June
2024

East and North Hertfordshire
NHS Trust

Quality Account 2023-24

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Part one

1.1 Chief Executive's Foreword

Much of my and the board's focus over the last 12 months has been on the implementation of the ENH Production System – the Trust's new partnership with the world-renowned Virginia Mason Institute which will place the patient at its centre and focus on a safety culture, reducing waste, and improving the experience of both patients and staff.

I know first-hand the positive impact this process has on health and care systems and I'm looking forward to seeing the improvement projects begin to take shape across our sites. This 2023/24 Quality Account will outline our achievements over the last 12 months, will identify where improvements could be made and will shape our future continuous improvement plans to be delivered through the ENH Production System.

In 2023/24 we published the Trust's Patient Safety Incident Response Framework (PSIRF) plan and policy, which has included recruiting our first patient safety partner who will support us with enabling safer systems within the Trust. We also introduced better standardisation and oversight of quality through ENHance – providing ward to board oversight of key quality priorities such as risk management, incidents, compliance, claims and requests. ENHance not only enables us to capture and respond to incidents, but also enables us to learn from good care. Through our good governance review we have also re-designed our risk management processes and, through an improvement programme, have seen a gradual reduction in the number of overall risks.

I'm delighted that our Friends and Family Test scores improved across all areas in 2023/24 and, even with the ongoing challenges, feedback from our emergency department has improved by 4% from last year. The dedication of our maternity colleagues has also been highlighted by the results of the 2023 CQC maternity survey, where we were the most improved Trust and performed significantly better on 15 questions compared to last year.

We continue to put patients and their loved ones at the heart of what we do – in 2023 we developed our offer for patient carers, providing them with much needed support whilst their loved one is in hospital; we also implemented the new Call 4 Concern service where inpatients and their loved ones at the Lister can ask for a second opinion if they have concerns about their care.

Despite the successes we have experienced, it's important to recognise the areas where we need to improve. This includes working with our partners in the community to focus on ensuring the timely discharge of patients, making use of Hospital at Home where clinically appropriate and continuing to reduce the amount of time patients are waiting in our emergency department. As an organisation we are committed to making these improvements, working closely with our staff and service users.

I'd like to take this opportunity to thank all those who have worked hard to ensure we can continue to provide high-quality compassionate care for our communities.

Adam Sewell-Jones

Chief executive

Performance overview

1.2 Accountability for quality: how we hold ourselves accountable

NHS organisations are required under the Health Act 2009 and the subsequent Health and Social Care Act 2012 to produce a document detailing information in relation to the quality of services provided to local communities, any achievements and/or improvements made and any areas where further improvements may be required for each financial year. The annual Quality Accounts are produced by the Trust as mandated under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010. The Quality Account is therefore a key mechanism which provides demonstrable evidence of measures undertaken in improving the quality of the Trust's services.

The aim of the Quality Account is to enhance the Trust's accountability to the public and its commissioners on both the achievements made to improve the quality of services for our local communities as well as being very clear about where further improvement is required. Quality Accounts are both retrospective and forward looking.

As part of the development of the Quality Account all NHS Trusts are required to identify measurable priorities mapped against Darzi headings of Safe, Effective and Patient Experience.

The purpose of the account is to:

- promote quality improvement across the NHS
- increase public accountability
- allow the Trust to review the quality of care provided through its services
- demonstrate what improvements are planned
- respond and involve external stakeholders to gain their feedback including patients and the public.

The Trust's overall vision is to be trusted to provide consistently outstanding care and exemplary service. We will deliver our vision by focusing on our strategic themes - quality, thriving people, seamless services, and continuous improvement which will in turn support operational performance.

Our strategic priorities are underpinned by our values and a series of enabling strategies including the people, quality, finance, and estates strategies.

1.2.1 Refreshed Trust Values

Our values underpin everything we do and describe what matters to us at the Trust. They are a promise of how we will carry out our work – how we will treat our patients, our staff, and our partners.

Following an extensive review and refresh of our strategy in 2021/22 (including a bottom-up review of service ambitions, our vision and strategic objectives, we are agreed we will:
Include: We value the diversity and experience of our community colleagues and partners, creating relationships and climates that provide an opportunity to share, collaborate and grow together.

Respect: We create a safe environment where we are curious of the lived experience of others, seek out best practice and are open to listening and hearing new ideas.

Improve: We are committed to consistently delivering excellent services and continuously looking to improve through a creative workforce that feels empowered to act in service of our shared purpose.

1.2.2 Clinical and Quality Strategy, 2019-2024

Our Quality Strategy has continued to support the continuous improvement journey toward an ‘East and North Herts Trust' quality management system. The successful procurement of a single Improvement Partner will enable a systems approach to manging quality. These will continue to build on the current quality objectives (see below).

Key objectives of the Quality Strategy include:

 **Understand where variation exists** and use data to proactively drive improvement by reducing the ‘unwarranted variation’. Aiming to enable staff 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 within which our efforts of continuous improvement will be focused. These are:

1. Valuing the basics
2. Keeping our patients safe
3. Good governance
4. Patient experience
5. Staff capability

Priorities identified through the strategy 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.

1.2.3 People strategy 2020

The people strategy was launched in January 2020, setting out a compelling vision for all staff working at East and North Hertfordshire Trust. The people strategy details plans based on four key pillars - work, grow, thrive and care. Despite the changing background and environment in which we are operating, the people strategy set out at the start of 2020 is still fit for purpose and is a key enabler for the Trust in delivering its strategic priorities.

Integrated business and workforce plans highlight what, where and how we as an organisation will focus on key areas to enable change in delivery models, workforce composition, including the types of roles needed in the future to meet the demands of the community we serve. These are aligned to the NHS Long term workforce plane and people promise requirements.

1.2.4 Organisational Structure

The Trust has four operational divisions. These are women and children, planned care, unplanned care and cancer services. 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 our clinical divisions are corporate teams covering areas including finance, business information and planning; digital; medical practice, education and research; nursing practice; estates and facilities; transformation, and workforce and organisational development.

Part two: Priorities for improvement and statements of assurance from the board

2.1. Progress with 2023/2024 priorities

Quality Priorities 2023 to 2024		
Domain	**Description**	**Key Focus Areas**
Effective	Excellent responsiveness Learning from incidents	Reduce unwarranted variation. Oversight of quality Good governance
Safe	Valuing the basics	Quality Fundamentals • Medication management • Sepsis pathway compliance • Safer invasive procedure standards • Deteriorating patients • Safeguarding adults and children • VTE risk assessments
Well Led	Good governance	Oversight of quality Good governance framework
Patient Experience	Respect patient's time	Improving discharge processes Waiting lists

In 2023/2024, delivery against identified quality priorities involved scoping opportunities to continue to build knowledge on quality improvement methodologies through procurement of a single improvement partner and drive a sustainable governance framework through standardising approaches to governance in response to the Trust's new operational management model structures.

The Trust has also published the patient safety incident response plan and policy. We have recruited the first patient safety partner; this role is key to supporting recruitment and development of more patient safety partners to co-design improvement and enable safer systems within the Trust.

Effective: The Trust has supported the standardisation and oversight of quality through introducing a digital system platform called 'Enhance'. This platform allows ward to board oversight of key quality priorities such risk management, incidents, complaints, NICE compliance, Claims and Inquests, Policy Compliance, Clinical Audits and key Nursing Quality Indicators. Audits and feedback can be captured in real time on handheld devices and data sets are triangulated and provide ability to link information across different domains.

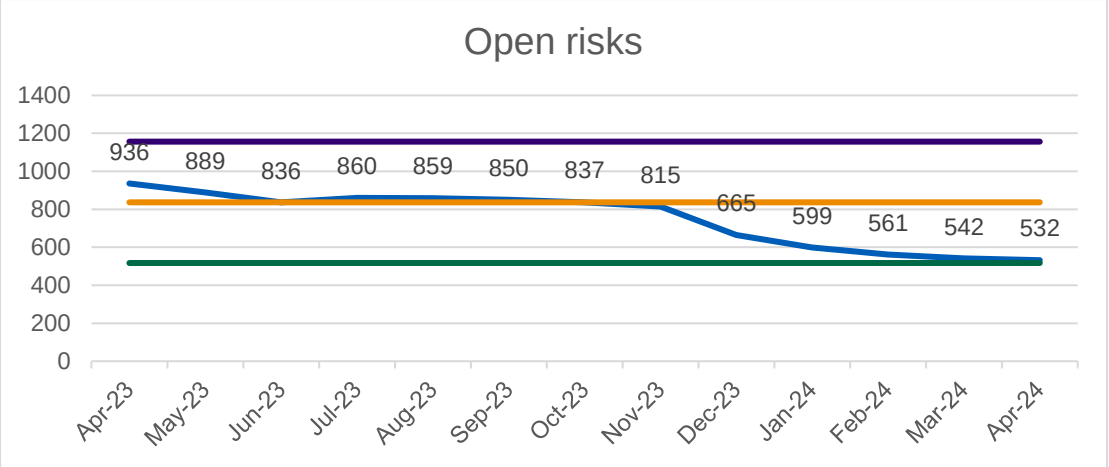
Safe: The Trust has published a Patient Safety Incident Response Plan and Policy. This has achieved compliance towards key National Safety Standards. This change has also enabled the new national Learning from Patient Safety Events (LfPSE) reporting criteria to be imbedded and has provided the opportunity to report and learn from episodes of good care and excellence. Good care is analysed for themes and trends and shared in equal measures as patient safety incidents.
Some examples of good care have been:

A patients grandma told me how pleased the mum was after Sharon assisted with feeding support. The mum had been reluctant to start pumping, however Sharon discussed the pro's with mum and she was much happier.

Preoperative Assessment team identified new symptoms possibly related to a patient's AAA whilst conducting a preoperative phone call. They urged the patient to attend ED and escalated to the vascular surgical team. The patient was assessed, deemed to have impending rupture and successfully operated on.

The nurse has been highlighted for using the sepsis screening tool effectively. Consistently performing the screening assessment and completing it accurately on Nervecentre. We have also seen increased use of the digital fluid balance chart. Through consistent use of the tool, we can see that patients are receiving good sepsis care aiding with preventing further deterioration and meeting the NICE guidance on sepsis management.

Well led: The Trust commissioned a good governance review to enable progression and strengthening of board oversight and assurance. Risk management processes have been redesigned, following the publication of our 2023 risk management strategy. An improvement program has been delivered in 2023/24 that has seen a gradual reduction in the overall number of risks. This remains a priority for 2024/25.



Patient Experience: The Trust saw a significant improvement in the CQC maternity survey 2023. The Trust performed significantly better on 15 questions; there was no significant difference on 38 questions, and we were not significantly worse on any questions making us the 'most improved trust'. We have included seven results in our action plan to improve our services.

