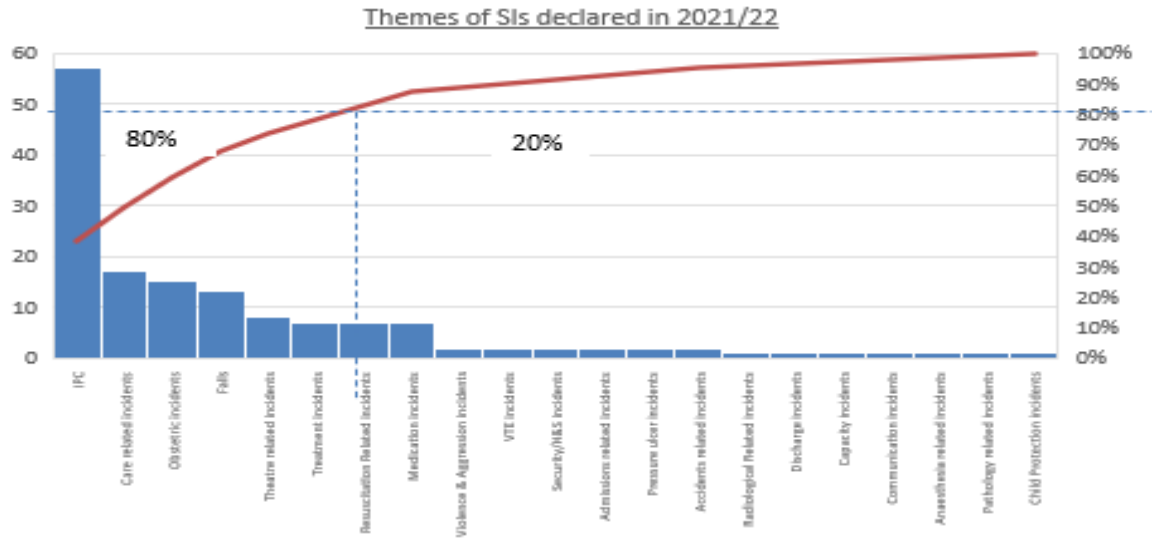
Figure 34
Monthly reporting number of serious incidents
(A pril 2020 March 2022)



The total number of cases declared was a marked increase from the previous year and is attributable to the hospital onset hospital acquired Covid-19 cases being declared. Of the 147 cases, 5 were Never Events, 14 were referred to HSIB for investigation and 4 were subsequently downgraded.

The graph below demonstrates the themes of SIs from 2021/22. As expected, infection prevention and control issues are the most common theme and this reflects the hospital onset hospital acquired Covid-19 cases. It is noted that there has been an increase in SIs relating to falls. In conjunction with this, there is a focus on ongoing continuous improvement through the Trust Harm Free Care Collaborative, with improvement objectives of; training and education, risk assessment compliance and post falls escalation and management. In addition to this, the Trust-wide use of revised digital falls documentation is being reviewed, along with an ongoing audit of the escalation process following falls.

The rapid assessment and documentation of patient care following a falls is being included in doctors' escalations programme of work and communication and escalation tools are being developed to support staff to have different conversations when Baywatch is in progress and conflicting, demanding task requests occur.



These themes are embedded within patient safety and patient experience improvement priority programs such as:

- The Deteriorating Patient Collaborative,
- Harm Free Care Collaborative
- Patient and Carer Experience (PACE) Improvement programs

The round table discussion format has been shown to be successful as a learning forum, attendance is mostly senior staff and it is an opportunity for staff involved in the incident and other frontline staff to be involved in the process. This can help provide early feedback to both those directly involved and also those more senior staff from the wider teams. This process is now embedded. The focus for 2022/23 is to streamline the process to improve the timeliness of reports being finally approved and shared with the patient/family.

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

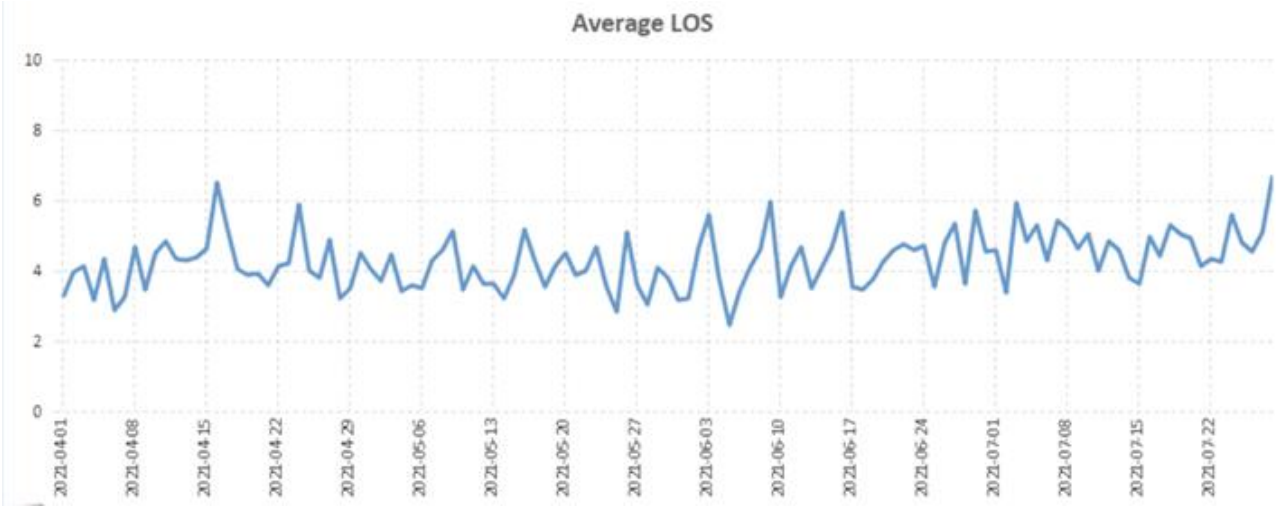
- Raise awareness of the Access Policy, including two week waits referrals and access plan, to review the consistency of the booking process between the Haematology Service and Contact Centre and to consider streamlining the booking process with the use of Contact Centre
- A LocSSIP, SOP and IVT treatment booklet were created and implemented within Ophthalmology
- The Trust's Harm Free Care programme has prioritised improving awareness of VTE risk assessment and prevention. This work includes structured daily safety huddles, site safety and hospital at night communication pathways.

Clinical effectiveness

Indicator	19/20	20/21	21/22	Aim (22/23)
Length of stay (non-elective / emergency)	3.78	4.04	**4.73**	≤4.3
Stroke – thrombolysis rate	11.2%	11.9%	**8.3%**	≥11%
Crude mortality – rolling 12 month rate	11	16	**11**	Reduce

Length of stay (LOS)

The length of stay has remained fairly constant throughout the year with an average LOS of 4.73 days. Work is ongoing to review and benchmark against the HRGs and work with the ICS partners on prevention of admission, criteria to admit and hospital at home to facilitate earlier discharge and less demand on inpatient beds.



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 six of the twelve months.

Domain	Metric	2021-22 Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Stroke	% of all stroke patients who receive thrombolysis	11%	11.3%	3.2%	3.4%	8.2%	4.2%	9.2%	12.5%	7.7%	4.1%	11.4%	12.9%	11.4%	
	%of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	70%	14.3%	0.0%	50.0%	57.1%	0.0%	16.7%	42.9%	33.3%	66.7%	62.5%	33.3%	50.0%	

A task and finish group has been established to support whole-system review of the thrombolysis pathway and to review improvement plans for recovery of performance. This has supported an improved performance apart from some months in relation to the

overwhelming pressure within the Trust and the clinical indication 'not safe to proceed treatment'. A review was undertaken of all patients that didn't meet the thrombolysis pathway, which indicated arrival outside the thrombolysis window and/or clinical need not to proceed, i.e. the patients required other treatment before thrombolysis could be safely administrated.

Considering the changes to all services due to COVID-19 both ambulance and ED triage, scanning protocols and swabbing process added some delays. Internal analysis of each case is to be carried out for future learning to be carried forward and to achieve the standard going forward. This is also supported by the ISDN South region implementation plans of the National Stroke Service Model (May 2021).

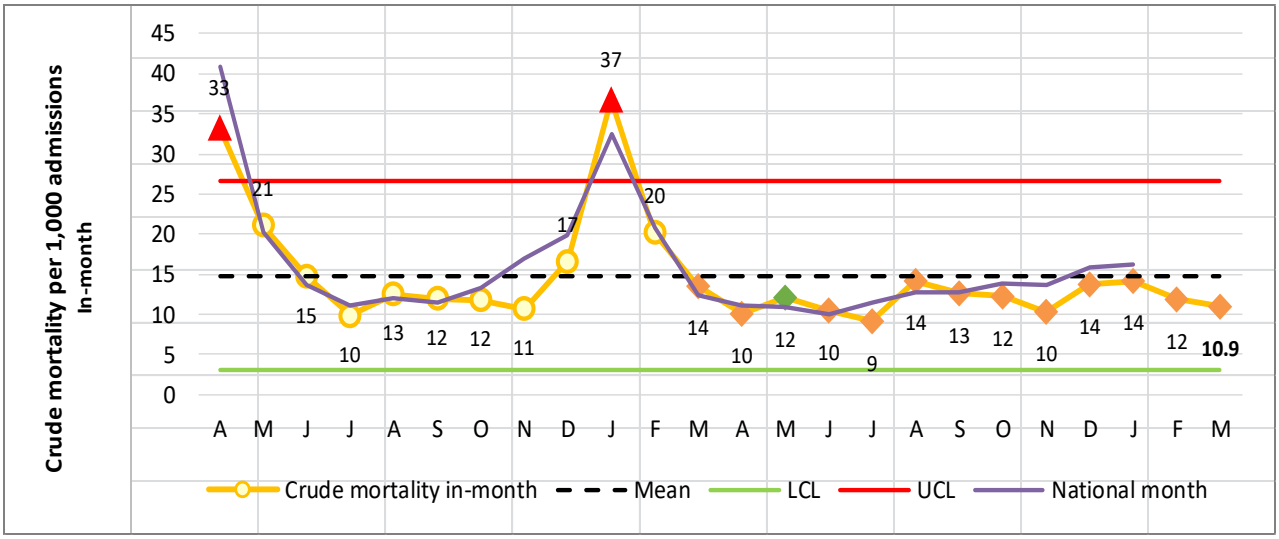
Crude mortality

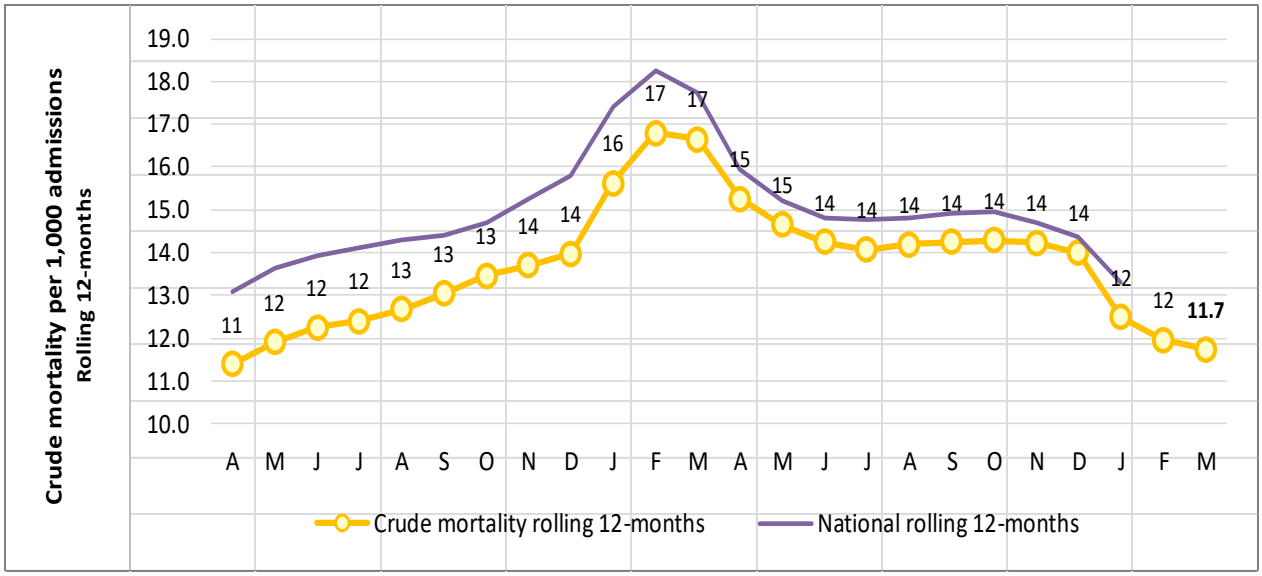
Crude mortality is based upon the number of patients who die in the Trust whilst an inpatient. It is measured per 1,000 admissions.

This measure is available the day after the month end and is the factor with the most significant impact on HSMR (see earlier section on mortality and learning from deaths).

The general improvements in mortality over recent years have resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work, together with a continued drive to improve the quality of our coding.

While the Covid-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average, with our rolling 12 month rate consistently tracking below the national rate.