2.2.1 Quality Domain: Effective

Quality Domain: Effective

Priority 1: Build quality improvement (QI) capability and capacity:

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

Quality improvement methodologies have been adopted through to transformation existing services, the development of new services and the collaborative working of partnerships.

Our priority for 2023/24 has been to work towards achieving substantive improvement partner. Following a competitive procurement process through 2023/24 the organisational is very proud to have now engaged with Virginia Mason Institute (VMI) and their client partner, Surrey and Sussex Healthcare NHS Trust (SASH) as our improvement partners over the next three years. As partners VMI and SASH will co-design and support our implementation of a Quality Management System (QMS), allowing us to learn from their proven expertise and experience.

We have chosen VMI as they work with various healthcare systems across the globe, including the NHS, winning multiple awards and accreditations. SASH was one five trusts involved in an NHSI collaboration with VMI, as part of their journey they moved from one of the worst performing trusts, to been rated as 'outstanding' by the CQC.

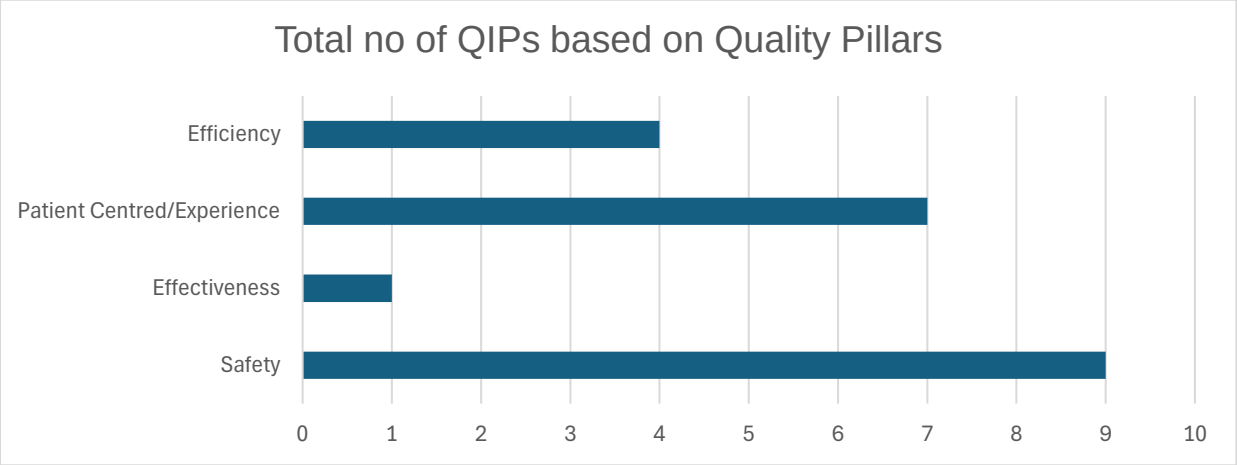
In 2023/24 the quality improvement team successfully delivered a programme of building improvement skills and knowledge through teaching and coaching and by demonstrating the impact of the methodology through running safety programmes for

harm free care and the deteriorating patient. Multiple curriculum offers through coaching clinics and bitesize teaching session were delivered through 2023/24.

The Trust successfully delivered a fourth cohort of our Clinical Leadership Programme through external accreditation by the Royal College of Nursing (RCN). The programme is a one-year curriculum delivered to 20 clinical leaders across nursing, midwifery and therapy teams to develop leadership skills through the lens of leading quality improvement initiatives.

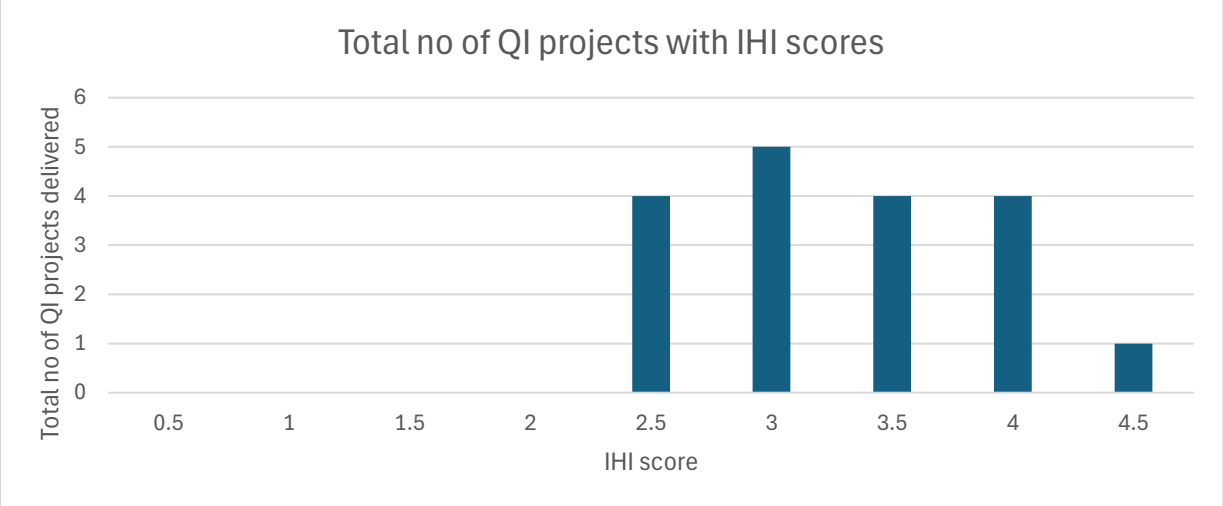
Most of our participants this year are in second-tier line management positions with a few first line management positions. All QI projects (QIPs) are working with either one or combination of quality pillars (see table 3).

Table 3: Total number of QIPs based on quality pillars



78% (14/18) of QIPS have demonstrated modest to sustainable improvements with rest of them still in the testing phase (see table 5).

Table 4: Total number of QI projects with IHI scores



As we progress with our new improvement partner, we are re-designing a three-year capability building plan for all staff. This will be published in early 2024/25.

Progress on our communication plans and celebrations
Local recognition for value based 'Improve awards' have been awarded through monthly nominations. Each month multiple 'improve' nominations are submitted and winners are recognised through celebratory leadership briefings and thanked by our senior executive team.

National recognition was also celebrated during the year. See table 5 below:

Table 5: Team and individual awards and wins for 2023/24

Commendations/Conferences/Presentations	**Team/Individual winners and finalists**
HSJ Patient Safety Congress, 2023	Faith O'Donoghue
East of England, Stroke Forum, 25 July 2023	Julia Sartorius, Stroke therapy team
NHS Fab Awards, December 2023	• ENHT QI Team, Fab QI team Award Winner • Faith O'Donoghue – Deteriorating patients QI project, Fab QI Individual award, Highly commended. • Jan-Axle Enabore – Improving Carer Support at ENHT, TNT Award, Highly commended. • Elizabeth Hale – Same Day Emergency Care In-reach team to improve patient care, Penguin Award – Winner • Faith O'Donoghue – Deteriorating patients QI project, 4 Candles Award, Winner • Mirriam Adey – Reducing HbA1c related cancellations for surgery in pre-op assessment, Hartley Larkin Award, Winner • Sharne Byrne – Here to improve patient experience post discharge

	in ED, 4 Candles Award, Nominee

In summary, the previously established QI coaching clinics, QI cafes and newsletters have enabled us to build readiness in preparation for the next phase of sustained continuous improvement with our improvement partner.

Other key highlights

In June 2023, the Trust's QI team have supported the co design and development of our newly launched Herts and West Essex QI ICS network (HWEQI network). We also successfully hosted a QI webinar in February 2024 sharing best QI practices across our local ICS network. During the course of the year, we have continued to support the recruitment of patient safety partners as part of our national requirement for meeting the National Patient Safety Incident Response Framework (PSIRF) and were involved in supporting the design and implementation of each of the four PSIRF work streams throughout last year.

Plans for 2024/25 Continuous Improvement

- Work with our improvement partner, Virginia Mason Institute (VMI), in the ongoing development of our new improvement method – the East and North Herts Production System.
- Achieve certification and accreditation for our new Kaizen Promotion Office.
- Roll-out new training and education programmes across all levels of the organisation to increase knowledge, awareness, and capability in our new improvement method.
- Establish a series of value streams to target incremental improvements using Rapid Process Improvement Workshops and Kaizen Events.
- Implement leader rounds to embed and sustain continuous improvements, led by those that do the work, where the work is done.
- Introduce daily management processes and standard work across wards and departments to foster a culture of continuous improvement.
- Ongoing network learning and sharing of best practice across the Integrated Care System.

Nursing Excellence

The Clinical Excellence Accreditation Framework (CEAF) was revised in April 2023. The revised CEAF now contains two parts. Part one is aligned to the CQC compliance standards and includes 71 fundamental standards of care. Part two includes standards relating to 'clinical excellence'. Wards will only progress to part two of the framework when a minimum of 85% of all fundamental standards of care are achieved. All 71 fundamental standards of care must be achieved, and the 'clinical excellence' part of accreditation completed, to become an accredited ward.

All adult and paediatric inpatient wards have commenced the accreditation framework. A formal assessment is undertaken to demonstrate compliance with the fundamental standards of care. This includes observation of practice, talking to staff and patients, reviewing documentation and performance/compliance data and reviewing the CEAF staff survey responses. Significant progress has been made to embed fundamental standards of care within all inpatient areas across the Trust. At

our first panel meeting Barley ward were successful in achieving over 85% compliance with the standards and have progressed onto part 2 of the framework.

Embedding fundamental standards of care

- Development of the audit steering group for nursing, midwifery and allied health professionals.
- Digitalisation of nursing audits and key performance indicator dashboards.
- Monthly CEAF progress meetings with ward managers and focus groups to agree specific actions to improve fundamental standards of care and sharing of good practice.
- Review of organisational progress with the Pathway to Excellence programme, in line with our designation requirements.

2.1.2 Quality Domain: Safe

Quality Domain: Safe

Priority 2: Keeping our patients safe

Reason: Part of our quality goals within the Trust's quality strategy- valuing the basics and keeping our patients safe (2019-2024)

Our priority for 2023/24 has been to work towards achieving:

2.1.2.1 Sepsis

Sepsis can be triggered by any infection, but commonly occurs in response to bacterial infections of the lungs, urinary tract, abdominal organs or skin and soft tissues. If caught early, patient outcomes are excellent. Left unchecked, patients are likely to spiral to multi-organ failure, septic shock and die. It is estimated that, every year, sepsis costs the NHS £2 billion and claims the lives of at least 52,000 people.