Patient experience

Indicator	19/20	20/21	21/22	Aim (22/23)
Number of formal complaints	1058	656	777	<previous year
Number of PALS concerns	3693	2935	3614	N/A
Number of PALS concerns closed within 5 days / %	2607 70.5%	2931 79.2%	2529 78%	80%
Complaints – response within agreed timeframe	82%	89%	72%	≥80%*

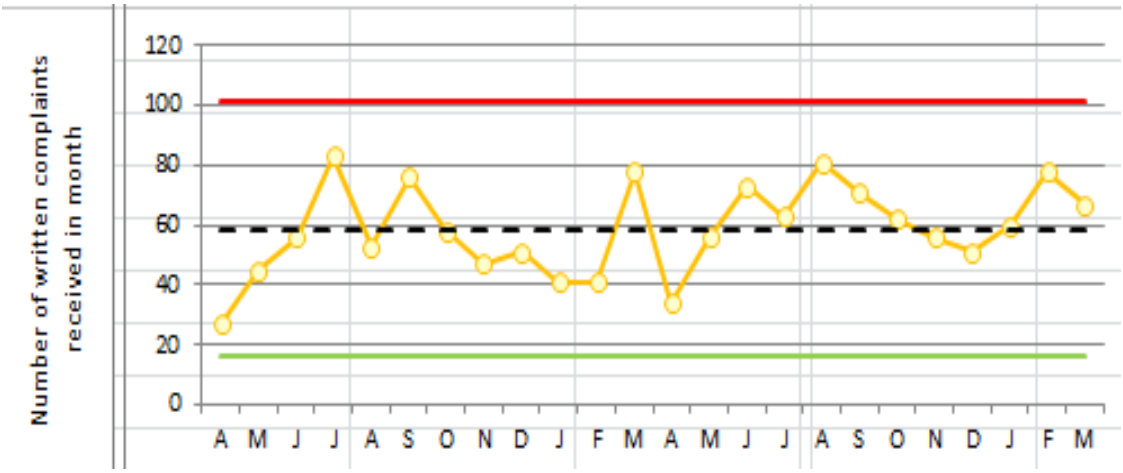
Source: Datix internal system & information held by local teams

*The Trust KPI is for 80% of formal complaints to be responded to within an agreed timeframe.

Patients and carers are encouraged to raise questions or concerns about their hospital experiences. The outcome of complaint investigations are shared with the relevant ward, department and divisions so that staff understand what they are doing well and where they need to make improvements.

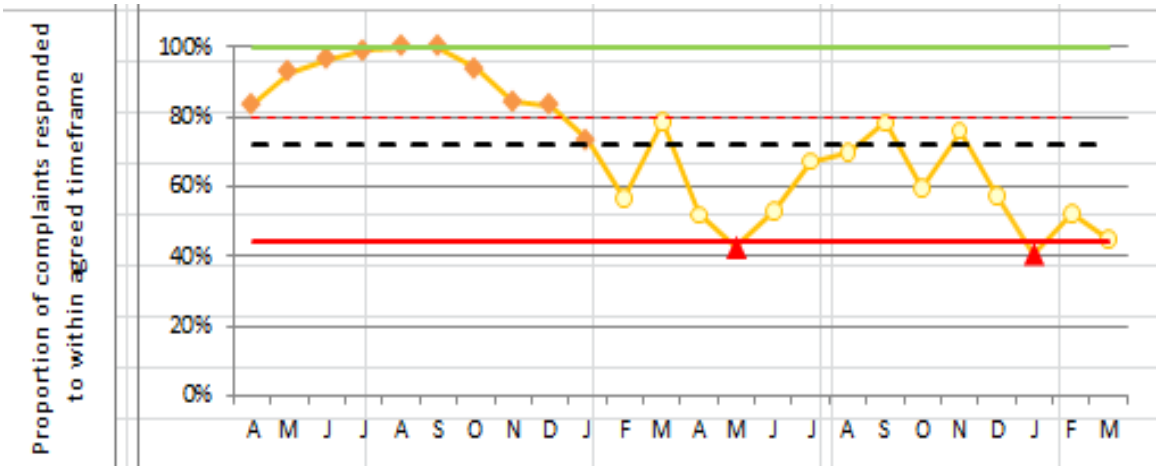
In 2021/22 777 formal complaints were received across all services (from 656 in 2020/21) within the Trust, and 3614 informal PALS concerns (from 2935 PALS 2020/21) were received.

The volume of written complaints received per month is shown below. Although numbers have risen slightly from last year, the volume has not reached pre-pandemic levels and on average between 60-70 written complaints were received each month.



The Trust aims to respond to at least 80% of formal complaints within an agreed timeframe. Current performance of responding to the patients and families is not within the expectations of the service, however the target continued to be challenging during 2021/22 due to the operational pressures within divisions during the pandemic and subsequent recovery phase.

The Trust is currently reviewing its Complaints processes and will conduct a service review in 2022/23. We remain committed to improving the quality and timeliness of responses through adopting the NHS Complaint Standards (PHSO 2021) and supporting divisions with complaint responses throughout the ongoing recovery stage of the pandemic.



The Patient Advice and Liaison Service and the Complaints Team received several contacts about the impact of visiting restrictions (due to Covid-19) on some of our patients. Throughout the pandemic, birthing partners were still able to support women in active labour. Face to face visiting was also facilitated for vulnerable patients and those at the end of life. All information regarding the visiting restrictions was made available on the Trust website and updated regularly.

Several contacts were made by patients chasing their appointments and consultations as the pandemic started to wane. These enquiries were dealt with by the Patient Advice and Liaison Service and were mostly resolved promptly.

Formal complaints were raised by relatives during the pandemic highlighting several communication issues; for example, not being kept up to date with care and treatment plans about their loved ones who were inpatients. The 'Here to Help' team was set up during the pandemic and deployed staff to call family members and update them on the location of loved ones and pass on messages.

Formal complaints were raised about patients attending the ED and the triage process which determined their priority and approximate waiting times to be seen. Patients felt they could be exposed to Covid-19. The triage process was continually reviewed to keep all patients and staff as safe as possible. Staff and patients were all encouraged to wear face masks to help prevent the spread of Covid-19 and patients were swabbed on attendance and before being admitted as inpatients.

As the Trust moved to the recovery stage and (visiting) restrictions started to be relaxed, patients were invited to attend appointments in person. Social distancing remained in place to protect both staff and patients. Due to social distancing, less patients were able to be seen in face to face clinics at any given time. The Trust reviewed access and made adjustments to implement infection control measures and improve the number of patients that could attend each clinic.

There have been recent contacts from patients who were concerned about the impact of Covid-19 on their waiting time for treatment or a procedure. Each patient is assessed on clinical need and both the Patient Advice and Liaison Service and the Complaints Team work closely together, communicating with patients and staff and managing expectations about waiting times which are under constant review.

Staff

The following table represents some indicators relating to staff.

	Plan	**Actual***
Permanent staff (whole time equivalent)	5918	5880
Vacancy rate	6%	6.6%
Turnover rate	12%	14%
Appraisal	90%	46%
Statutory / Mandatory training 100% complaint	90%	87%

*March 2022

Appraisal and statutory/mandatory training are key indicators to leadership and the support our staff are receiving from their managers. Throughout the pandemic it was recognised nationally that face to face training even for statutory/mandatory purposes could not take place. These training sessions were therefore placed on hold with incremental progression unaffected. Over the course of the last year our subject matter experts supported by our capability team have converted most face-to-face training to online learning events. With the development and implementation of our online learning platform which went live in May 2021 we have enabled all our staff to have easier access to training and implemented an improvement plan which has led to improved compliance with essential learning from 46% in March 2021 to 87% in March 2022.

In April 2022, we implemented a new grow together (appraisal) process and window with all appraisals now taking place between April and August 2022, rather than at various periods during the year. All appraisals were paused from January 2022 to meet the new window requirements and we expect our compliance to improve in line with this revised targeted approach.

National staff survey

The national staff survey was carried out between September and November 2021. 2647 staff completed the survey representing a response rate of 42%. The overall findings are shown in the chart below.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.8	6.6	5.9	5.2	6.0	6.6	6.8	5.7
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,639	2,639	2,597	2,614	2,489	2,628	2,634	2,640	2,641

Reference: https://www.nhsstaffsurveys.com/results/

For 2022/23, we will focus on making improvements on

- We work Flexibly
- Safe and Healthy
- Recognised and rewarded
- We are always learning

The survey results show improvement in questions such as staff experience of bullying and harassment and staff feeling secure in raising concerns. However, our lowest scoring themes are in areas such as ‘Recognised and Rewarded’, ‘Safe and Healthy’, ‘Always Learning’ and ‘Work Flexibly’ as well as ‘Morale’.

The trends for EDI has seen our position improve in several areas such as ethnicity, disability, age and in opportunities for career progression. However, areas such as religion and gender have shown a decline. While the EDI lead and our network groups have made some significant changes in engaging the wider Trust in a host of initiatives, such as inclusion ambassadors on recruitment panels and a reciprocal mentoring programme, as well as a number of annual celebratory and recognition events, to improve in this area, ongoing intervention is needed to continue to support organisation wide change.

The theme of bullying and harassment has seen very little variation over the last 5 years. As a Trust we consistently score worse in this area than the average for our sector. However, this year we have seen an increase in the number of staff feeling able to report incidences of bullying where it is experienced and a decline in the numbers experiencing bullying from line managers compared to 2020. The Trust is undertaking a number of initiatives to improve culture including an ongoing values refresh programme, as well as introduction of and continued interventions to improve the psychological safety of staff. This will include training more Mental Health First Aiders, introducing a Care Support Pyramid, training Freedom to Speak Up Champions and recruiting a Freedom to Speak Up Guardian, running reflective space sessions and Schwartz rounds with a focus on providing psychological safe environments to listen, reflect and share feedback.

The staff flu vaccine campaign is detailed in Annex 3.

3.2 Performance against national requirements

National standards

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

	19/20	20/21	**21/22**	**Aim 22/23**
Max 18 weeks from referral in aggregate – patients on incomplete pathways	77.4%	60.36%	**58.78%**	≥92%
Four hour maximum wait in A&E	80.2%	Not Met 83.47%	**72.78%**	≥95%
62-day urgent referral to treatment of all cancers	79.82% (full year)	Met 86.13% (full) year)	**86.6%**	≥85%
Maximum 6 week wait for diagnostic procedures	99.48% (to Feb)**	Not met 33.07% (Full year)	**39.27%**	>99%

In response to the Covid-19 pandemic, the Trust reconfigured services and wards to provide Covid-19 and Non-Covid-19 areas for patients, within the emergency department, assessment areas and across the wards. All minor injuries and illnesses were redirected to the Urgent Care Centre at the New QEII Hospital to support these reconfigurations. The

Trust also increased capacity in the Critical Care Unit and worked in partnership with the independent sector to continue to treat urgent and cancer patients.

All surge capacity has been filed away or 'flatpacked' to ensure that the detailed response to Covid-19 demand and the resultant service capacity can re – emerge in response to triggers, so that the organisation remains responsive to any potential and subsequent surges. Performance against the key operational standards should be considered in the context of the unique challenges posed by the pandemic.

18 week referral to treatment (RTT) performance was under the national average, though it is recognised that waiting times increased substantially as a result of the Covid-19 pandemic. The Trust is making good progress in reducing long waiters and achieving on cancer targets.

Freedom to Speak Up / Raise Concerns

The Trust is committed to achieving the highest possible standards of quality and continues to develop a great place to work that supports and encourages an open and just culture. This is where staff feel safe and able to speak up about any issues which may affect their experience at work and in turn may hinder them from delivering safe and high quality individualised care to our patients.

Current 2022/2023 plans include a refreshed Freedom To Speak Up (FTSU) vision and strategy to reflect our organisation's commitment to 'Speaking Up'. This is being led by our newly appointed full time FTSU Guardian.

This strategy will be underpinned by our core values and behaviours and will foster a workplace culture that has psychological safety at the heart of all interactions

Our Trust has various avenues for colleagues to raise concerns including line managers, divisional leaders, Employee Relations Advisory Service (ERAS), Trade Unions, Speak in Confidence and the FTSU Guardian. A priority for 2022/23 is to design and deliver a refreshed FTSU awareness campaign, in collaboration with the staff experience hub to effectively inform staff of the various support services available to them. This will include targeting pivotal areas such as:

- Induction: FTSU Guardian or FTSU Champion will participate in our Trust corporate induction to ensure all new starters are aware of their obligations as advocated by Freedom to Speak Up and the support available to fulfil this obligation.
- A regular communication rhythm: Provide regular and diverse communication to ensure that everyone is aware of how they can speak up and the benefits of speaking up
- Training for managers programme: Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively

- Governance and monitoring: Ensure monitoring and evaluation of the number and nature of concerns is timely and supported by appropriate governance.
- Shared Learning: Ensure that key learning related to concerns is articulated to all in an open and transparent manner, while respecting confidentiality

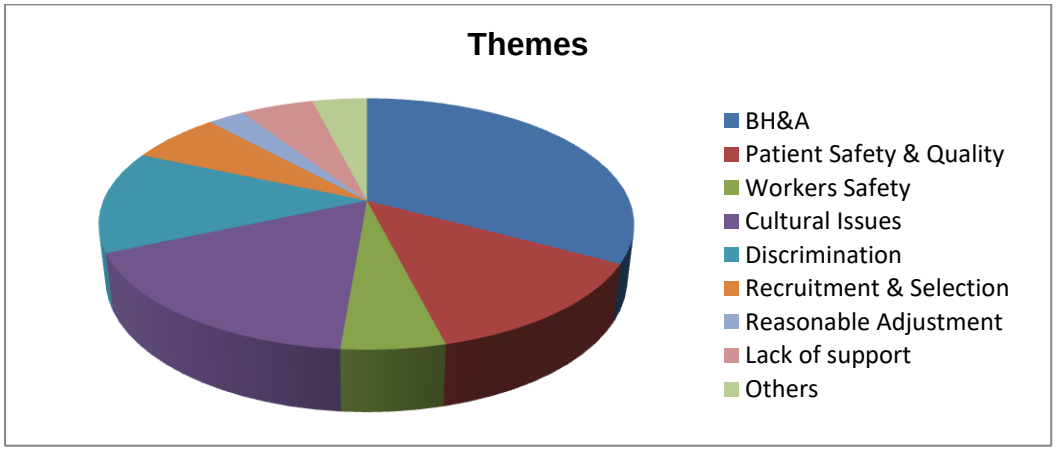
A gap analysis against NHS Improvement guidance shall be undertaken to support the development and design of ENHT FTSU strategy and priority plan. The new National FTSU strategy is being developed by the National Guardian's Office (NGO) and this will be comprehensively considered before reviewing and updating our current policy. We plan to launch a new ENHT FTSU strategy in Sept 2022 that will crucially incorporate the NGO recommendations to promote psychological safety in the work place and speaking up.