Aims:

- Achieve >95% in sepsis pathway compliance
- Achieve 50% compliance with reliability of all observations
- Improve Physiological Observation Assessment Competencies for nursing staff
- Roll out patient status at a glance (PSAAG) dashboards on all wards

Achievements to date:

Sepsis pathway compliance

	Aim	**Achieved**
Antibiotics in Emergency Department (ED) within an hour	>95%	83%
Antibiotics on the ward within an hour	>95%	64%
Neutropenic sepsis antibiotic within an hour	>95%	67%
ED Sepsis six bundle	>95%	60%
Inpatient (IP) Sepsis six bundle	>95%	37%

Compliance with achieving timely delivery of the sepsis pathway bundle continues to be an improvement priority. Individual elements of the 'sepsis six' have shown fluctuating compliance, however improvements have been targeted at achieving more reliable fluid balance monitoring. Changes to improve this have included the transfer of fluid balance documentation to the same digital platform as observations, and now fluid balance management is mandatory. Looking at the year, sustained improvement is noted particularly in the Emergency Department (ED) during Q4. Inpatient areas' compliance rates are in response to smaller sample size in comparison to ED. In order to push for improvement a sepsis task and finish group has been implementing quality improvement projects to strive for better sepsis

management. Some of these projects have included rolling out the SBARD communication tool as well as the digital implementation of mandatory fluid balance for all patients with NEWS2 above 5 or 3 in one parameter. These changes have seen improvement in fluid balance compliance across the Trust and we will be looking to now sustain this going into 2024/25.

Our key focus in 2023 was devising and implementing a digital sepsis screening tool which was rolled out in the summer across adult settings. This tool is designed to aid in sepsis compliance and clear documentation of sepsis management, which is something which has been absent since the Trust documentation became digitalised. It is being discussed and taught in all teaching sessions provided by the team.

Education and Training
The team have continued to focus on optimising sepsis education. The team regularly deliver sepsis sessions at Trust inductions, at team times and have spent three months providing weekly sepsis sessions in ED/AMU. The team have delivered a varied range of education (formal, informal, face to face, teams and simulation) and continues to cover sepsis during BEACH (Bedside Emergency Assessment Course for health care assistants) sessions alongside the critical care outreach team (CCOT) and resus teams. 2024 will see the introduction of sepsis/acute kidney injury (AKI) link nurses across the Trust with study days for link nurses happening in May and June. Through having link nurses across the Trust it is hoped they will aid the team in championing improved sepsis management and therefore compliance. Mandatory sepsis e-learning is live on ENH academy and is currently being updated by the team to reflect latest guidance released in February 2024. Multi-disciplinary sepsis/AKI simulation sessions have been hugely successful since their introduction in 2023 and are an education resource we are aiming to continue to utilise further throughout the upcoming year. Sepsis refresher sessions have also been delivered to medical junior doctors and surgical junior doctors as well as repeated sessions to the frailty team which has been well received with further sessions planned across the year.

2.1.2.2 Venous thromboembolism (VTE) risk assessments

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. 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.

Aims:

- Achieve >95% compliance with VTE risk assessment stage 1 and 2 by March 2024
- Embed digital risk assessment platform into clinical practice.

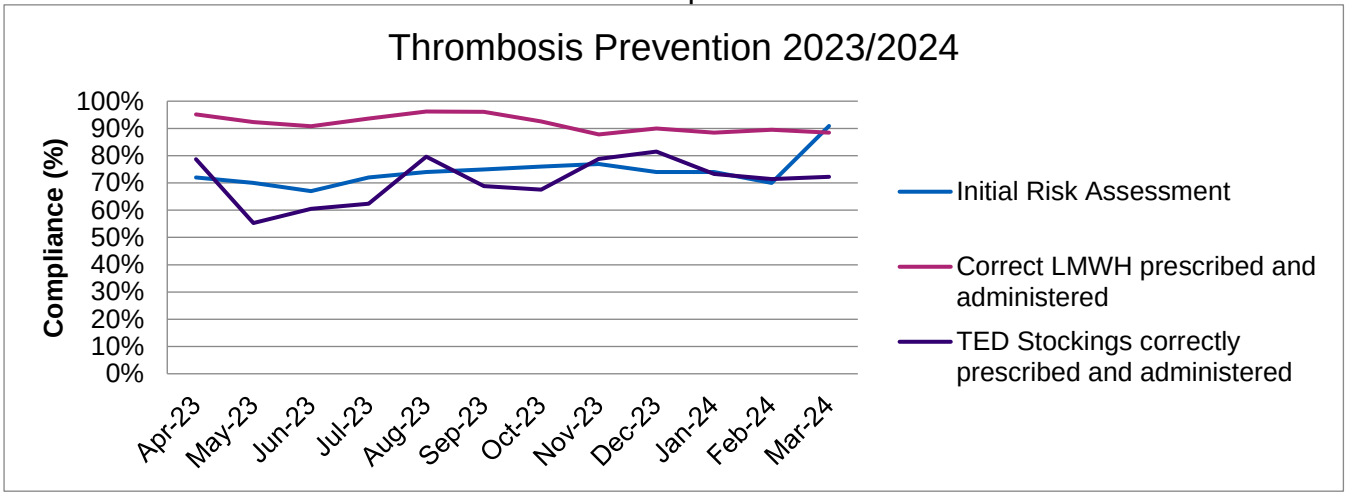
Achievements to date:
As per our Trust guidance, the initial risk assessment is completed on admission or by the time of the first consultant review (within 24 hours). Subsequent risk assessments are completed when the patients' clinical condition changes.

VTE risk assessments were audited regularly via the digital system producing weekly data at the speciality, ward and consultant level. Reporting is presented at ward and divisional meetings and at the Trust's Thrombosis Action Group which reports to the Patient Safety Forum and subsequently into the Quality and Safety Committee.

The graph below demonstrated the Trust performance against the audit criteria throughout the year. The March data set was pulled later in the month resulting in higher VTE compliance for March than expected.

Figure 1: Audit data of clinical area's compliance with VTE prevention 2023/2024.

National aim of >95% VTE risk assessment completion rate.



At the beginning of the financial year 2023/2024 the Trust rolled out digital reporting which allowed for robust data, better oversight, real time feedback and targeted quality improvement (QI) work. Correct prescribing and administration of low molecular weight heparin (LMWH) continued to be maintained above 85%. In June 2023, Trust guidance moved in line with VTE Exemplar Centre guidance to focus on timing of risk assessments, with the first on admission and subsequent as clinical condition changes, removing the requirement for a second reassessment within 24 hours. The Trust focused on quality improvement to increase risk assessment compliance from generally below 70% in 2022/2023 to achieve greater than 70% from July 2023 onwards following implementation of the updated guidance.

Root Cause Analysis (RCA) investigations are undertaken when potential hospital associated thrombosis (HAT) cases are identified. The learning is then fed back through the Trust's Thrombosis Action Group then disseminated through various channels including areas like quality huddles, FY1/FY2 training sessions and Trust rolling half days. This financial year saw a comparative percentage of preventable HATs to the previous financial year, 2022/2023. In 2023/2024 there were 14 potentially preventable HATs, one of which was declared an incident and was reviewed in line with the PSIRF, sparking a full system and process learning review.

Thrombosis prevention improvement work is one of our harm free care priorities in our Patient Safety Incident Response Plan.

Common themes include:

- Inappropriate omissions of LMWH ie LMWH held prior to surgery but surgery subsequently cancelled and LMWH not reinstated
- VTE risk assessment completed but LMWH not prescribed
- As platelets or renal function improve or worsen, chemical prophylaxis isn't always reviewed, restarted or reduced/increased

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
- 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%
- Transformation of the HAT process 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 Trust's VTE policy was reviewed, updated and relaunched
- Established regular clinical engagement to share VTE data, improvement work and learning from HATs.
- Reporting in real-time on the 'patient safety at a glance' (PSAAG) board to provide a 'prompt' as a visual reminder.
- Digital reporting at the ward, speciality and consultant level to support targeted improvement projects.
- Engaged in a patient information quality improvement project with patient partners to alert to signs and symptoms of VTE on Trust wide discharge letter given to patients on discharge.

Since the beginning of this financial year, the following changes and improvements have been made to support the Trust's VTE compliance improvement:

- Regular engagement sessions with junior doctors and clinical staff to obtain learning from the service user and then feedback to enable change
- VTE team focussing on areas with the lowest compliance
- Digital reporting at the ward, speciality and consultant level to support targeted improvement projects.
- Reviewed and strengthened guidance for risk assessments in line with VTE Exemplar Centres
- Scale and spread local QI projects with sustained improvement. All wards involved in VTE QI projects in 2023/2024 have seen sustained change through several PDSA cycles focused on an MDT approach. In the upcoming

financial year, to continue to take the local learning and lessons and spread to additional areas.

Plans for 2023/24:
Improvement priorities to ensure we meet our Trust and national aim of >95% of patients have a VTE risk assessment by March 2025 include:

- Achieve Trust target of greater than 85% by December 2024 then roll out second stage of improvement work to reach greater than 95%
- Continue to embed
- Continue to improve patient engagement and review VTE patient information via roll out of a digital admissions package
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.

2.1.2.3 Medicines management

Medicines management is a system of processes and behaviours that support, determine and guide how medicines are used within an acute setting and by patients.

Aims:

- Achieving less than 3.5% in omissions of critical medications
- Achieving greater than 90% in antimicrobial stewardship
- Work towards ePMA benefits realisation

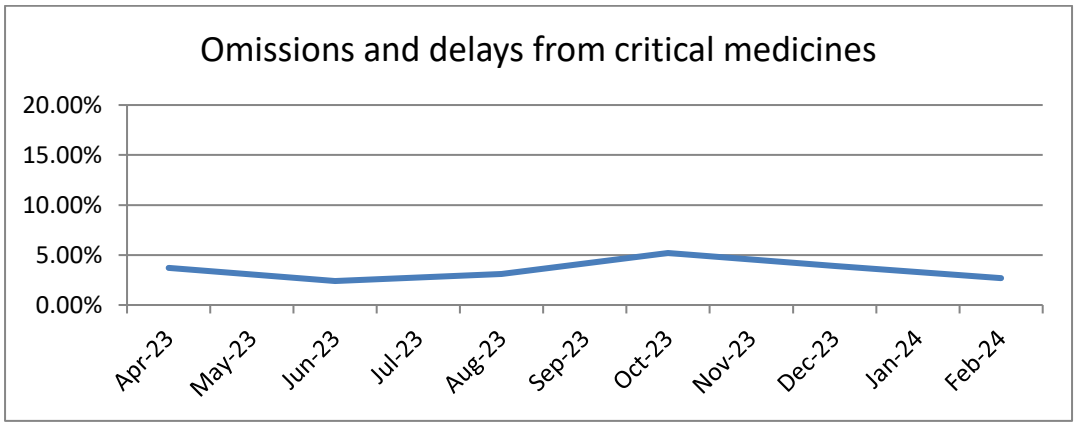
Over the last year the pharmacy department has focused on rewriting and launching the new Trust medicines optimisation strategy and working towards benefits realisation of ePMA. Examples include obtaining antimicrobial reports to supports antimicrobial stewardship (AMS) and the clostridium difficile agenda and supporting the review of high risk antibiotics over weekends and bank holidays. The pharmacy department has also focused on fundamental standards such as reducing the number of delayed and omitted doses of critical medicines, venous thromboembolism (VTE) prevention and AMS.