The Freedom to Speak Up Office

The Trust appointed a full time Freedom To Speak Up guardian in Dec 2021. The FTSU case numbers for 2021 increased significantly from 30 in 2020 to 90 in total in 2021.

Bullying and harassment has been a predominant theme, as illustrated in figure 35 below. Other major themes were patient safety and quality; discrimination and cultural difference, both of which can cause issues within the working environment.

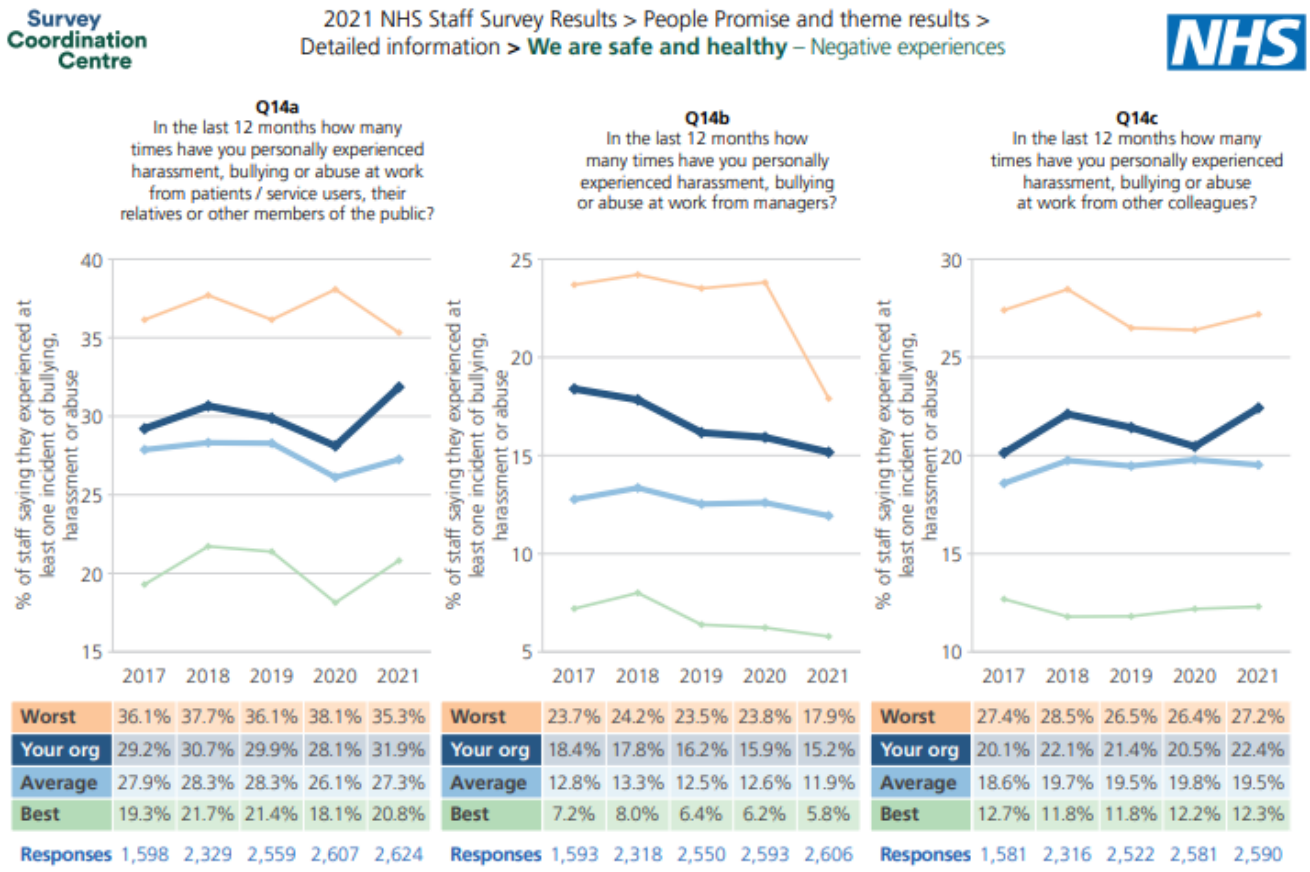
Figure 35 Themes reported in 2021/22 through the Freedom to Speak up Office



Recent staff survey results (2021) whilst evidencing some improvement, demonstrate that bullying & harassment continues to be an issue with our organisation and our scores are higher than the national average score (figure 36).

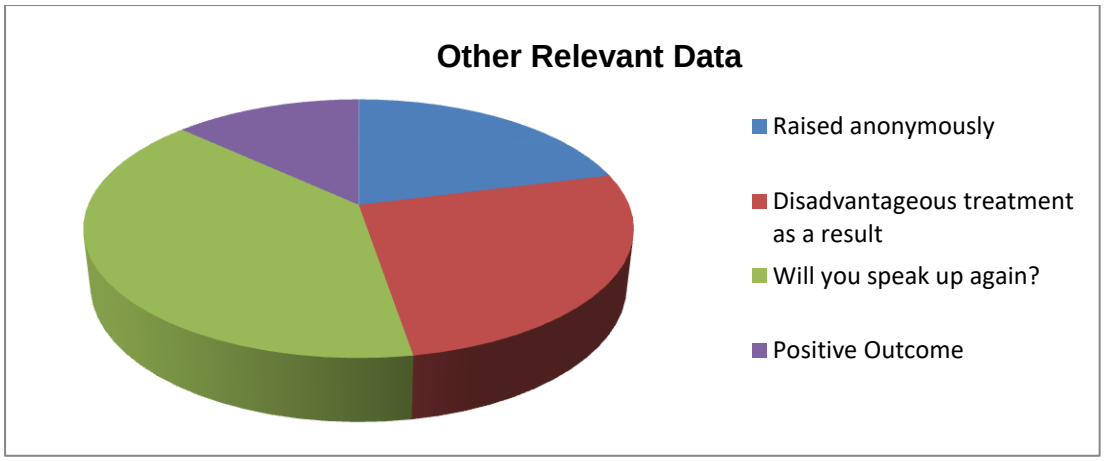
Whilst it's encouraging to know that our colleagues are speaking up, we have more work to do to achieve our goal of 'speaking up becoming business as usual'. We need to continue to foster speaking up culture and do more to support colleagues who have the courage to speak up.

Figure 36



The data in figure 37 below gives some assurance that 33%, (a third of all cases) of colleagues who have spoken up are willing to speak up again. The report also showed 22% of our colleagues have suffered some detrimental effect as a result of speaking up. Likewise, 17% of cases were raised anonymously; this presented a challenge in terms of investigating the matter as well as providing effective feedback. 11% of colleagues reported a positive outcome they were satisfied with, which could mean others may not be satisfied.

Figure 37



Black, Asian, Minority Ethnicity Pilot, NHSE/I

East and North Hertfordshire NHS Trust volunteered to be one of the pilot sites after undertaking a FTSU Board review with Advocacy & Learning team colleagues.
In May 2021 NHSE/I set out a proposal to work collaboratively with three pilot sites and other NHSE/I colleagues to:

- Raise awareness of FTSU with BME workers and build confidence in the speaking up process.
- Advise on how the FTSU guardian recruitment process can be more inclusive
- Understand some of the specific challenges that BME staff face to speaking up and what would make it easier for them to speak up
- Support organisations to develop an action plan for continuous improvement.

The 2 x 2 half day workshops were held on 28 October 2021 and 3 November 2021: one in the morning and the other in the afternoon. The workshops followed the same format for each session and had the following attendance;

- Workshop 1: 16 attendees
- Workshop 2: 11 attendees
- Workshop 3: 17 attendees
- Workshop 4: 24 attendees

Workshops 1 to 3 were aimed at BME workers and Workshop 4 was open to workers from all ethnicities.

The main observations coming from the pilot were as follows:

- Participants from this pilot were not as vocal as other pilots. When explored in greater depth there were no real reasons for that but it was noted by facilitator.
- There were a couple of concerning stories of issues that happened during Covid-19 and BME staff being penalised for this.
- There was less acknowledgement of champions. Some staff were not aware of FTSU champions and guardians and publicity of FTSU could be more forthcoming
- The fourth workshop was open to all workers and there was a marked difference in the type of conversation at that workshop. It was noted that a number of participants were from a higher band and the issues discussed were more around managers and senior leaders, whereas lower banded attendees' focus was around their own managers and more HR type issues.
- It was noticeable from the fourth workshop that attendees in breakout rooms did not have as many major issues with their managers

Recommendations and actions shall be included as strategic priority actions though 2022/23 FTSU office progression.

Freedom to speak up champions

Our organisation's commitment to ensuring an open, civil, inclusive and collaborative culture will be evidenced through our Trust's FTSU champions, who will work with FTSU Guardian in collaboration with the staff engagement team to play a key role in encouraging staff to raise concerns at the earliest opportunity. The FTSU Guardian will support our champions and the people team will help develop a network of FTSU champions throughout the organisation.

FTSU champions will:

- Act as an independent and impartial source of advice to staff at any stage of raising a concern.

- Champion and raise awareness of FTSU and the value/ benefits to staff experience and patient safety.
- Be visible and accessible to staff within their departments.
- Raise the FTSU profile by attending Trust events and meetings
- Instil confidence that concerns will be listened to and addressed, regardless of job role or personal background/characteristics.
- Escalate and report issues to the FTSU Guardian in a timely manner, and in particular report serious issues (such as those with legal, safeguarding or professional implications) to the FTSU Guardian or a senior manager without delay.
- Ensure confidentiality is maintained on all issues raised.
- Support the FTSU Guardian with providing feedback to staff on the outcome of investigations into the concerns they have raised.

Rota gaps

Gaps to rotas of doctors and dentists in training are monitored on a monthly basis. The table below shows the total number of rota gaps across all specialties in the financial year April 2021 to end March 2022.

The average junior doctor rota gap is similar to last year, with an average of 11.5 per month.

Month	Total Vacant Trainee Posts
April 21	**2**
May	5
June	8
July	10
August	8
September	8
October	12
November	12
December	19
January 22	18
February	20
March	16

Actions continue to be taken to improve vacancies:

Direct

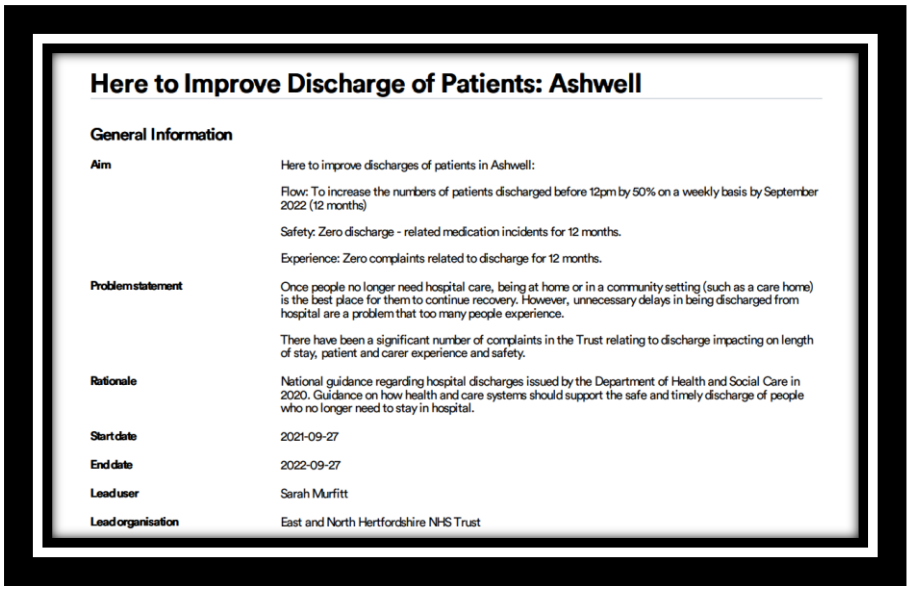
- Recruitment of Trust Grade, Clinical Fellows in temporary posts
- Recruitment of other training grades (e.g. MTI – medical training initiative for foreign doctors)
- Recruitment of temporary Locums to cover gaps and provide the clinical service

Indirect

- Improve or enhance training posts to make posts more attractive to schools
- Reconfiguration of rotas to optimise the number of trainees on each

Annex 1 Examples of Quality Improvement (QI) projects and initiatives

Discharge QI project

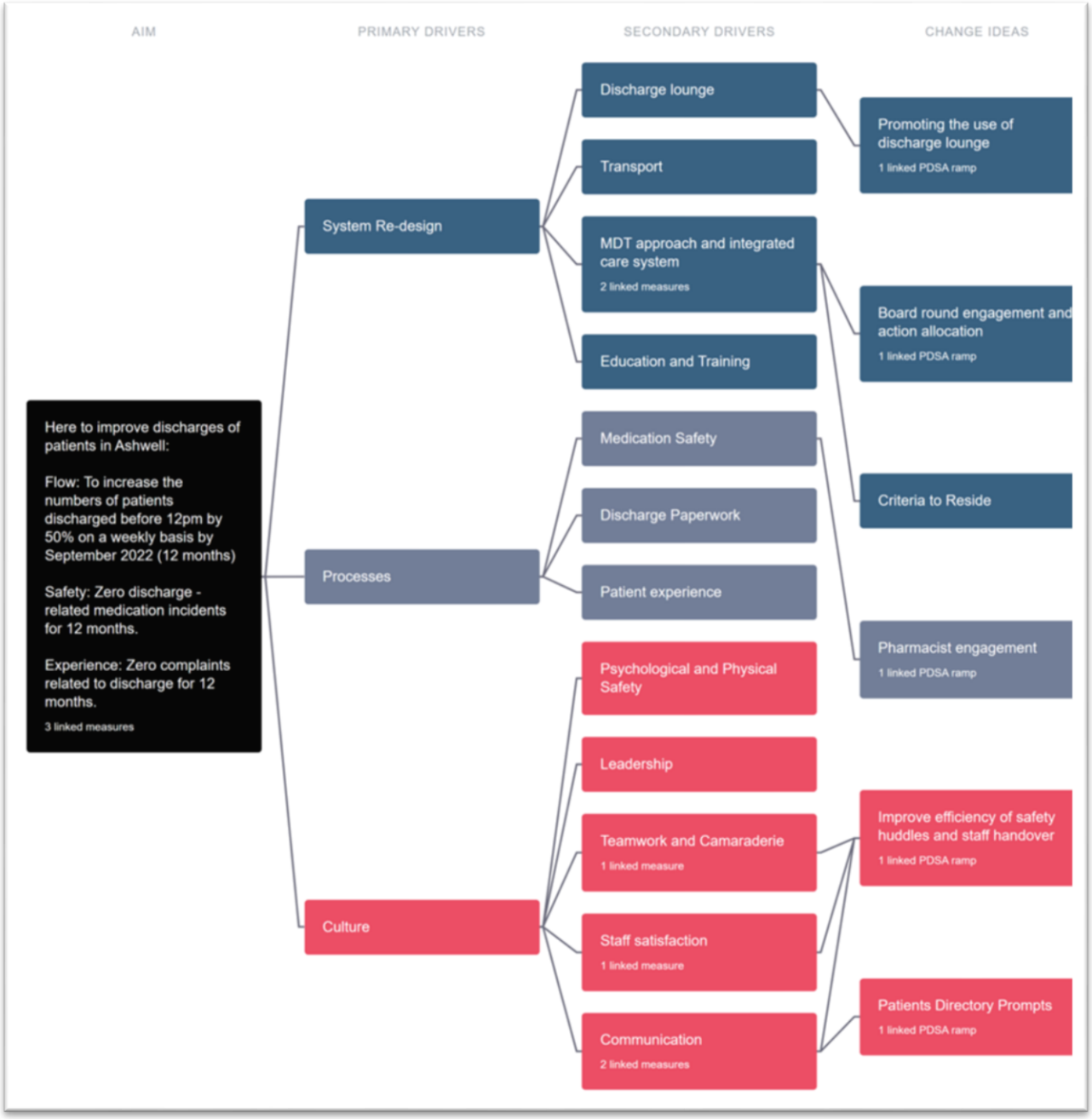


Here to Improve Discharge of Patients: Ashwell

General Information

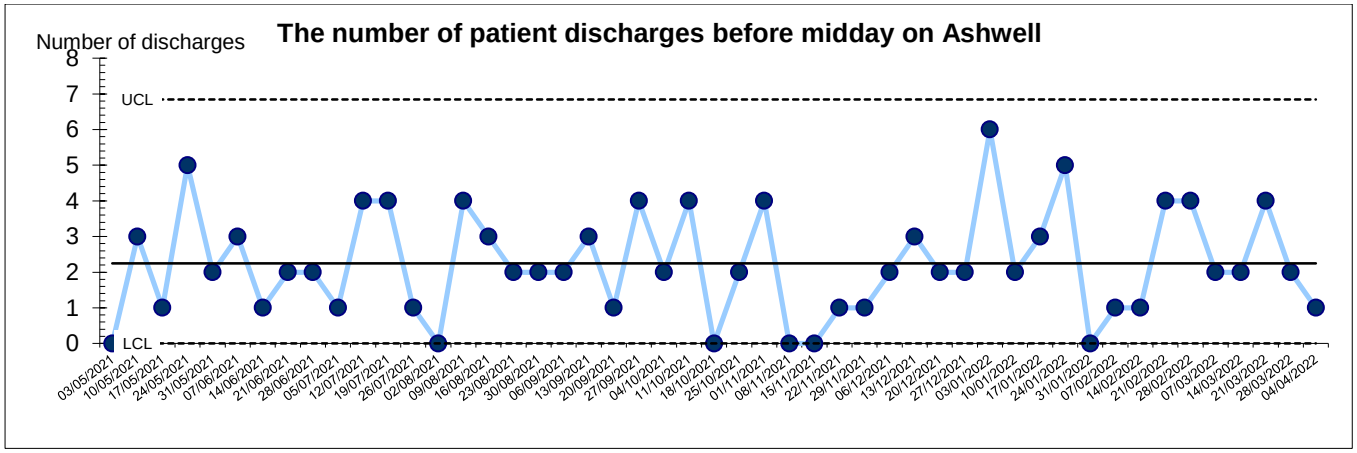
Aim	Here to improve discharges of patients in Ashwell: Flow: To increase the numbers of patients discharged before 12pm by 50% on a weekly basis by September 2022 (12 months) Safety: Zero discharge - related medication incidents for 12 months. Experience: Zero complaints related to discharge for 12 months.
Problem statement	Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. There have been a significant number of complaints in the Trust relating to discharge impacting on length of stay, patient and carer experience and safety.
Rationale	National guidance regarding hospital discharges issued by the Department of Health and Social Care in 2020. Guidance on how health and care systems should support the safe and timely discharge of people who no longer need to stay in hospital.
Start date	2021-09-27
End date	2022-09-27
Lead user	Sarah Murfitt
Lead organisation	East and North Hertfordshire NHS Trust

Below is a driver diagram of primary drivers in the system identified to support improving the quality and safety of discharges from the hospital, influencing across wider health care systems.

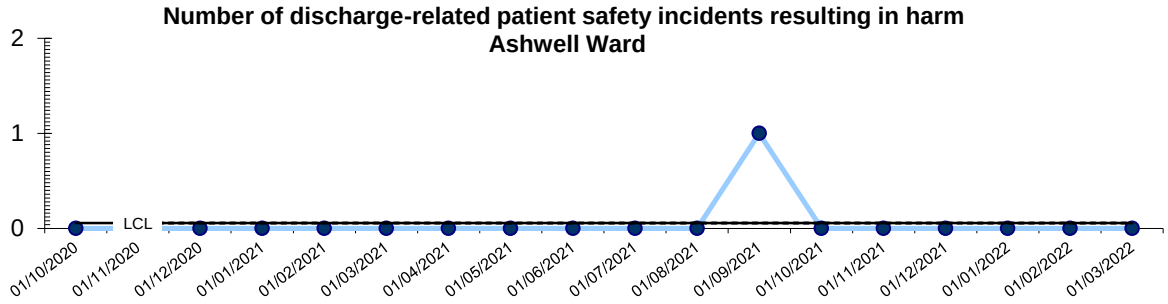


Discharge quality improvement family of measures:

1. **Patient Flow:** Improving the timely discharge of patients before midday on Ashwell ward. The chat below shows common cause variation between 1-6 patients, and an average of 2 patients each day discharged before midday.

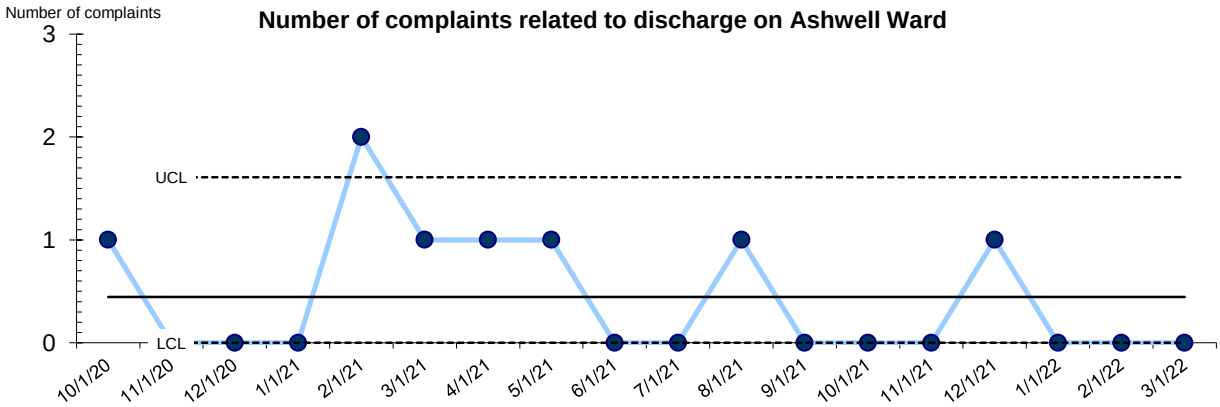


2. **Patient Safety:** The Ashwell ward leader started this project following an incident resulting in harm to a patient in September 2021. To date, the ward has not had any further discharge –related incidents resulting in harm to patients.



3. **Patient experience –** formal complaints

Formal complaints are tracked through the complaints team; the chart below shows Ashwell ward received 6 complaints related to discharge in the first 6 months October 2020-June 2021, and only 2 complaints related to discharge July 2021 – March 2022



Evaluation of the improvement project

Challenges:

- Communication between team members
- Data collection was a challenge and some data cleansing is required
- Staffing sickness
- Capacity of team members to test new ideas

Enablers:

- Very motivated and committed team and leader
- Involvement of clinical and non-clinical team members
- Respect for other team members time and boundaries and have been completing the actions agreed upon.

The impact of the project will be reviewed at completion in 2022. There have been nil discharge-related medication errors in the last 5 months on Ashwell ward. Qualitative feedback has been positive about medications for discharge being completed earlier in the process.

Learning and next steps:

- Collaboration between all members of the team is essential.
- Coaching reported as an enabler.
- Improving QI capability among team members may lead to faster progress.
- The board rounds have been successfully implemented.
- The team allocated a communication space to post updates about the project. This allowed the team to celebrate learning and learn from failures.
- Currently, the ‘criteria to reside’ portion in nerve centre is not completed consistently as the ward has no dedicated patient flow coordinator.

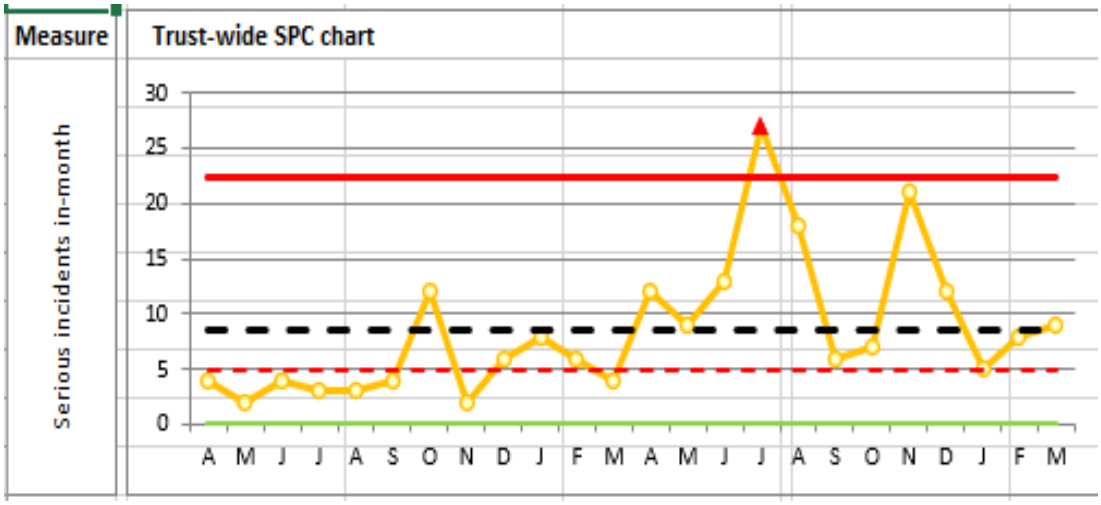
Progress on Outcomes/HFC Programme Goals 2021/22:

Refer to table below for progress on HFC Programme April 2021/22:

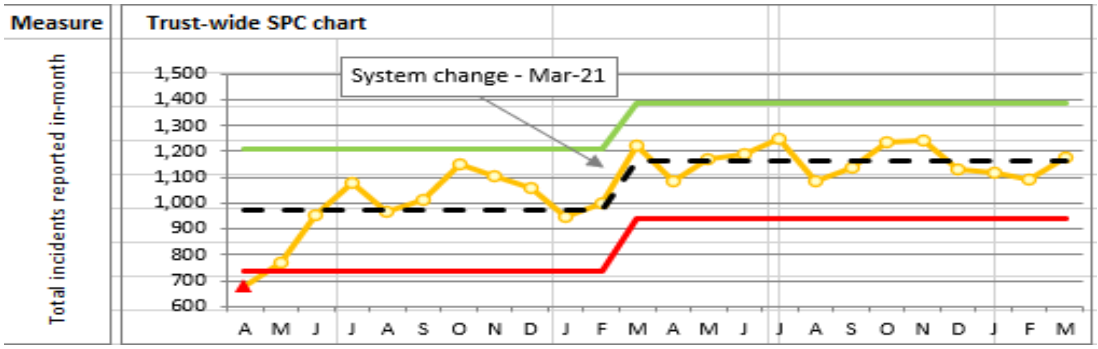
HFC Goals 2021-2024	July 2021	March 2022
1. All 6 HFC safety work streams to complete minimum 1 QIP by April 2022, target 6 QIPs by April 2022 with a minimum IHI score of 3.5 – 5	• Currently QIPs with IHI score of 1.5 -2.5	• 2 QIP : 1.5 • 2 QIP: 2.5 • 3 QIP: 3 - 3.5
2. 100% of HFC leads completed bitesize QI and coaching/ leadership in QI training by April 2022, [Based on Dosing formula], by April 2022,	• All HFC leads completed bitesize training • 3/6 have access to IHI licenses	• All HFC leads access to IHI licenses • All HFC leads have access to QI coaching (minimum two/month)
3. All HFC leads have involved minimum of 1 service user in QIP, target 7 (including programme partner), by April 2022	• 2/7 involved (including programme partner)	• 3/7 involved in QI projects (including programme partner)

The aim of the programme was a 50% reduction in Trust wide serious incidents (moderate and serious harm combined) from monthly average of 8-4 by April 2022.