Achievements to date:

KPI	Target	Achieved 2023/24
Omitted and delayed doses of critical medicines	<3.5%	3.5%
Antimicrobial stewardship, 24-72 hour review	>90%	80.7%
Trusts medicines optimisation strategy	Launch the strategy	Achieved
KPI dashboard	Review	In progress
Epma	Work towards ePMA benefits realisation	Achieved
Trust's medicines management training	>90%	77%

Update on Critical medicines

The critical medicines audit is conducted across the Trust on a bimonthly basis. The numerator is the number of doses of critical medicines that have been delayed (>2hours) or omitted in the previous 24-hour period. The denominator is the total number of doses of critical medicines prescribed in the previous 24 hours.

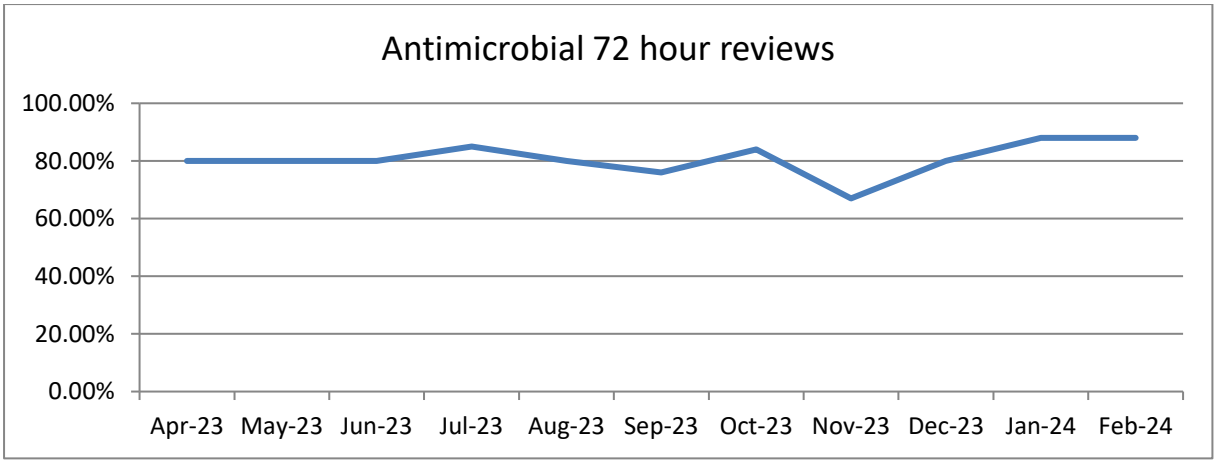


Aims: To achieve less than 3.5% omissions of critical medications that should not be missed or given late. During 2023/2024 the Trust achieved an average of 3.5%.

Update on Antimicrobial stewardship

Antimicrobial stewardship (AMS) is a co-ordinated 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 and antibiotic stewardship.

Various training sessions have been delivered throughout the year – including undergraduate medical teaching, junior doctor inductions and liaising with the clinical practice nursing team to provide an interactive stewardship talk to student nurses/midwives as part of World Antimicrobial Awareness Week. Additionally, due to increased cases of clostridium difficile within the region, a Trust-wide presentation was delivered on initiatives to ensure appropriate prescribing and review of antimicrobials. In order to avoid antimicrobial medication incidents, the clinical pharmacy team have started to review patients prescribed high risk antibiotics which require therapeutic drug monitoring to ensure appropriate blood samples are taken to assess effectiveness of the medication and advice on dose adjustment where necessary.



The graph above demonstrates the results of the monthly audit that assesses the antimicrobial reviews for inpatients admitted to the Trust. The team have been focusing on targeted education and training towards AMS, which has led to an increase in audit compliance in January and February to 88%.
The Trust has taken part in the NHSE CQUIN on appropriate intravenous (IV) to oral switches at 72 hours (target <40% of patients at time of review remaining on IV antibiotics.) The average percentage throughout the year was 15% and microbiology IV to oral switch ward rounds have supported us meeting the target. The Trust is one of the best performing trusts in the East of England for this CQUIN.

Update on medicines optimisation
The new medicines optimisation strategy was approved at Quality and Safety Committee in January 2024 and launched across the Trust at quality huddle and corporate rolling half day in March and April respectively.

Areas of progress this year have included:

- The medicines management policy is regularly audited across the Trust; quarterly controlled drugs audits are performed by pharmacy, unlicensed drugs audits and safe and secure medicines are all performed on a regular basis.
- The medicines optimisation key performance indicators (KPIs) on Qlikview have been presented at planned care divisional board, the nursing quality huddle, medication forum and pharmacy rolling half day.
- Therapeutics Policy Committee and New Drugs and Formulary Group biannual report was presented to the Clinical Effectiveness Committee in January 2024.
- Trust wide medicines management training was launched in 2023 and to date 77% of all doctors, nurses and pharmacists have completed the online training.

Plans for 2024/25:

- Working towards the launch of Orbis the integrated EPR and ePMA system
- Implement the updated pharmacy and medicines management KPI dashboard in terms of reporting, targets and presentation
- 90% of relevant staff to complete essential medicines management training
- 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 2024/25.
- 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.
- Review discharge medicines incidents and support the Trust's work on improving discharge processes.

2.1.2.4 Deteriorating patients

The deteriorating patient is a patient that moves from one clinical state to a worse clinical state, increasing their risk of disease, organ failure, prolonged hospital stay or death.

Aims:

- Achieve compliance with 50% reliability of all observations
- Improvement work aimed at supporting physiological observation assessment competencies with our nursing staff (registered and non-registered) to NEWS2 training
- Roll out improved patient status at a glance (PSAAG) dashboard on all our wards

Achievements to date:

Education and Training: To improve our nursing staff (registered and non-registered) knowledge and abilities in identifying and swiftly responding to patients who are deteriorating, we implemented extensive education and training programmes. We have therefore successfully re-rolled out ALERT (Acute Life-Threatening Events Recognition and Training) Trust wide with courses now booked throughout 2024/2025. We also continue to provide BEACH (Bedside Emergency Assessment Course for HCAs) training to our non-registered staff to teach and embed the basic skills of recognising and responding to deterioration. To compliment the BEACH course, the critical care outreach team (CCOT) are supporting the training of all new clinical support workers with observation training.

The CCOT have also supporting the implementation of PROMPT training with our maternity colleagues. PROMPT training is a maternity safety and learning programme. The program covers the clinical management of obstetric emergencies with an emphasis on communication, teamwork, and the role that human factors play. Training is based in the clinical setting with all members of the multi-disciplinary team. The overarching goals of PROMPT are to reduce preventable harm and enhance maternity care outcomes. In addition to CCOT supporting the clinical practice teams, we are now involved with individualised training on an 'ad-hod' basis for wards across the Trust. We meet with specific wards and tailor our training to their needs.

Standardised Communication: This year we have created and implemented standardised communication tools and processes to provide prompt, effective communication between healthcare professionals. Regular interdisciplinary meetings, the use of standardised documentation templates, and the implementation of methodical handover procedures can all help achieve this. This has been done by launching and implementing SBARD, throughout the Trust (including maternity) with success. The goal is to keep rolling out to Hertford County, New QEII, and Mount Vernon.

Call for Concern: This year, the CCOT has implemented a significant project. Patients and their families have the option to escalate their concerns if they feel their condition is deteriorating. Improving patient outcomes is the main aim of this initiative. The next part of this project is to roll out the guidance mandated by Martha's Rule. After falling off her bike and becoming sepsis-ridden in the hospital, Martha Mills passed away in 2021 from pancreatic injuries. When Martha's family expressed worries about her failing health, no action was taken. A coroner concluded in 2023 that Martha would have likely lived if she had been admitted to intensive care sooner at Kings College Hospital London. The Secretary of State for Health and Social Care and NHS England pledged to implement "Martha's Rule" in response to this and other cases involving the management of deterioration. This rule aims to guarantee that the patient's and those closest to them have the most important concerns heard and taken seriously.

We were successful in our expression of interest submission and will now be one of the first sites implementing Martha's Rule. Being part of this, we will help the NHS devise and agree a standardised approach to all three elements of Martha's Rule. Once fully implemented, patients, families, carers and staff will have round-the-clock access to a rapid review from critical care outreach.

The three elements of Martha's Rule that have been suggested are:

Martha's Rules	Status
If any member of staff in an NHS trust has concerns about a patient, they should have round-the-clock access to a critical care outreach team for a speedy review.	Achieved
Every patient, along with their families, carers, and supporters, should have equal access to a critical care outreach team's 24/7 quick review. This team can be contacted by mechanisms posted around the hospital and beyond if there is cause for concern over the patient's status.	Achieved
The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily.	To be achieved by 2025-2026.

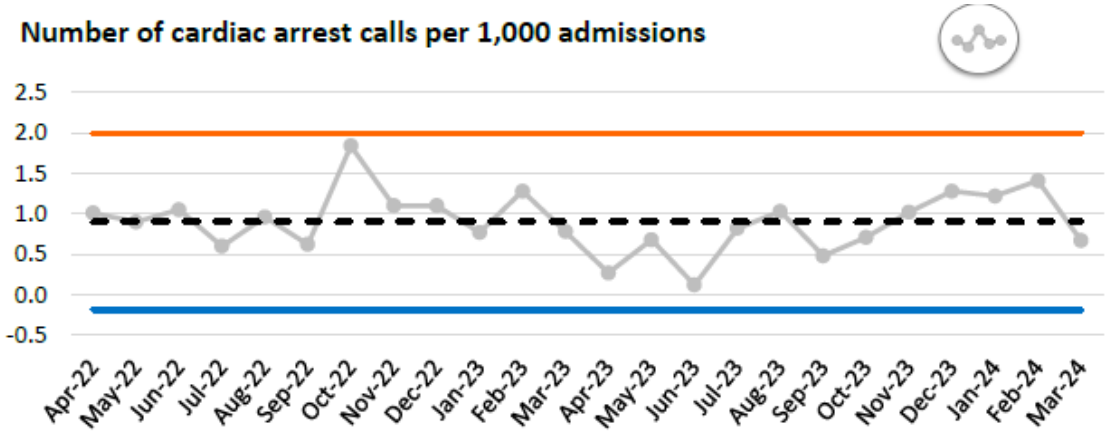
Update on Hospital at Night plans

The term "hospital at night" describes an organisational structure intended to make hospital services safer at night. It entails putting in place a complete systems

approach to care coordination at night. This programme provides clinical jobs at night in a safe and equitable manner. A multidisciplinary team-based approach is employed to deliver our patients safe and effective patient-centered treatment overnight. The team is composed of medical professionals, clinical support workers, and senior nurses. The concept is that the night team works as a cohesive unit, with clinical responsibilities assigned to team members based on their qualifications and experience by a clinical coordinator. A viable hospital at night (HAN) approach is necessary to sustain ongoing control over patient safety and staff well-being. Currently, the Trust has our Critical Care Outreach Team (CCOT) that is available 24/7 to answer to emergency calls on the Lister site as well as alerts regarding patients who are deteriorating. They act as the senior nurse on site in this role, which is sometimes a difficult one. We are planning to recruit to a (senior practitioner) coordinator role for the hospital at night team by September 2024. This additional role would help with prioritising our sickest patients and improving outcomes. The coordinator role would triage all calls and assist with troubleshooting and escalating to the most appropriate member of the night team.