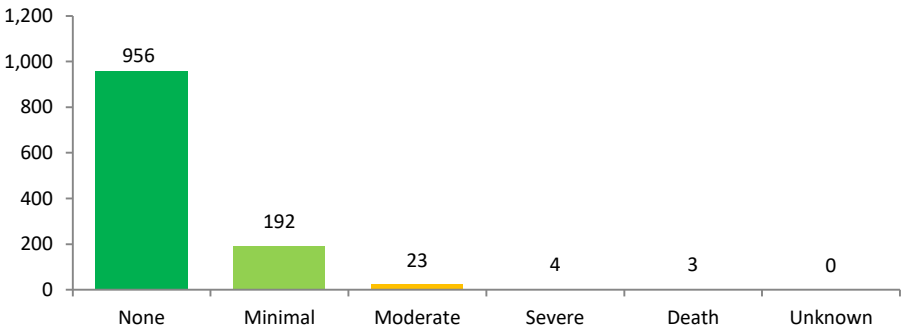
The chart below shows an average of 8 Serious Incidents (SIs) were reported per month, with a variation seen in July 2021, due to an increase in the reporting of hospital onset Covid-19 infections.



A 5.50% improvement in Trust wide incident reporting has been seen through an increased monthly average of 1110 to 1665 average per month, by March 2022.



97% of all incidents reported were low or no harm.



Summary of HFC Programme:

Enablers:

- Improved improvement capability and standardised use of our methodology i.e. 7 Step model of continuous improvement has proven successful. HFC programme score progressed from IHI score of 2.5 to 3 indicating over 20% improvement in 4/6 harm specific processes.
- Use of data to drive better clinical decisions
- Governance in place to deliver the programme
- Regular QI coaching for HFC leads and project teams has demonstrated a strong positive relationship between benefits of coaching and progress with projects

Barriers:

- Variation in organisational capacity and conditions for undertaking improvement
- Significant variation remains in Trust wide site safety communication and safety culture amongst frontline teams. This learning has been identified during PDSA cycles of testing on various wards, highlighting variation in awareness of risks, communication and responsiveness to safety critical information on wards.
- Variation in multidisciplinary team working on wards

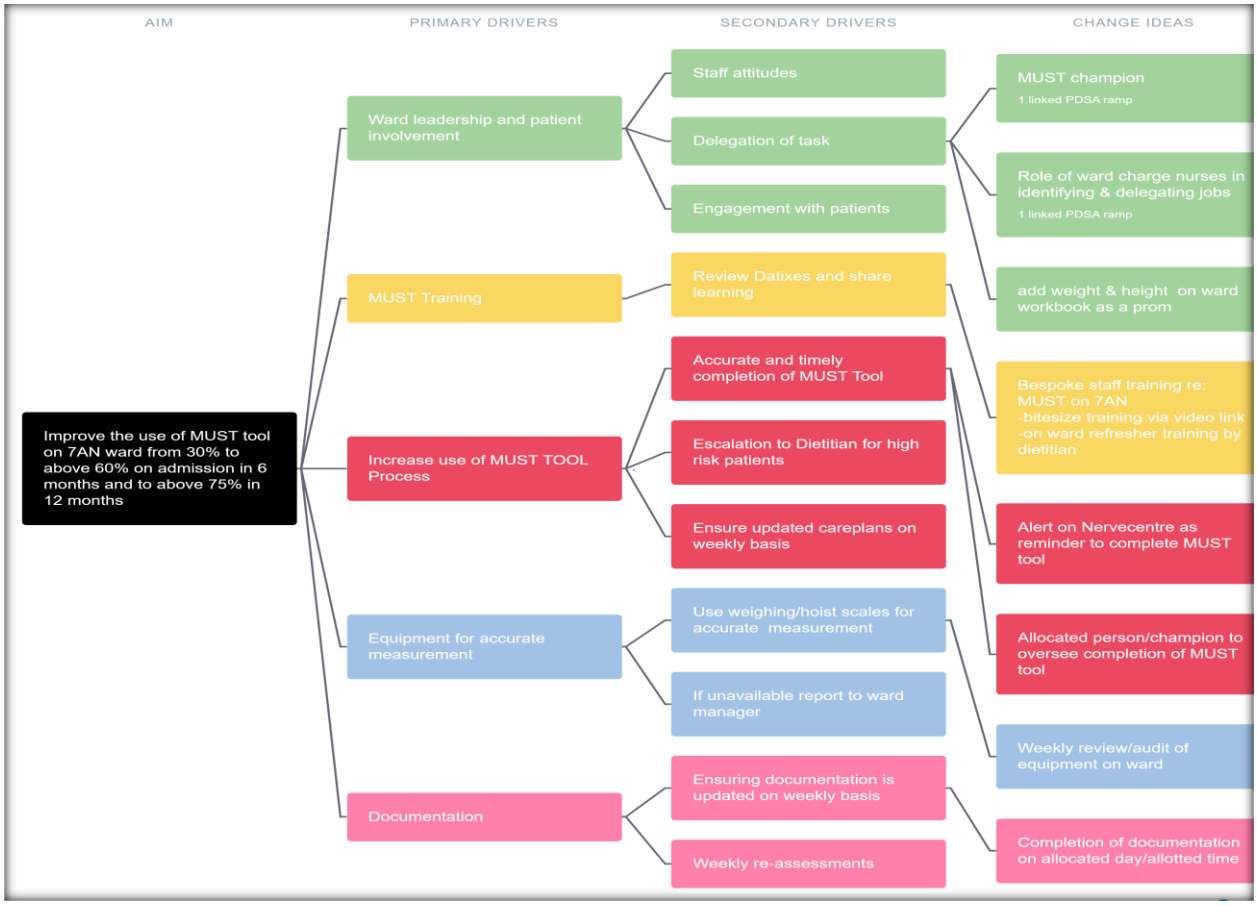
Example of Nutrition & Hydration QI project in HFC programme: ward 7A

Background: Use of MUST (Malnutrition Universal Screening Tool) is important to reduce risks associated with malnutrition and dehydration such as impaired wound healing, increased risk of infection, longer hospital stay as well as poor patient experiences. National guidance suggests malnutrition accounts for approximately 30% of hospital admissions and costs the NHS £19.6 billion per year. The Trust wide audit of the use of MUST in March –April 2021, demonstrated a compliance of only 30-40% of MUST on level 7 and 9B wards on admission. Learning themes identified: variation in accurate measurements, lack of equipment and poor documentation of follow up care plans. Additionally, a lack of MUST measurement plan and formalised training for MUST were other areas identified as requiring improvement. This triggered a quality improvement (QI) project on 7a ward to improve safety and effectiveness of processes on the ward.

AIM: To improve use of the Malnutrition Universal Screening tool on 7AN ward from 30% to > 60% on admission in 6 months and to > 75% in 12 months.

Project Team: 7AN ward team adopted the 'Here to Improve' seven step model for continuous improvement to structure the project with support from a QI coach and partnered with Hertfordshire Community Trust (HCT) colleagues i.e. Acute Dietician lead who provides an in reach service to ENHT.

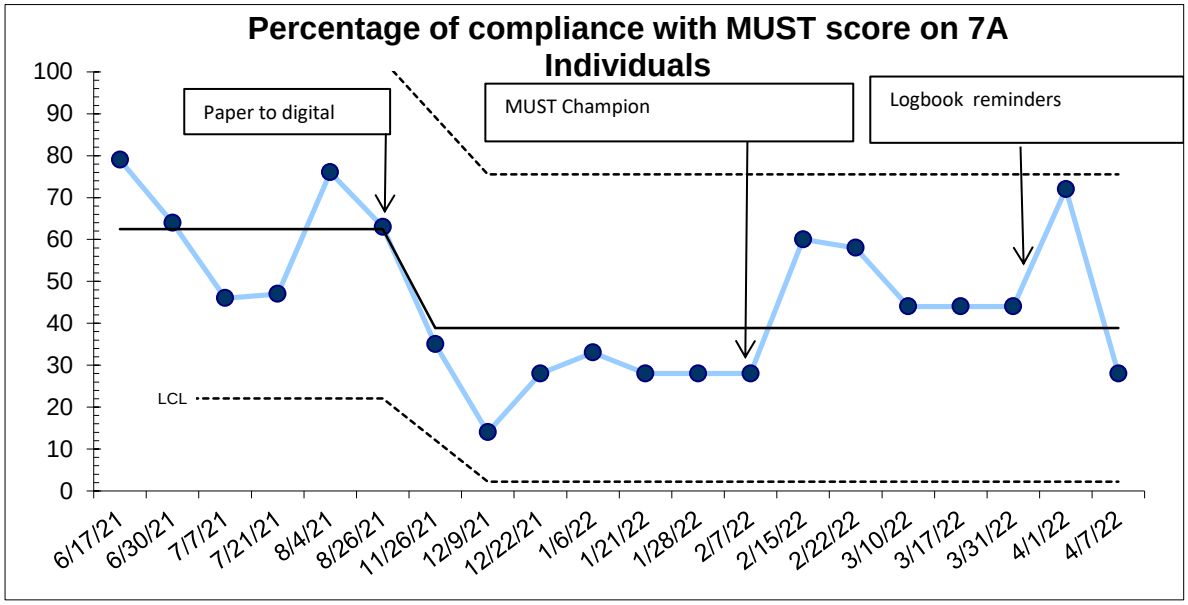
The driver diagram below highlights the primary drivers in the system identified to drive improvements through tests of change.



Measures: The % of patients with a completed MUST risk assessment on admission to the ward within 24 hours.

Change ideas: Teams have developed a theory of change and Plan-Do-Study-Act (PDSA) cycles to test change ideas such as role of MUST champion and role of shift charge nurses to put reminders in the log book as a way of prompting staff to complete their risk assessments. Currently data has demonstrated common cause variation, figure 38 and learning from PDSA cycles are being incorporated in further tests of change.

Figure 38



Summary: Over the year, focus has been on building awareness and engaging ward staff. The project teams have developed a robust measurement plan for MUST, and a Trust wide MUST training package is on ENH Academy

Wins: The QI approach was systematic and supported the development of a measurement plan and a Trust wide MUST training package. The project IHI score has progressed from 0.5 – 2.5 over the last year and the team has put structures and processes in place with plans to continue to test ideas for the year ahead.

Enablers/Learning: from QI work (enablers) has further resulted in

- An increase in collaborative and integrated partnership working with our Hertfordshire Community Trust (HCT) colleagues over the last year.
- Team engagement in 'change' through embedding weekly debrief QI team meetings, has resulted in early signs of collective engagement and ownership of the project from frontline staff.
- Consistent support and involvement of ward leader and matron has been crucial to the delivery of the work on the ward.

Challenges/Barriers to Improvement:

- Variable capacity and time i.e. variation in conditions to deploy and test improvement ideas on ward
- Staff engagement has been challenging on the ward
- Silo working and variation in how communication re QI work/learning has been cascaded to all frontline staff on the ward

Feedback from HCT Acute Dietitian lead on using QI and partnership working with ENHT.

‘’Initially I had little experience of QI work so it has been a learning curve. Previously quality improvement work has been attempted within the department but with little understanding or knowledge of how these improvements can be sustained longer term. Therefore, it has been interesting to understand the theory behind successful quality improvement in terms of how to test an idea, ways to engage staff with the project and developing some resilience so if one idea doesn’t work, there will always be another idea or angle to approach from.’’

Trust wide Nutrition and Hydration Quality Improvement plans

1.Awareness on Nutrition and Hydration – In March 2022, as part of Nutrition and Hydration week, the dietetic team targeted some of our inpatient wards to try and understand what staff felt about MUST and check their understanding of it and any barriers they were facing. This feedback will inform the future improvement work .

The team had also put some key messages in our Trust wide bulletin; the aim was to endorse ‘Nutrition and Hydration’ week and our focus on MUST was to create more awareness around the tool. Over the summer ward dieticians will continue to raise awareness and offer refresher/bitesize sessions to ward staff.

2. Capability building update: The Trust wide MUST training package is ready to go live on our ENH academy over the summer. Data on ENH academy will be monitored for uptake of training by staff. Plans to add an additional video are also in place to focus on how to complete MUST on Nerve centre .Our aim is to improve adoption of digital MUST assessments and care plans as part of our ‘Keeping our patient safe’ digital programme - Also, it has been agreed that the nutrition assessment nursing proforma (NAP) is going to be joined with the MUST tool which should lead to better compliance rates as staff will be prompted to fill in the assessment and MUST tool following some preliminary questions in the NAP.

3.Additional Quality Improvement plans: QI work on testing a process for developing a volunteers feeding competency framework is to commence on Elderly care wards. A pilot QI project begins over the summer of 2022 aiming to provide safe Nutrition and Hydration care for patients with general feeding needs supported by our volunteer service.

Discharge programme

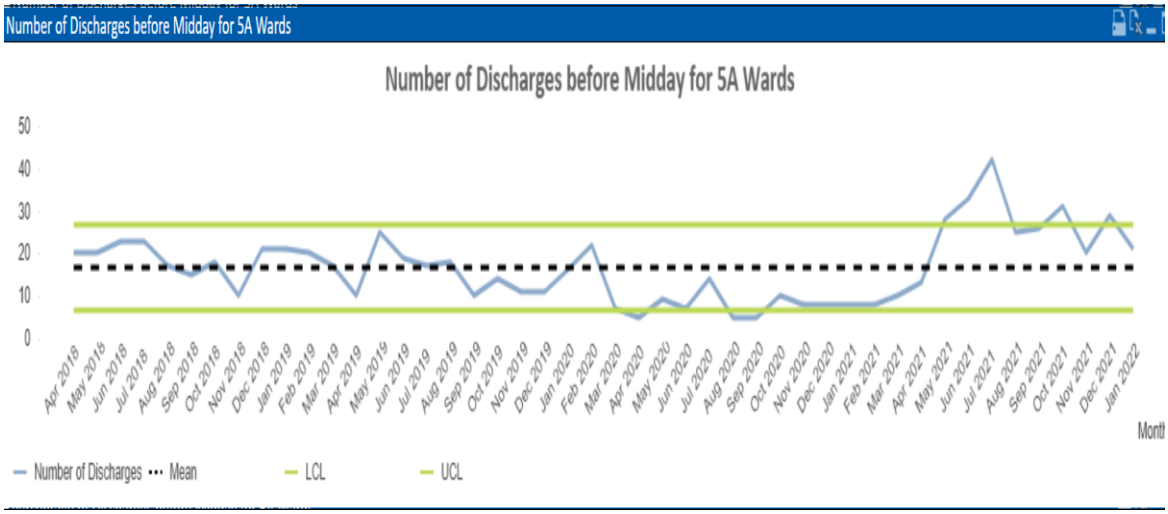
Aim: Improving the flow, safety and experience of discharge by end of March 2022

- Flow- 1 discharge before 12pm daily
- Safety – Reduce discharge clinical incidents resulting in harm by 50%
- Experience- Reduce complaints including discharge related issues by 50%

Driver diagram:

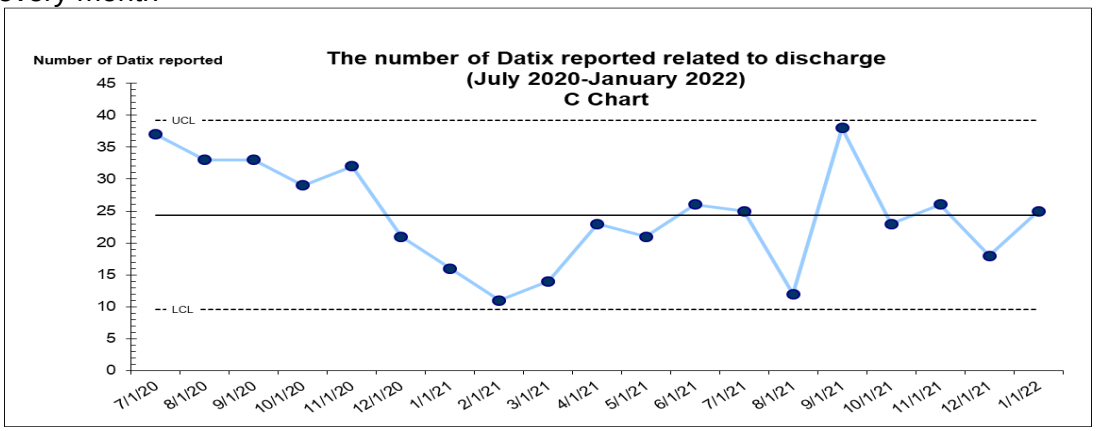
Measurement

1. Flow- discharges before 12. This was improved on ward 5A and no change on Ashwell or 8A and the number decreased on 6A and 10B

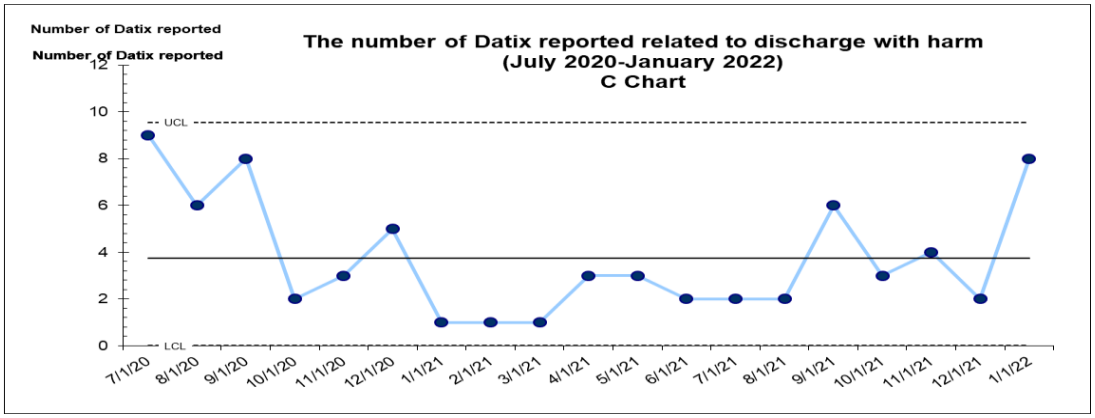


2. Safety:

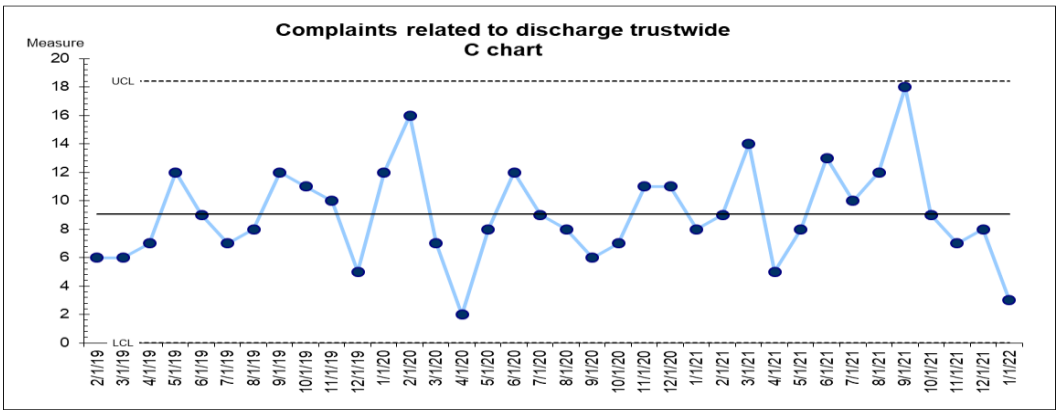
Incidents related to discharge- no change in numbers in the Trust overall with a mean of 24 every month



Incidents with harm related to discharge also showed no change apart from during Covid-19 which we suspect was due to a reduction in reporting overall



3. Experience- no reduction in the number of complaints related to discharge



Barriers to improvement:

- National guidance only which needed to be adapted for local use, no local discharge policy and clear definitions of board round, MDT, EDD
- True collaboration and identification of what good looks like from board to ward could not be agreed
- Digital-Ease of use of the digital passport, discharge letters on Lorenzo
- Capacity to do improvement work as a team
- Fatigue and burnout in our team
- Communication and messaging about operational pressures and how clinicians should respond can be improved
- Accuracy of data to be investigated- local records of those discharged to discharge lounge and those recorded on Qlickview show discrepancies

Enablers for improvement:

- Focus on safety and experience resonates with teams
- Communication between the teams and the patients and carers can lead to improved safety and experience
- Training required in national policy terminology and implementation
- Digital systems supporting human factors

Deteriorating patient programme

The sepsis, critical care outreach, acute kidney injury and resuscitation teams work together with our associate directors of safety to run improvements in their teams. They are also required to support the Trust to make improvement towards the outcomes of our deteriorating patients. Plans to run a collaborative across the Trust have been affected by the capacity to do this in our clinical teams. These subject matter experts and teams offer training and support to the clinical teams in the Trust however this is yet to be formalised into a larger number of improvement projects. The teams are testing and learning ideas on ward 7B around improving reliability of observations and escalations based on these observations.

Learning has included:

- The need to simplify some procedures, for example procurement of safety equipment by ward leaders.

- Safety risks emerge /become apparent when training capacity is reduced within clinical teams
- Reduced capacity for multi-disciplinary teams to work together to test new ideas for change.

Patient and carer experience programme

In 2021-2022 we set up and ran the 'what matters to you?' volunteer team. This was in response to several different circumstances:

- Visiting remained restricted due to Covid-19 infection prevention and control guidelines/policy.
- Demand for acute services was high
- Capacity was often affected by isolation required for Covid-19 positive staff members
- Well-being of the teams was a consideration due to the pandemic and the resulting stress levels inside and outside of work

We acknowledged all of these factors may have an impact on patient and carer experience. To this end we set up the 'what matters to you?' team with the help of some funding for a coordinator from the East and North Hertfordshire Charity. The role of the coordinator was to set up a team of volunteers to do three things:

- Book and carry out virtual visiting
- 'What matters to you' conversations- ask, listen and do what was within their remit and handover to the clinical teams if this was outside of their remit
- Data collection for improvement- support the collection of Friends and Family Test (FFT) data and 'what matters to you' data in order to drive patient and carer experience projects

Outcomes and measures are covered in the patient and carer experience sections of this report.

Annex 2 Clinical Audit- actions to improve healthcare

The reports of 15 national clinical audits were reviewed by the provider in 2021/22 and ENHT intends to take the following actions to improve the quality of healthcare provided.

National clinical audits reviewed by the provider in 2021-2022	Actions ENHT intends to take to improve the quality of healthcare provided
NCEPOD - Know the score - A review of the quality of care provided to patients aged over 16 years with a new diagnosis of pulmonary embolism (15779)	• Discuss BNP protocol with Cardiology & Medical Director • Discuss formalising a PE treatment network at Divisional Board
MBRRACE-UK Perinatal Confidential Enquiry Stillbirths and neonatal deaths in twin pregnancies (15867)	• Update trust guideline • Implement the Perinatal Institute Bereavement notes checklist • Contract agreed with Cambridge for perinatal pathology
MBRRACE: Confidential Enquiries Maternal Deaths & Morbidity - Saving Lives, Improving Mothers' Care (audit period 2016 to Sept 2018) (15870)	• Update trust guideline
MBRRACE-UK Perinatal Mortality Surveillance Report (15872(2))	• To undertake a review of 2020 PM uptake, including ethnicity and deprivation for discussion at next PMRT meeting
NCEPOD Acute Bowel Obstruction Delay in Transit: A review of the quality of care provided to patients aged over 16 years with a diagnosis of acute bowel obstruction (Published January 2020) (15905)	• Provide consistent hydration status measurement & documentation across all wards • Agree joint clinical network pathways of care that enable improved access to stenting services
NCEPOD Time Matters: A review of the quality of care provided to patients aged 16 years and over who were admitted to hospital following an out of hospital cardiac arrest (16093)	• To procure targeted temperature management equipment
National Diabetes Audit, 2019-20 Type 1 Diabetes, England and Wales (16118)	• Business plan agreed to expand workforce to increase numbers on pump
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) Children and young people asthma clinical and organisational audits 2019/20 (16167)	• To procure Feno device • Review clinic capacity • Review requirement for specialist nurses
MBRRACE-UK Perinatal Mortality Surveillance Report 2019 (UK Perinatal Deaths for Births from January to December 2019) (Published 14th October 2021) (16394)	• Training on signs of life for incorporation into annual bereavement training programme
The National Hip Fracture Database Report 2020, Falls and Fragility Fracture Audit (FFFAP). Based on data: between 2017 and 2019 (16689)	• To increase pre & peri- operative use of assessment benchmark/bone protection table & anaesthesia run chart
National Perinatal Mortality Review Tool: Learning from Standardised Reviews When Babies Die - Third	No actions required as meeting audit recommendations

Annual Report. (Published: 13th October 2021) (16752)	
National Diabetes Inpatient Audit (NaDIA) Harms 2020 - Annual Report (16788)	• Formal Clinical Governance meetings in progress with leads to improve identification of people with diabetes on admission to hospital
NCEPOD - Inspiring Change: A review of the quality of care provided to patients receiving acute non-invasive ventilation (9341)	• Include a mandatory audit of all acute non-invasive services to the annual clinical audit plan • To review appointment of clinical lead for NIV
Adolescent Mental Health, Focusing on Self Harm (NCEPOD) (9642)	• Plan to upgrade to electronic patient records • To review appointment of clinical Mental Health lead for children and young people • Plan for compatible MH and ENHT software
Maternal, Newborn and Infant Programme: Learning from SARS-CoV-2-related and associated maternal deaths in the UK (COVMBRACE2)	• Remote Consultations for bookings.

The reports of 107 local clinical audits were reviewed by the provider in 2021/22 and ENHT intends to take the following actions to improve the quality of healthcare provided.