Update on cardiac arrest prevention and management
The Trust cardiac arrest rate remains stable (rate = 0.8) and demonstrates normal variation The Trust continues to submit cardiac arrest data into the National Cardiac Arrest Audit (NCAA).

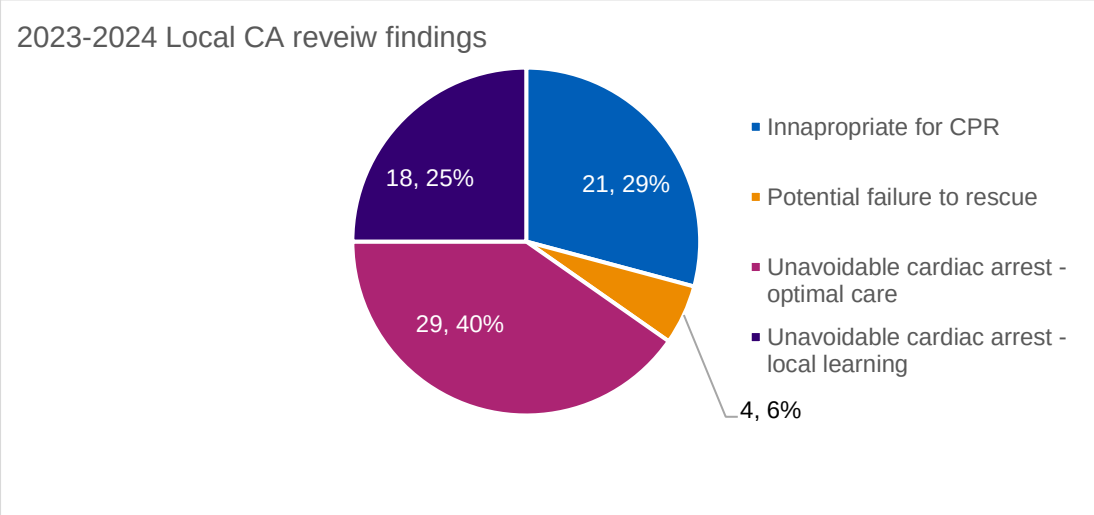
Figure 1 below represents Trust wide cardiac arrest rate per 1000 admissions.



Cardiac arrest rates per 1000 admissions across the wards is below the national average. This excludes areas that may manage their own deterioration and cardiac arrest, such ED, CCU and ACU.

Analysis of the care preceding 2222 calls can provide great opportunity for learning. Understanding the local data in relation to unavoidable cardiac arrest, potentially inappropriate CPR attempts and potential failures to rescue, are key for driving improvement.

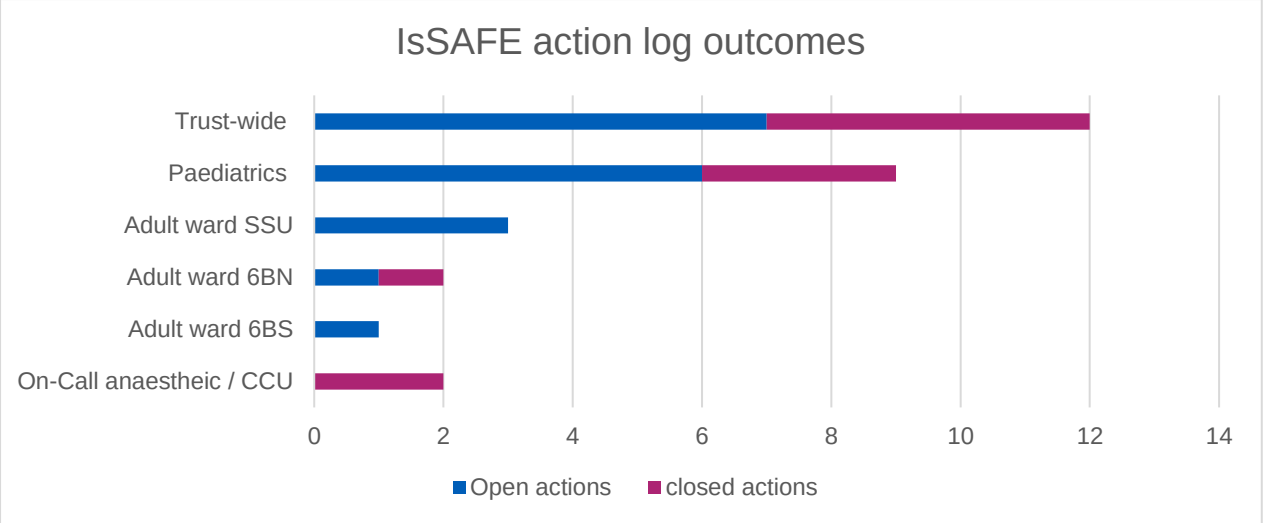
Figure 2 below shows the local CA findings.



40% (n=29) of cardiac arrests were deemed unavoidable, 6% (n=4) reviewed as potential failures to rescue, 25% (n=18) had learning identified and 29% (n=21) reviewed as may have potentially benefitted from improved decision making in relation to the suitability for resuscitation intervention. Advanced care conversations are key to establishing patient's wishes.

Studying 'human factors' to improve learning from 2222 events has been undertaken in 2022-2023. An analysis of all 2222 calls took place for a six-month period. The data has undergone a thematic analysis during 2023-2024 to inform system-change in relation to acute patient deterioration. Human factors analysis has increased opportunities to understand the key factors which influence human behaviour when responding to patient deterioration. As a direct response from the initial findings a further service evaluation was launched in March 2023 exploring both the human factors that impact the response, management and debrief of 2222 calls (deterioration and cardiac arrest). The service have adopted the use of in-situ simulation, to facilitate muti-disciplinary team (MDT) evaluation of human factors impacting the care management of deteriorating patients, in a safe and controlled environment.

Update on IsSAFE (In-situ simulation applying human factors evaluation)
IsSAFE was launched and is now embedding into practice. The learning from Trust patient safety incidents informs the themes and scenario to be explored through simulation in the clinical areas. Real-time patient care episodes are simulated using live systems, environments, processes and responding teams, facilitating evaluation of organisational systems and processes which impact human behaviour and the care of patients. MDT debriefs evaluate human factors (focusing on behaviours and context) and key learning outcomes are established, enabling improvement actions. Trust wide themes are escalated via the Patient Safety Forum and are monitored on the Trust risk register. Figure 3 below shows IsSAFE action log outcomes.



2.1.2.5 Safeguarding Adults and Children

Safeguarding adults and children remain an integral priority for all Trust services. The Trust is committed to ensuring that our statutory safeguarding responsibilities are routinely executed as outlined in the Care Act (2014), Children's Act (1989 and 2004), Working Together to Safeguard Children (2023) and the Mental Capacity Act (2005).

The Trust safeguarding team members along with the chief nurse (who is the executive lead for safeguarding) continue to be members of the Hertfordshire wide safeguarding partnerships for both adults and children. We are also involved in the workings of the various subcommittees associated with these partnerships thus continuing our longstanding emphasis on a multi-agency approach to safeguarding through effective collaboration with our key partner agencies.

Aims:

- Increased focus on Trust wide safeguarding education
- Recruitment of a lead nurse for learning disabilities

Achievements to date:

During 2023/24 through a grant provided by the police and crime commissioner's office we employed a domestic violence adviser and a sexual violence advisor to work alongside our children's sexual violence advisor. We continued to make enhancements to our electronic patient records system to insure prompt and efficient communication of safeguarding management plans directly to our patient facing staff. A key development during the year was the introduction of a discharge passport to enhance communication with care providers in the community for patients who are reliant on others to meet their care needs.

During Q4 of 2023/24 our safeguarding team developed an improved 'was not brought system' to monitor and escalate safeguarding concerns for individuals under the age of 18 years or individuals with a learning disability who are not being taken to hospital outpatient appointments. A practitioner within the Trusts children's

safeguarding team developed a child exploitation pathway which has been adopted by other NHS organisations. During 2023 we set up a revised safeguarding champion's forum in the organisation. All safeguarding related policies are in date and published on the Trust's intranet for our staff to reference. Currently our children's, adults and maternity safeguarding teams are staffed to funded establishment.

Both children's and adult safeguarding referrals have continued to rise and remain above pre-Covid levels; this is likely to be a result of improved detection and escalation of concerns by frontline staff brought about through staff education and the employment of specialists' practitioners in domestic abuse and sexual violence who work alongside our patient facing staff. The incidence of domestic abuse is noted to be high amongst residents living in the Trust's catchment area and accounted for 24% of all safeguarding concerns escalated by our frontline staff during 2023.

Deprivation of liberty (DoL): 701 applications for deprivation of liberty safeguards were made in 2023 which represents a 23% increase when compared to 2022.

The Trust's safeguarding committee, through its associated clinical governance processes, continues to ensure that learning from various types of safeguarding reviews is incorporated into practice and that the business of safeguarding is communicated to the Trust board.

Plans for 2024/25:

- Continue to develop Trust wide procedures in response to learning identified from section 42 enquiries, serious adult case reviews, domestic homicide reviews, rapid reviews and child safeguarding practice reviews.
- Continue the Trust trend noted in 2023/24 in respect to an increase in the numbers of DoLs applications made by clinical areas within the Trust and focus on education across the Trust in respect of the MCA for 16 and 17 year olds.
- Increase focus and spotlight on consolidating learning from reviews within maternity services and developing a strong quality assurance approach to sustaining improvements.
- Consolidate the success of our safeguarding champion's forum with an emphasis on providing staff with safeguarding educational content focusing on a 'think family' approach.
- Recruit a lead nurse to oversee our learning disability strategy in our children's services.

2.1.2.6 Safer invasive procedures standards

Safer invasive procedures standards are designed to reduce misunderstandings or errors and to improve team cohesion. The standards, written by clinicians from multiple professions and specialties, re-launch the World Health Organisation (WHO) checklist. The checklist mandates key stop moments when the standard pathway is confirmed, and patient-specific details clarified.

There are local safety standards for invasive procedures (LocSSIPS) in place with continuous audit of maintenance of the standards in all of the main areas where

invasive procedures take place (theatres, cath lab, radiology and endoscopy). These audits show good adherence to all standards. Work is ongoing to ensure that they are in place for every single invasive procedure done anywhere in the organisation.

2.1.3 Quality Domain: Patient experience

Quality Domain: Patient experience

Priority 3: Respect our patient's time through improving flow through inpatient and outpatient services

Reason: Further improvements required to embed and sustain progress made**.**

Our priority for 2023/24 has been to work towards achieving:
Discharge summaries:

- Continued focus on recent and historical 24hr/7 days discharge summary compliance.

ED 4 hour waiting times

- Continued focus on improving ED 4 hour waiting times
- Establishment of a surgical assessment unit and new patient pathways will be a focus for 2023/2024.

Achievements to date:

2.1.3.1 Discharge summaries:

The Trust established a series of interventions (electronically assessed training modules for staff involved in hospital discharge, standardising discharge templates and removing barriers within the discharge pathway) aimed at improving its performance. Some improvements have been noted although set targets were not met.

- Efforts underway to enhance communication between secondary and primary care via improved discharge summaries.
- Pre 2024 is now cleared so no historical discharge summaries remain. This is the first time in a few years that we are now working in year.
- Surgical Assessment Unit (SAU) is the main hotspot for outstanding summaries, focus to improve in this area. A Surgical SDEC is to open and will use Nervecentre to process their patients with an easier quicker discharge summary. Backlog of Lorenzo summaries is the main focus for improvement.
- Quality concerns escalated to educational leads.
- Ongoing evaluation to determine appropriate correspondence for patients with outpatient procedures, leading to increased outstanding summaries. Discussions and planning taking place to have a robust plan going forward to capture all the outpatient procedures and complete suitable discharge summaries on the day of procedure.

- Organisation remains committed to improving the transfer of patients' care information.

2.1.3.2. Mid-day discharges:

On average, the Trust achieved 15.6% of midday discharges-a slight decrease in comparison to the previous year.

Although the data shows that the number of discharges before 12 midday remained more or less the same there was an actual decrease by 0.18% from 15.78% reported the year 2022-2023 to 15.6% for year 2023/2024

To improve the above 2 year averages and be in line with the national 40% before midday discharge target, the Trust has implemented the following strategies and actions:

- Re-focus on 40% of discharges before 12pm
- New discharge lounge policy has been launched and gives staff guidance on the actions required to optimise the use of the discharge lounge as a single point of discharge
- The Trust has committed to aim to discharge two patients per ward before midday, and all clinicians are encouraged to use the SHOP model (reviewing the sick patients first and then all patients being discharged on that day)
- The Trust has introduced the get ready model supported by the patient flow co-ordinators, site operations, discharge lounge and IDT (the model supports clear lines of communication between the wards site and the discharge lounge. The focus is on optimal use of the lounge and supporting the wards to unlock any barriers to early discharge)
- Launch of discharge task and finish group aimed at engaging ward leaders and clinicians around discharge planning and removing barriers to discharge ; focus on discharge letters, TTOs and pathways; this feeds into other work-streams within the wider system
- The Trust introduced the criteria lead discharge model, which has since been rolled out on two services. The Trust is in the process of rolling out this model to other services; this model aims to support early discharges

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

Length of stay reviews occur weekly within divisions for every patient with a LOS of over 14 days. The Trust continues to work with community partners to safely expedite patient discharge in a timely way, as well as plans and actions developed to manage at ward level.

On average 24.12 % of beds were occupied by patients where the length of stay was more than 14 days: an increase of 3.6% from last year.

The Trust has a new board and ward round standard operating procedure aimed at supporting timely discharges as well as developing a criteria-led discharge competency framework (CLD).

The average length of stay for patients with a LOS >14 and > 21 days has significantly decreased by 5.53% on average from 28.31% to 22.78% for 14 day delays for year 2023 /2024 and by 9.72% from 22.78% to 13.06 % for 21 day delays for 2023/2024.

This was driven by the implementation of the ward and board rounds, the roll out of criteria lead discharges across two services and the collaborative working between the acute Trust and the transfer of care hub (TOCH).

There has been a real focus on addressing delays both internal and external and there is still some work around understanding the root cause of delays and hence the following strategies and actions are being adopted both at place and at system level.

This improvement work has been picked up at 'place' through the newly launched discharge task and finish group; this group aims to imbed the processes that were agreed and implemented by the Trust's discharge improvement group and this feeds into the various work-streams at system level, aimed at standardisation of processes and improve discharges across the system.

- Ward and board rounds compliance: focus on updating expected date of discharge (EDDs), criteria to reside (CTR) data and to ensure the patients pathways are updated in real time throughout the patients journey
- Optimise the use of already embedded alternative pathways on offer and drive the hospital at home (H@H) agenda which has already seen an significant increase in the number of referral to that service in the last year (for example there were 91 referrals in the month of August 2023 and a 35% rejection rate those referrals have continued to improve since then with 154 referrals in March 2024 alone and a rejection rate of 20%; one thing to note is that 15% of the rejections are not driven by capacity but by location, the service is on offer for patients within the localities and not out of area patients. The introduction of the QDS intravenous antibiotic pathway, in-reach nurses by TOCH as well as the collaborative work between site operations team and TOCH has had a significant impact on the discharge process and well as the overall length of stay; this piece of work has now been picked up by the newly appointed H@H service manager who is now focused on exploring new opportunities around trauma and orthopaedic oncology, colorectal and general surgical pathways
- The Trust is linking in with TOCH and ICB to explore ways to improve delays affecting out of area patients, patients going to new care home placements (care homes do not offer a seven day service), equipment delays (equipment delivery is offered fine and a half days a week instead of seven days a week
- The Trust is supporting admission avoidance pathways offered by TOCH and has welcomed the introduction of the garden hospice frailty pathways which initially focused on ED and frailty unit. This has now been rolled out to the rest of the Trust. On average, two patients are discharged into that pathway daily and the aim is to save at least 800 bed days a year; that will have a significant impact on the average length of stay for the 7,14 and >21 day measures.

2.1.3.4 Reduce delays by >90% for ED 4 hour waiting time

To improve performance against the four-hour standard, the Trust embarked on a multi-project programme to develop a new emergency care model.

The national four-hour standard still remains at 95% with a recovery trajectory set at 76% of patients arriving at the Emergency Department (ED) to be admitted to hospital, transferred to a more appropriate care setting, or discharged home within four hours by the end of March. In April 2023 the Trust's 4-hour performance was 64.2% and the Trust achieved 73.8% in April 2024

The ambition of the programme was to transform emergency care pathways to provide alternative(s) to the ED where appropriate, thereby reducing the volume of patients in ED and improving patient flow and experience.

With the support of Hertfordshire and West Essex Integrated Care Board (HWE ICB) funding, a new Adult Urgent Treatment Centre (UTC) opened in January 2024 on the Lister Hospital site. The service is open from 8am to 10pm/7 days per week and can treat a range of minor illnesses and minor injuries for adults aged 16 years and over that would otherwise have gone to ED. In the first seven weeks of opening, the UTC treated more than 2,500 patients, with the average time from arrival to discharge of 1 hour 43 minutes. Plans are in development to expand the service to include children (under 16 years) which will enable the Lister UTC to fully mirror the successful model at the New QEII Hospital.

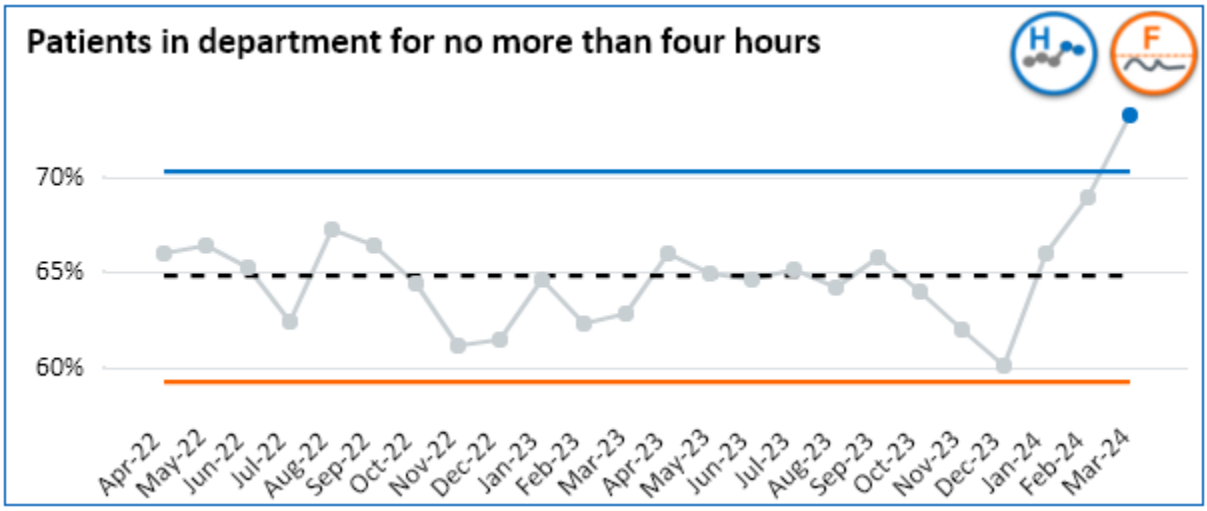
Acute Medical Services (AMS) reset their service model to increase the flow through the department, resulting in a 148% increase in transfers from the Acute Medical Unit to either a patient's preferred place of discharge or to an inpatient bed. The Medical SDEC opening hours were also extended until 10pm to provide additional capacity for patients who had either been directed to the medical team by their GP, or who were identified as requiring medical team intervention by the ED.

A Surgical Assessment Unit (SAU) was formally re-established in January 2024 having been stood down during the COVID-19 pandemic. This is a dedicated service for the assessment of emergency surgical patients who may be referred directly by their GP or who have presented to the ED and referred to surgical specialties for further assessment and possible inpatient admission. Since opening the SAU has cared for over 1,000 patients. The service also supports a Surgical SDEC which will continue to expand its capacity in line with recruitment of workforce.