Local clinical audits reviewed by the provider in 2021-2022 *(*101 audits listed as 4 audits were audited and re-audited and 1 audit was audited and re-audited twice in 2021-22)*	**Actions ENHT intends to take to improve the quality of healthcare provided**
Use and documentation of tourniquets in operative management of distal radius fractures	Improved documentation of type of tourniquet & pressure parameters to be included in the intraoperative notes.
(Re-Audit of 17674) To assess the appropriateness of cases treated by our local Urgent Eye Care Service during COVID-19, post-intervention	Improve nurse education re eye emergencies, triage and management to empower the nursing staff workforce to deal with ≥50% of the presenting patients without recourse to an Ophthalmologist.
5 years of NovaSure ablation what have we learnt?	Share learning at Clinical Governance meeting as reminder to Hysteroscopists to check endometrial biopsy results.
An Audit into the timing of diagnosis provision on MRI Lumbar spine for a suspected cauda equina syndrome (CES) at Lister Hospital	To raise awareness of CES guidelines. We have updated the proforma for T&O doctors, with information regarding local guidelines for MRI/CES imaging. We have also provided additional CES pathway information via the survey we distributed to ED and T&O staff. The audit results and relevant information were also presented to the department and shared with Radiology clinical director and MSK lead who are currently involved in the a CES

	pathway committee, set up to formulate an up to date trust wide clinically led pathway.
An audit on follow-up for paediatric patients diagnosed with transient synovitis	Trust guidelines fully met no actions identified for improvement.
Anaemia in elderly care - how well were investigations carried out?	Improve staff awareness on what investigations need to be carried out for each anaemia subtype and which teams to contact for further aid on treatment/invasive investigations
Antenatal Care	To improve Midwives: - transcribing of booking bloods and anomaly results into the green notes, - where safe to do so undertake 36/40 C02 monitoring, - ensure staff aware of new Antenatal guideline and it's recent amendments to enhance compliance with the Ockenden asks
Assessing the standard of T&O written operation notes: an audit & departmental quality improvement	Improve operative note recording, typed operative notes will provide better standard of care in relation to clarity of instructions, availability of notes for all responsible clinicians at any time.
Asthma Discharge Care Bundle (Paediatrics)	Improve paediatric staff awareness in of the care bundle (presentation and print our forms for the Children's Assessment Unit and Bluebell ward
Audit of adequate documentation of risk consent in neck of femur fracture patients in accordance to British Orthopaedic Association Guidelines	Improve the documentation of the risks of surgery explained and consented by patients undergoing surgery for fractured neck of femur.
Audit of emergency obstetric anaesthesia practice & outcomes	Trust guidelines fully met no actions identified for improvement.
Audit of Intraoperative Notes for Tooth Extractions under Local Anaesthetic at Lister Hospital	Design and implementation of notes proforma to ensure all the necessary information is documented.
Audit of provision of general anaesthesia for obstetric procedures	Identify process to enable all obstetric general anaesthetic cases to be reviewed. Add RCoA specified adverse effects to Epidural Audit System.
Audit of tonsillectomy day-case and readmission rates	Performance within national standards, no actions identified for improvement.
Audit on compliance with national acitretin prescribing guidelines re-audit	Audit results to be shared and acitretin prompt to be recirculated.
Audit on guidelines for management of Squamous Cell Carcinoma Re-audit	Share audit results, and remind the surgical excision is appropriate for the clinical features of the tumour and clearly documented in the medical notes - with team and create posters for minor op theatre room.
Audit on Post dural Puncture Headache (PDPH)	Improve CLU Anaesthetic staff awareness of RCOA quoted risk of PDPH and achieve appropriate clinical training to achieve this outcome.

Baby Friendly Assessment re-audit - Infant Feeding: Mother interviews using the UNICEF audit tool	Increase antenatal and postnatal conversations which give women the information to make informed decisions and help them be successful at breastfeeding.
BAD Photodynamic therapy Re-audit	Review protocol and increase staff awareness re initial clearance rates of actinic keratosis, Bowen's disease and superficial BCC at 3 months after last treatment.
Blood Pressure Monitoring Audit	Increase staff awareness of need for more consistent blood pressure monitoring at the time of admission.
Cancellation of Orthopaedic elective theatre patients due to urinary tract infection - An Audit	Current pathway fully met no actions identified for improvement.
Clinical Audit Of Change In Practice With Intracorporeal Ureteric Stents At Lister Hospital	Reduce incidence of blocked stents by routinely use Bander stent for every patient.
Combined Audit - EP C, EP I.1 & EP I.3 for Treatment	Remind staff of importance of checking Treatment Verification Log
Combined Audit - EP C, EP I.1 & EP I.3 for Pre-Treatment	Confirmation of consent and pregnancy task to be added to the pre-treatment pathway on Carepath. Reminder training for Radiographers re process for checking patients have been giving written information.
Covid Mortality among Neck of femur fracture and Periprosthetic fracture patients during the 2nd wave - A review and re-audit	To improve covid testing pre-op and to ensure patients get uninterrupted Orthogeriatric input post-op.
Criteria Led Discharge Form Audit	Improve clarity of documentation re when a patient is safe for discharge to empower nurse led discharges were possible.
DESCENT: Departmental Evaluation of Scrotal Imaging Considering European and National Testicle Guidelines	Addition to be made to ICE requests to prevent inappropriate ultrasound scan requests being made and review scan requests process with GP liaison team.
Do you know what 'nil by mouth' really means?	Remind staff that correct medications need to be given for nil by mouth patients and need to predict theatre timings to reduce prolonged period of nil by mouth for patients.
Early management of Tonsillitis/Quinsy patients within 1 hour of presentation in ED to reduce number of hospital admissions	Review process for ensuring all tonsillitis/quinsy patients receive initial treatment in A&E to reduce unnecessary admissions.
EP A Pt 1 - Patient Identification Compliance - pre-Treatment	Revisit training of photo ID process to improve cross checking patient photo among other radiographers prior to upload. Amend protocol to ensure camera photos always deleted immediately after upload.
EP A Pt 2 - Patient Identification Compliance	Organise refresher training/presentation of patient identification procedure
EP B.1 - IR(ME)R Operator Audit	Competency framework to be

	implemented to define each bioengineers scope of practice.
EP B.4 - IR(ME)R Justification and Authorisation of Concomitant Exposures	Refresher training for all operators to improve justification, authorisation and documentation of additional imaging.
EP D.1 Radiotherapy Dept Policy Developing Standard Operating Procedure Documents	Procedure fully met no actions identified for improvement.
EP D.3 Clinical Audit	Procedure fully met no actions identified for improvement.
EP F - IR(ME)R Procedure for Diagnostic Reference Levels Audit	Procedure fully met no actions identified for improvement.
EP K Reduction of probability and magnitude of Radiation Incident	Improve follow up and evidence for acceptance testing and clinical trials audits.
EP L IR(ME)R Procedure Incident Reporting	EP L IR(ME)R Procedure Incident Reporting and EP L document to be updated to reflect update to procedure.
EP M IR(ME)R Non Medical Exposures Audit	Audit criteria fully met no actions identified for improvement.
EP N IR(ME)R Procedure Comforters and Carers Audit	Procedure fully met no actions identified for improvement.
Excision rate audit for BCC and SCC - reaudit	Audit criteria fully met no actions identified for improvement.
External Cephalic Version (ECV) re-audit	Update leaflet and procedure to increase awareness re all scans performed within last two weeks are valid for ECV purpose.
Febrile Neutropenia - New Risk Stratification Pathway	Refresher training for clinical team to cover identification of eligible patients for the NRS pathway, improving early IV antibiotic administration and use of oral antibiotics.
Flexor Tendon Repair Audit	Revisit importance of; meticulous care in writing the op notes, coding documentation for the procedures and measuring the range of movement for the affected joints and the TAM. Repeat audit annually.
Foreign Body Artifact causing dilemma in X-Ray based diagnosis of Hand Injuries	Reminder to all staff to ensure removal of jewellery prior to Hand X-Rays to avoid issue in X-Ray based diagnosis of Hand Injuries.
Fragility risk assessment and Re-audit	Refresher training to increase awareness of FRAX score and fragility risk assessment.
Gestational Diabetes Management (GDM) re-audit	Add 1 more Joint weekly clinic to manage the increasing demand and to enhance patient experience by reducing the movement of patients between different clinics.
GP 31 Scheduling of Treatment Task Carepaths	Review and rewrite parts of document and implement recommended changes to current site specific Carepaths - GP 31.
GP23 – Carepath Tasks for Radiotherapy Patients	Audit criteria fully met no actions identified for improvement.

GP3 Uniform Policy in the Radiology Department	Staff reminder of no coloured undershirts and correct below the elbow hygiene technique.
GROW GAP re-audit	Further targeted training for Community Midwives on saving babies lives care bundle.
Guidelines for management of cutaneous warts re-audit	To share and discuss the re-audit results with the team as guideline refresher training.
Intensive Care Unit - Re-audit of review of the post-take ward rounds	Update clerking proforma with parent team information/involvement. Update the Induction booklet to help train newcomers of their responsibilities.
Intrathecal morphine versus diamorphine in spinal anesthesia for Cesarean sections	Refresher training on measures to reduce postoperative nausea and vomiting to be undertaken.
Intrathecal morphine versus diamorphine in spinal anesthesia for Cesarean sections (Re-Audit)	Procedure fully met no actions identified for improvement.
IR(ME)R EP B.3 - Referral Form Audit	Update to form to include - Histology section available on all sites, Treatment Planning Scan parameters sub-headings with drop downs. Rewording of referring to modality and Cardiac Device to be located under one subheading on all Casper forms.
Major Obstetric Haemorrhage (MOH) Re-audit	To improve documentation of early escalation and MOH call.
Management of Polyhydramnios and Oligohydramnios	Update guideline to reflect current clinical practice re place of NG tube for neonate/ feeding. Departmental teaching to highlight role of checking combined screen, anomaly scan and drug history in oligohydramnios.
Manual vacuum aspiration (MVA) re-audit - one year service review and patient feedback survey	Audit criteria fully met no actions identified for improvement.
Monitoring and analysing recurrent attendance to DAU	Procedure/protocols fully met no actions identified for improvement.
Monitoring liver functions after methotrexate usage in managing ectopic pregnancy/ PUL	Protocol/pathway fully met no actions identified for improvement.
MRSA and COVID-19 swabbing prior to admission to CAU and Bluebell Re-Audit	Incorporate IPC reminder on Team time and at handover. Already part of IPC induction for doctors.
Neurology Advice and Guidance Safety	To fine tune communication to GPs re referring back to our Trust if onward referral to originating trust is unsuccessful and where the GP has organised an MRI for suspected inflammatory disease, that any abnormalities should be discussed urgently with department.
Non-Melanoma Skin Cancer Surgical Excision Audit	To share and discuss audit results with team as clinician refresher training of surgical excision margins.
Outcomes of patient presenting with Cauda Equina Syndrome (CES) with time frame to MRI and tertiary	To propose a business model aimed at delivering out of hours emergency MRI for

referral outcomes	suspected cauda equina for discussion at departmental level.
Out-patient management of patients with differentiated thyroid cancer who have undergone radio-iodine treatment	Protocol fully met no actions identified for improvement.
Paediatric Pyelonephritis acute antimicrobrial prescribing	Refresher training for staff re reviewing antibiotic resistance and reassess antibiotic prescribed, documenting advice provided and prescribing of analgesia in acute pyelonephritis.
Palliative Care Response to Referrals Audit	Audit criteria fully met no actions identified for improvement.
PC 15 - Care of Patient during Radiotherapy Treatment	Procedure fully met no actions identified for improvement.
Postnatal VTE Risk Assessment and Prophylaxis, including LMWH prescribing and Mechanical Thromboprophylaxis	Guideline refresher training and format of the perinatal institute postnatal notes guidance.
Pre-Operative Management of our Testicular Cancer Patients: How are we doing? And Re-audit	Formal pathway to deliver timely Testicular Cancer Quality Performance Indicators.
Prevention of Admission Audit	Development of same day emergency care (SDEC) and hot clinics. Integration of the acute medical take within the Emergency Departments.
PROMPT: PROstate Medications Post TURP (Transurethral Resection of Prostate)	Update discharge summary advice for doctors and urology handbook re including advice to stop drugs post TURP.
PT 13 - Pelvic CT scanning audit	Add to work instructions and provide refresher training for staff.
PT 14 - Head & Neck Scanning	Procedure fully met no actions identified for improvement.
PT 19 - Activity Capture in Aria 15	Procedure fully met no actions identified for improvement.
PT 51 Responsibilities of Radiographer 2 and Radiographer 1 in CT during scanning and Re-audit	Protocol to be reconfigured to accurately reflect tasks of each radiographer. Revised Protocol to be brought to staff notice and training implemented
PT4 – CT Simulation Breast	Procedure fully met no actions identified for improvement.
Quality of Chest x-rays	Regular monthly 24 hour audits and results to be shared with radiology department. The results of this audit to be shared with lead radiographer and to be discussed in morning meetings. To r-audit in 6 months' time.
Re-audit of babies admitted with Jaundice to Children's assessment unit	Clear documentation of discussions between paediatric and surgical teams during admission and to conduct joint ward rounds with paediatric and surgical teams.
Review of management of nasal fractures in the acute clinic	Discuss audit findings with team and agree process for all patients booked for MUA under general anaesthetic to have Specialty Registrar review.
Rheumatology Advice Line (Lister and QEII)	Increase coverage of advice line Monday

	to Friday with job plan review. Consider impact on nursing and admin team in patient numbers and work flow with increase in consultant WTE. Contact BT/switch board so call time on advice line can be recorded.
RT 11 Radiotherapy Department Procedure for non-adaptive gynaecological patients	Reminder to staff re checking of the Treatment Verification Log.
RT 14 Adaptive Bladder Treatment Technique	Reminder to staff re checking alignments prior to moving the patient.
RT 16 Real Time Position Management (RPM) on the VARIAN TruBeam	Procedure fully met no actions identified for improvement.
RT 18 Radiotherapy Treatment Technique Audit – SINGLE ISO Breast tumours in DIBH	Reminder to staff at next Team Leads meeting re using rendered images for all patients receiving Breast treatment.
Scaphoid fracture audit	Review and agreed change to scaphoid pathway to reduce waiting time for CT/MRI.
Sepsis six compliance in ED	Restructure the preceptorship and pre-registration/newly qualified Nurse training to include IV and sepsis training. Wards to consider running a sepsis study day. Sepsis training to be included in Emergency Departments Team time.
Stillbirth Audit July 2020-2021	Reminder to staff re documentation standards required for IUD diagnosis. Commence placental histology at Addenbrookes. Recruit preterm birth midwife role. Reintroduce CO monitoring post covid change.
Supracondylar fracture management during 1st and 3rd waves of COVID-19 pandemic	Share audit findings in team meeting and discuss documentation improvement requirement.
Surgical Site Infection rate in patients post elective clean neck surgeries.	To implement the surgical site bundle; considering the use of pre-operative antibiotics.
Telephone Consultations for patient satisfaction	Complete a review to measure the effectiveness of phone consultations.
The management of Covid in Pregnancy	All staff refresher training re; Documentation to include individual risk assessment for COVID infection, record of COVID vaccine advice, use of antenatal COVID risk assessment sticker in antenatal clinical records, COVID risks discussion, daily Obstetrical review and handover of COVID cases.
The management of urinary incontinence	Reminder to clinicians of NICE NG123 guidance and to use a validated urinary incontinence-specific symptom and quality-of-life questionnaire.
To assess the appropriateness of cases treated by our local Urgent Eye Care Service	Develop/introduce an up-to-date triage tool that is easier to use, and allows more accurate triage.