In addition to alternative services, the ED has revised nursing and medical workforce rosters to ensure the staffing model aligns with expected peak times in patient arrivals to the department. The new rosters came into effect in January 2024 and continue to be embedded across all staffing groups, providing more support during peak hours. Work is also ongoing to increase diagnostic capacity with an additional CT machine expected to open for ED patients and inpatients from April 2024. Paediatric ED has also been part of the ED improvement programme and further focus on new space for time to triage during peak times, development of the CDU and redesign of the medical workforce to align with expected peak demand is forecast to improve paediatrics ED four-hour performance further in 2024/25.

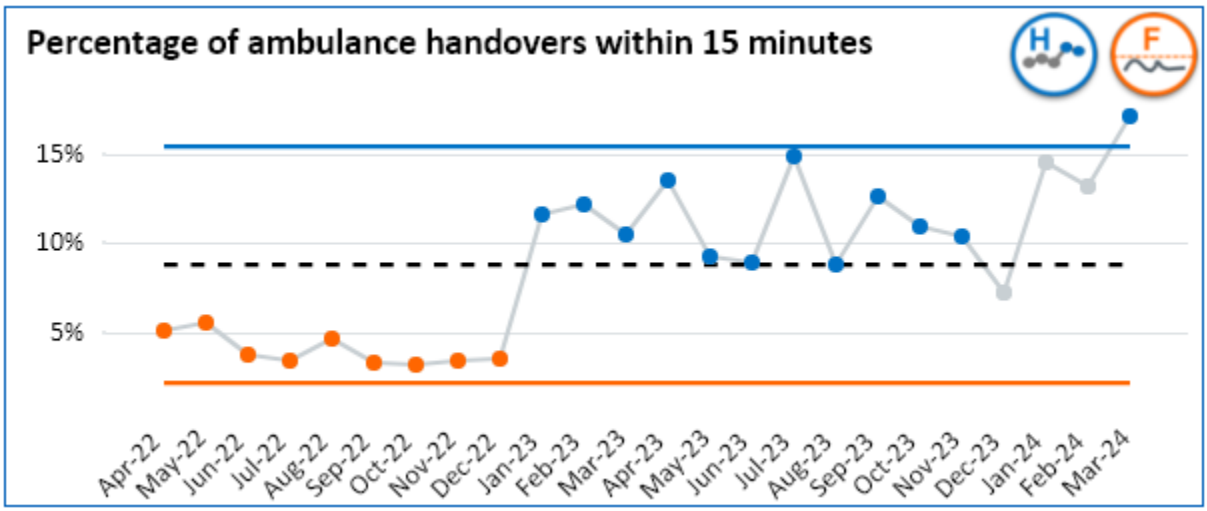
All Urgent and Emergency Care (UEC) services are operating under a model of continuous improvement with processes constantly reviewed to identify areas of opportunity. The ED has reviewed and refined their streaming and triage models to ensure patients are directed to the most appropriate service at the earliest opportunity. Further areas of development and improvement will be identified and driven in 2024/25.

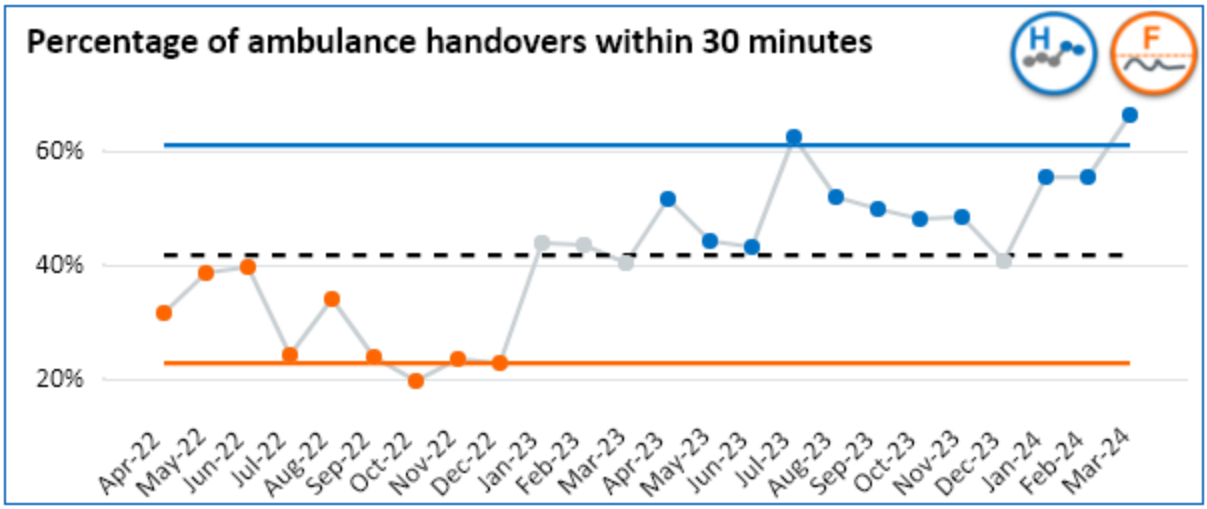
In March 2024, the Trust's four-hour performance standard increased to 73.18%. Many of the improvement initiatives did not commence until January 2024 therefore it is anticipated that as new pathways and services embed performance will continue to improve in this area in-line with the target of 78% for 2024/25 but will remain under close observation.



Update on Ambulance handover

The Trust with East of England Ambulance Service NHS Trust (EEAST) and other partners such as Hertfordshire Community Trust and the other acute providers, worked hard to significantly reduce handover time for those patients bought to the department by ambulance. Despite the number of conveyances, the Trust through its actions and work on the urgent care pathways has significantly improved handover time therefore enabling ambulances to get back out into the community and patients arriving to the department getting the care they require in a quicker timeframe.





Plans for 2024/25:

ED 4 hour waiting times

- Continued focus on improving ED 4 hour waiting times in-line with the target of 78% for 2024/25
- Increase diagnostic capacity with an additional CT machine expected to open for ED patients and inpatients from April 2024.

2.1.4. Quality Domain: Patient experience

Quality Domain: Patient experience

Priority 3: Respect our patient's time through improving the flow through inpatient and outpatient services

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

Our Priority for 2023/24 has been to work towards achieving:

- Develop and implement an electronic system for the capture of identified carers.
- Set up a quarterly carers forum to ensure that the objectives are being met and challenged

Achievements to date:

Friends and family test (FFT) scores

We have continued to have sustained performance in all categories of our friends and family test scores with positive feedback received. Through developing and implementing specific initiatives based on themes from the previous year's FFT survey, utilising feedback data and reviewing other sources of patient feedback, we have been able to determine where key focus can be given to improve our position.

Theme	21/22	22/23	23/24
Patient feedback	Inpatient 96.69 Outpatient 95.52 Maternity 95.90 Emergency Department 85.98	Inpatient 96.37 Outpatient 96.09 Maternity 96.25 Emergency Department 88.10	Inpatient 96.45 Outpatient 96.34 Maternity 98.17 Emergency Department 92.61

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

Develop and implement an electronic system for the capture of identified carers

The Trust now has the ability to record on electronic records if someone is a carer, unpaid carer, young carer or cared for. This has been a great improvement to ensure we are monitoring and providing any additional support to these groups whilst in hospital.

Set up a quarterly carer's forum to ensure that the objectives are being met and challenged
The Trust has been successful in setting up quarterly forums, both face to face during the day and online in the evenings to ensure we are capturing everyone's views and experiences.

Initiatives to improve patient and carer experience during the year included

- Introducing a quarterly carers forum. This includes a face-to-face quarterly meeting and also and evening online session to provide inclusive options for carers.
- An elderly care ward has taken a proactive approach to improving communication with carers through a quality improvement project. Feedback from carers highlighted that carers are not consistently receiving timely updates.
- From April 2023 to March 2024 the forget-me-not volunteers have given over 918 hours of their time, equating to 24 working weeks, to provide 924 support visits.
- Alerts on the hospital digital system so carers and cared for can be identified when using any of the hospital services.
- Promotion of local resolution meetings when a formal complaint is raised to provide compassionate resolution when difficult experiences have been shared.

2.2 Quality Priorities for Improvement 2024-2025

Introduction to 2024/25 quality priorities
The Trust's board recognises that the foundation to excellent care delivery lies in the skill, enthusiasm and innovation our staff teams bring to their individual roles. This means that we will now actively seek to build on this and achieve an organisational culture that empowers our staff to take the initiative, deliver high quality care guided by the care fundamentals and therefore make lasting changes that benefit patients accessing our services and the community at large.

Our Trust mission is to provide high quality compassionate care for our communities.

We will drive our system to develop expertise and business as usual approaches to continuous improvements through embracing a quality management system approach through our 'ENH production system' (ENH PS).

In 2023, we started the next phase of our improvement journey supported by our partner the Virginia Mason Institute. This will provide an infrastructure that ensures we put the patient first, lead with quality and remain a sustainable organisation. We are committed to trying new approaches and positively learning from failures through the adoption of a method that champions the voice of the people who know the work best and contribute to improving our systems. We have called this improvement method, the ENH production system (ENH PS).

The ENH PS is based on lean methodologies that will provide a unified way of thinking and acting through a set of philosophies and practices. This approach has been grounded in a wealth of evidence that is built on the foundational belief that by

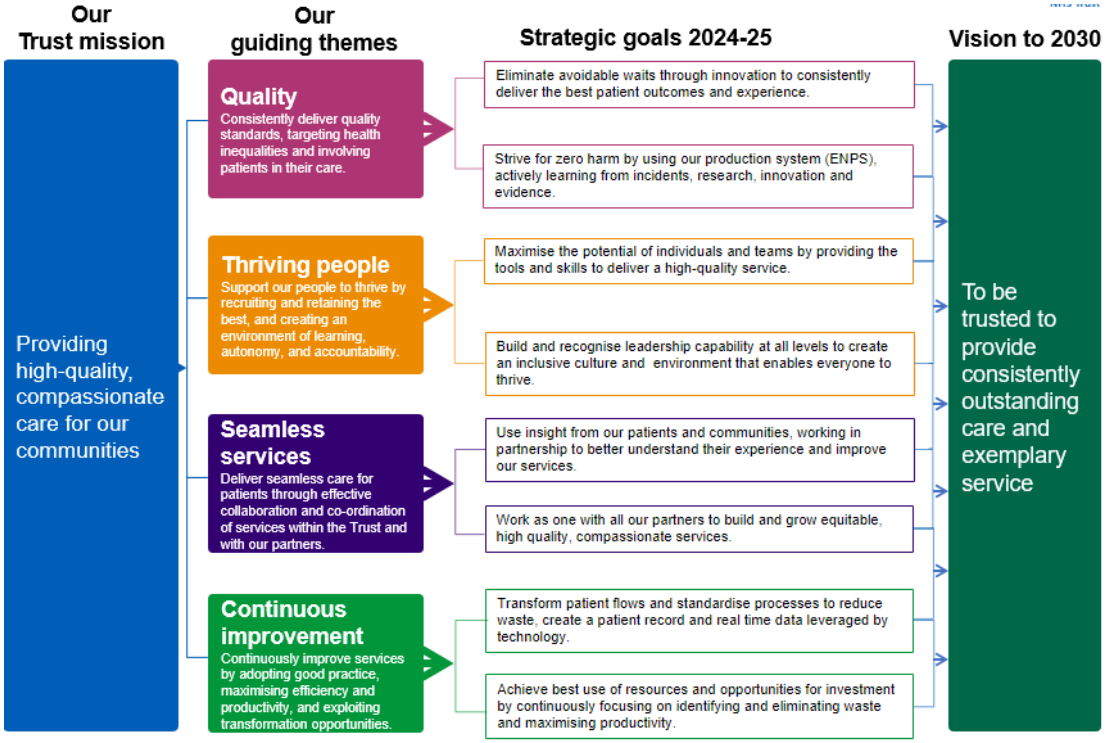
eliminating waste, organisations can improve quality and safety and increase staff satisfaction. It is from this belief that our improvement philosophy was created.