	Increase nurse education, improve telecommunication services between eye care providers and improve public understanding of eye emergencies and where to seek help. Review transforming a 'walk-in' eye casualty into an acute referral clinic or a telephone triage service.
To investigate if all aspects of the VTE risk assessments in Ward 10b are completed accurately and correctly as per NICE & Trust Guidelines	Organise teaching sessions for medical juniors re VTE assessment requirements as per the NICE/trust guidelines. Display posters and leaflets/flyers on the ward for all staff explaining the importance of the VTE assessment and its correct/accurate completion. Complete a re-audit
TR3 Training Supervision & Competency for Therapeutic Radiographers Audit	Audit competency framework criteria fully met no actions identified for improvement.
VTE prophylaxis in Trauma and Orthopaedic In patients	Staff refresher training highlighting the issue to the Junior ward teams – On call teams to ensure the weight/estimated weight is always recorded at the time of admission.
VTE Risk Assessment and Administration of VTE Prophylaxis (and 1st cycle re-audit and 2nd cycle re-audit)	Education presentation to foundation trainees and reminder letter to surgical nursing staff re importance of VTE prophylaxis. Discussion with surgical nurses regarding feasibility of admission form/checklist Formal presentation and discussion in M&M meeting and reminder notification on Nervecentre to complete assessment and use/issue of TEDS.
VTE Risk assessment upon discussion and resultant VTE thromboprophylaxis prescribing	Refresher training for all staff re VTE assessment requirements as per the NICE/trust guidelines.
Waterbirth documentation on MLU	Audit guideline criteria fully met no actions identified for improvement.

Annex 3 Staff flu vaccine campaign

Vaccinating healthcare workers prevents the transmission of influenza (flu) to our patients, colleagues, our families, and our community. Immunisation is the most effective intervention to reduce harm from flu and reduce pressures on health and social care services. From October 2021 all employees were strongly encouraged to have the flu vaccine, the vaccine was also avaliable to volunteers, temporary workers, students and contractors working on Trust sites.

Vaccines were avaliable in booked appointments and drop in sessions at a vaccine hub at Lister. The vaccine hub was open 12 hours a day 7 days a week. Roaming clinics were also held in clinical areas of Lister, QEII, Mount Vernon Cancer Centre, Hertdford County and renal units. Vaccines were recorded on a live national immunisation and vaccination system (NIVS).

The flu vaccine was administered with COVID-19 booster vaccines, both vaccines were offered either in a single appointment or in two separate appointments, however, some people chose to only receive the COVID-19 booster and decline the flu vaccine. Reasons given for this include: concerns about side effects, beliefs that the flu vaccine is not effective or necessary.

Vaccine uptake

3,595 employees (63%) received the flu vaccine, this exceeds the East of England average of 61% and national average of 60.5%.
There was variation in uptake levels between some staff groups. Uptake was lower in staff under the age of 30, there was also lower uptake recorded in BAME staff, these variations are also seen nationally.
The uptake in the previous year was 70.5%, however, this is not directly comparable because the 2020-21 data only included frontline staff, but the 2022-23 data reflects all staff.

Plans for 2022-23

The national staff flu vaccine target for 2022-2023 is for 70-90% uptake in clinical and non clinical staff who have any contact with patients, this is included as one of the quality indicators in the 2022 to 2023 Commissionning for Quality and Innovation (CQUIN). This is an ambitious target, the plans for increasing vaccination uptake include:

- Involvement of key stakeholders and staff networks in planning and promoting vaccine uptake
- Offering a combination of booked appointments and drop in sessions suitable for all shift patterns
- Access to a central vaccine hub and mobile vaccination teams
- Recruiting a team of temporary workers to support the Health at Work Service to give flu vaccines
- A comprehensive communication plan involving webinars, posters, social media, news articles, huddles and friendly competition. Trust leaders, the network of wellbeing champions, staff networks, staff side reps and infection prevention and control link practitioners will support the dissemination of information to support the campaign.
- Provision of uptake data by the Trust Digital team to enable the monitoring of uptake and identificaytion of departments or staff groups requiring additional support.

Annex 4 Research and development

Examples of research projects carried out by the Trust

Cancer research
The Research team at East and North Hertfordshire NHS Trust were announced as winners of the inaugural Cancer Research Excellence Team Award at the regional 2021 National Institute for Health Research (NIHR) Clinical Research Network (CRN) Cancer Conference.

The CRN Eastern Cancer Research Excellence Awards recognise individuals and teams who demonstrate outstanding contributions in delivering NIHR cancer research. The East and North Hertfordshire NHS Trust team were recognised for their enormous efforts to ensure cancer research continued in the face of the challenges presented by the pandemic, including offering significant opportunities to patients to take part.

The award was accepted by Phillip Smith, Associate Director of Research, and Carina Cruz, Lead Research Nurse, on behalf of the Trust. On winning this prestigious award, Phillip said:

"We all know that research is a team game when it comes to the set-up and delivery of studies and that it is more of a community endeavour when you think about those who choose to participate. It can be unfair to identify any individual because this would favour those whose activity is more visible or deemed to be more important. So this is why I've nominated a team of teams: from delivery to research office to pharmacy to pathology and so on and on. A very large number of people have worked really hard in times of exceptional difficulty to ensure that cancer research has been able to continue over the last 12-18 months during Covid."

Some examples include:

- Continuation of cancer research during Covid. The Trust recorded the second highest recruitment to cancer studies (518 participants) in the East of England after Cambridge University hospitals NHS Foundation Trust (1,603 participants) in 2020/1.
- Patients suffering from a rare cancer of the eye can now hope for increased survival rates thanks to a new treatment trialled at the Mount Vernon Cancer Centre https://www.enherts-tr.nhs.uk/news/breakthrough-in-treatment-for-rare-eye-cancer-at-mount-vernon-cancer-centre/
- Enrolling 85 patients into the Delta Trial (integrateD diagnostic solution for EarLy deTection of oesophageal cAncer) as part of a service redesign at Lister Hospital. https://www.bbc.co.uk/news/uk-england-cambridgeshire-57404797
- High recruitment (>350 recruits) to the Lung Exo-DETECT (Lung Cancer Detection using Blood Exosomes and HRCT) at Lister Hospital over the last 18 months.

Cardiology Research

Anticoagulants (blood thinners) are used in patients with atrial fibrillation to reduce the risk of clots forming which can lead to stroke. However, these medications can significantly increase the risk of bleeding. A new class of medications, selective factor XIa inhibitors, may be able to prevent clot formation without increasing the risk of bleeding.

The Cardiology team at the Lister Hospital were the highest recruiters in the country into the two Phase 2 studies examining the optimal dose of a novel factor XIs inhibitor in patients with atrial fibrillation (PACIFIC-AF trial) and inpatients with a recent heart attack (PACIFIC-

AMI trial). The results published in the Lancet in April 2022 indicate that this approach can reduce the risk of bleeding, compared to the best current anticoagulants used in patients with atrial fibrillation.

Full details available here https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00456-1/fulltext#articleInformation

Annex 5 Statements from stakeholders

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

East and North Hertfordshire Clinical Commissioning Group (ENHCCG) welcomes the opportunity to provide this statement for East and North Hertfordshire Hospitals NHS Trust (ENHT).
2021/22 continued to be significantly affected by the Covid-19 pandemic, and all organisations across our healthcare system have continued to adapt services to deliver safe care to our patients including a new focus on recovery of services. The CCG recognises the work of the Trust and thanks all of their staff and volunteers for their efforts and dedication during this incredibly challenging time.

The information provided within this account presents a balanced report of the quality of healthcare services that ENHT provides and is, to the best of our knowledge, accurate and fairly interpreted, is easy to read and well set out. The Quality Account clearly evidences the improvements made and highlights innovation achieved in 2021/22 despite the Covid-19 pandemic; and recognises where further improvements are needed.

During the course of 2021/22 the CCG have worked closely with ENHT, meeting regularly to review quality and safety, including risks relating to the pandemic. The CCG also re-instated Quality Assurance Visits to seek assurance regarding the quality of care provided, and where identified improvements were needed, provided relevant support to embed change.

Following the Care Quality Commission's (CQC) inspection in 2019, the Trust's rating has remained as 'Requires Improvement'. The Trust had a number of CQC Transitional Monitoring Approach reviews during 2021/22 which were positively received. The Trust continue to focus on their CQC Improvement Plan and progress is regularly reported to the CCG as well as Trust Board and CQC.

During 2021/22 ENHT 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 initiatives being undertaken. This is particularly key in relation to recognition of deteriorating patients and the Harm Free Care programme. The CCG also welcomes the progress made by the Trust with the Clinical Excellence Accreditation Framework.

The CCG notes the recent improvements in relation to sepsis care and will continue to seek assurance that the improvements will be sustained going forward. The CCG does however remains concerned regarding venous thromboembolism (VTE) risk assessment completion and will be looking for improvement over the coming year.

Recognising that there have sadly been a high number of Covid-19 related deaths nationally and locally, it is positive that non-Covid-19 mortality rates have remained stable

overall and SHMI data reported throughout the year has remained in the 'lower than expected' range. Where any outliers are identified the Trust has worked pro-actively to identify any improvements required. It is also encouraging to see the work being done to reduce mortality and ensure learning and robust processes are in place.

In relation to Infection Prevention Control (IPC), it is positive to see that the Trust reported no MRSA bacteraemia cases for 2021/22. However cases of C.difficile have been above the annual ceiling. The CCG will continue to have oversight and seek assurance regarding this for 2022/23.

During 2021/22 the Trust reported 5 Never Events; an increase from the 3 reported the previous year. The CCG are pleased to note the ongoing improvement work because of identified learning and would expect to see a reduction in Never Events occurring in 2022/23. We will continue to seek assurance that learning has been identified, and that relevant actions and improvements are being implemented to prevent reoccurrence.

The timeliness of the serious incident reports and complaint responses has seen a decrease in performance during 2021/22. However, the CCG acknowledges the additional pressures that have impacted on this, and the work planned by the Trust in 2022/23. The CCG looks forward to seeing improvements in this area to ensure patients and families receive timely responses.

Previously there has been significant work undertaken by the Trust to improve the quality and timeliness of discharge summaries. Whilst the CCG recognises the continued focus that the Trust has had in relation to this, we note that performance has declined. The CCG expects this to be an ongoing focus for 2022/23 and would like to see a continued focus on the timeliness of both discharge summaries and clinic letters sent to primary care to support patient care.

Cancer performance was sustained over the course of 2021/22. The 62 day cancer target was achieved for all except two months, and the year-end position showed compliance with six of the eight cancer standards. The CCG is pleased to see that improvements continue to be made and would now like to see the Trust build on this in order to consistently deliver all key cancer standards.

The 2021 annual staff survey results for the Trust remain similar to the national average in many areas. However, despite some improvement, bullying and harassment continues to be a theme. The CCG recognises the ongoing work to make the necessary improvements, including appointing a full time Freedom to Speak Up Guardian, and will continue to seek assurance regarding this area.

The CCG supports the Trust's 2022/23 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, the CCG wishes to see ongoing improvement in the timeliness and quality of discharge summaries which is essential to support ongoing safe care in the community, 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 Integrated Care System and the place based Health Care Partnership, 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 2022/23.

Sharn Elton
Managing Director
May 2022

Hertfordshire

Quality Account 2021/2022

On behalf of the Hertfordshire Health Scrutiny Committee I would like to thank East & North Herts Trust (ENHT) for the services it continued to deliver during the pandemic and its response in recovery. We are aware of the challenges facing the NHS and will seek to continue working constructively with the trust.

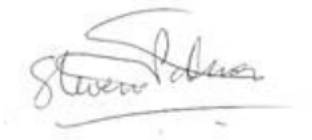
Members of the committee have been appreciative of the support ENHT has provided during this challenging period this has included, for instance regular attendance at Committee meetings, providing written updates when requested and briefings when concerns have been raised by the community. The contribution from the trust has meant the committee has maintained its overview of the health system across the ICS. It has enabled our health scrutiny members to hear about the impact on services and how the health system is seeking ways to address on-going needs and additional pressures.

Despite the demands of the pandemic and recovery there has been regular communication between the Health Scrutiny Committee, Scrutiny Officers and ENHT over the last 12 months. ENHT has supported the scrutiny process when approached and the Committee look forward to working with the Trust in the future.

Yours sincerely

Dee Hart
Chairman Hertfordshire Health Scrutiny Committee

Healthwatch Hertfordshire values the relationship with East and North Hertfordshire NHS Trust and welcomes the opportunity to support the development of the new patient involvement model. We look 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, June 2022

Annex 6 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

30 June 2022 Date Chair

30 June 2022 Date Chief Executive