Through focusing on high quality and high reliability within our systems, the tools of the ENH PS will be delivered through behaviours and attitudes that emanate inclusion of our patients and partners, being respectful of everyone's contributions and with a driving focus of continuous improvement.

A key action will involve developing approaches to standard work, for example executive rounding throughout the organisation. Senior leaders will spend time engaging staff where they work, to listen and solicit feedback and opportunities for making their departments and the whole organisation better.

We acknowledge that staff experience directly connects to patient satisfaction; therefore the ENH PS will proactively offer patients the opportunity to engage in our improvement events, especially those who may have had a less-than-perfect interaction with our Trust or system.

Strategic goals 2024 to 2025



2.2.1 Highlighted below are our priorities which are aligned with the Trust's quality strategy priorities. These priorities were developed following appropriate consultation with relevant parties.

Quality Priorities 2024 to 2025		
Domain	**Description**	**Key Focus Areas**
Effective	Good governance • Excellent responsiveness to incidents • Learning from incidents	Digital transformation Ward to board assurance of Patient Safety Incident Response Framework (PSIRF) safety standards Pathways to excellence - drive effective outcomes in response to service level quality standards
Safe	• Valuing the basics: Keeping our patients safe	Nursing quality fundamentals improvement programme Medicines management and antibiotic stewardship Medical devices – improved EBME service and equipment library Infection prevention control (IPC) – C.Diff improvement programme Safeguarding oversight and triangulation with other domains of quality Documentation – adopt new documentation standard to include SBARD Adult and paediatric deteriorating patients (including sepsis) – National pilot for Martha's rule and imbed call for concern End of life care – Gold Standards Framework Invasive procedures LocSSIP compliance across non theatre specialities Discharge transformation programme - safe and timely discharges

Patient Experience	• PACE programme	Responsiveness to complaints – driving improvements across key themes Excellent engagement and co-design following patient safety incidents
Well Led	• Good governance compliance framework	Staff survey Clinical leadership programmes- nursing excellence faculty Quality assurance framework – standardised across new operational management model Freedom to speak up- strengthening the FTSU MDT network People strategy – Equality diversity and inclusion (EDI) actions Imbedding risk management strategy

These quality priorities and other key quality indicators will be monitored regularly with oversight at various quality and patient safety fora. A quarterly report on progress against these priorities will be produced for the Trust Management Group and the Quality and Safety Committee.

2.3 Statements of Assurance from the Board

Review of services

The Trust continued to provide a range of acute and specialised services in 2023/24, including directly provided and sub-contracted services across four care divisions. The Trust has reviewed the data across all the relevant health services and operated in accordance with the NHS Operating Framework. For further details please refer to the Trust Annual Report.

Participation in clinical audits
The Trust continues to maintain an active clinical audit programme and reviews current clinical audit processes to ensure we are able to evidence improvements in clinical practice, patient experience and outcomes.

During 2023/2024 the Trust participated in 60 National Clinical Audit and Patient Outcomes Programme (NCAPOP) and other national quality improvement programmes NHS England advises Trusts to prioritise for participation. During this period the Trust participated in 92% of the NCAPOP and other prioritised national quality improvement programmes relevant to the Trust's provided services.

National Clinical Audit and Patient Outcomes Programme (NCAPOP) and NHS England prioritised national quality improvement programmes participation
The National Clinical Audit and Patient Outcomes Programme (NCAPOP) and other prioritised national quality improvement programmes the Trust has participated in, for which data collection was completed during financial year 2023-2024 are listed below alongside the number of cases submitted, expressed as a percentage of the number of eligible cases required.

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
Adult Respiratory Support Audit		Y	62 patient questionnaires (100% case ascertainment) 1 organisational questionnaire (100% case ascertainment)
British Association of Urological Surgeons (BAUS) Nephrostomy Audit	Nephrostomy audit	Y	7 cases (100% case ascertainment)
Breast and Cosmetic Implant Registry		Y	20 cases
British Hernia Society Registry		**N	**Trust unable to participate because the registry was trialled amongst BHS committee member sites.
Child health clinical outcome review programme (National confidential enquiry into patient outcome and death NCEPOD)	Juvenile idiopathic arthritis	Y	4/5 (80%) clinical questionnaires 5/5 case notes 1 (100%) organisational questionnaire
Case Mix Programme (CMP)		Y	Intensive Care Unit: 873 cases (Q4 data in validation) Respiratory High Dependency Unit: 295 cases (100% case ascertainment)
Elective surgery national PROMs programme		N	

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
Emergency medicine QIPs	Care of older people	Y	Data collection in progress. Project cycle commenced in October 2023 to October 2024
	Mental health (self-harm)	Y	Data collection in progress. Project cycle commenced in October 2023 to October 2024
Epilepsy12: national clinical audit of seizures and epilepsies for children and young people		Y	Cohort 5 submission, and non-participation organisational audit.
Falls and fragility fracture audit programme (FFFAP)	National audit of inpatient falls (NAIF)	Y	13 (61.5% case ascertainment)
	National hip fracture database (NHFD)	Y	459 (100% case ascertainment)
Improving quality in Crohn's and Colitis (IQICC)		N	Trust did not participate
Learning from lives and deaths of people with learning disability and autistic people (LeDeR)		Y	15 notifiable cases (100% case ascertainment)
Maternal, newborn and infant clinical outcome review programme (MBRRACE)	Perinatal mortality surveillance	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	Perinatal morbidity and mortality confidential enquiries	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	Maternal mortality surveillance and mortality confidential enquiries	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	Maternal morbidity confidential enquiries	Y	Continuous data submission. Exact numbers of cases submitted not available at the time of reporting
Medical and Surgical clinical outcome	Endometriosis	Y	6/6 (100%) clinical questionnaires and case notes

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
review programme (National confidential enquiry into patient outcome and death NCEPOD)			1 (100%) organisational questionnaire
	Care at the end of life	Y	6/6 clinical questionnaires (100%) 5/6 case notes (83% case ascertainment) Organisational questionnaire not yet released
National adult diabetes audit (NAD)	National diabetes footcare audit (NDFA)	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	National diabetes inpatient safety audit (NDISA)	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	National pregnancy in diabetes audit (NPID)	Y	48 Cases
	National diabetes core audit	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National asthma and COPD audit programme (NACAP)	COPD secondary care	Y	550 cases
	Adult asthma secondary care	Y	138 cases
	Children and young people's asthma secondary care	Y	29 cases
National audit of cardiac rehabilitation		Y	Initiating Event Record: 392 Patient Record: 314 Early CR: 393 Core CR: 284 Assessment 1 Records: 142 Assessment 1A Records: 7 Assessment 2 Records: 80
National audit of care at the end of life (NACEL)		Y	Project commenced January 2024 and is in progress
National audit of dementia (NAD)	Round 6 care in general hospitals	Y	60 cases (100% case ascertainment)

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
National cancer audit collaborating centre	National audit of metastatic breast cancer	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	National audit of primary breast cancer	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National cardiac arrest audit (NCAA)		Y	93 (data for Q4 in validation)
National cardiac audit programme (NCAP)	National heart failure audit (NHFA)	Y	305 cases
	National audit of cardiac rhythm management (CRM)	Y	681 cases
	Myocardial ischaemia national audit project (MINAP)	Y	363 cases
	National audit of percutaneous coronary intervention (NAPCI)	Y	376 cases
National child mortality database (NCMD)		Y	Data not submitted directly by the Trust
National comparative audit of blood transfusion	2023 audit of blood transfusion against NICE quality standard 138	N	0 cases submitted
	2023 bedside transfusion audit	Y	Audit in progress, cycle closes at the end of April 2024.
National early inflammatory arthritis audit (NEIAA)	Year 6	Y	123 cases submitted
National emergency laparotomy audit (NELA)		Y	125 cases submitted
National gastrointestinal cancer audit programme (GICAP)	National bowel cancer audit (NBOCA)	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
	National oesophago-gastric cancer audit (NOGCA)	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National joint registry (NJR)		Y	Hips 397 Knees 240 Ankles 8 Elbows 16 Shoulders 30
National lung cancer audit (NLCA)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National maternity and perinatal audit (NMPA)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National neonatal audit programme (NNAP)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National ophthalmology database (NOD) audit	National cataract audit	N	
National paediatric diabetes audit (NPDA)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National prostate cancer audit (NPCA)		Y	Exact numbers of cases submitted not available at the time of reporting
National vascular registry (NVR)		Y	*CQUIN* **35** AAA repair **33** Carotid procedure **25** Bypass procedure **12** Angioplasty procedure **53** Amputation Procedure **23**
Perinatal mortality review tool (PMRT)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
Perioperative quality improvement programme		Y	254 cases submitted

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
Sentinel stroke national audit programme (SSNAP)		Y	941 cases (≥90% case ascertainment)
Serious hazards of transfusion UK national haemovigilance scheme		Y	20 (100%)
Society for acute medicine benchmarking audit	SAMBA23	Y	Lister: 76 QEII: 21
Trauma audit and research network (TARN)		Y	
UK renal registry	Chronic kidney disease audit		Continuous data submission. Exact case numbers submitted not available at the time of reporting
	National acute kidney injury audit	Y	Stage 1: 3315 cases Stage 2: 507 cases Stage 3: 295 cases

During 2023/2024 the Trust was ineligible to participate in the following 18 NCAPOP projects because the services are not provided by the Trust.

NCAPOP
Cleft registry and audit network (CRANE) database
Falls and fragility fracture audit programme – fracture liaison service database (FLS-DB)
Mental health clinical outcome review programme
National asthma and COPD audit programme (NACAP) - pulmonary rehabilitation
National audit of cardiovascular disease prevention in primary care (CVDPrevent)
National audit of pulmonary hypertension
National bariatric surgery registry
National cardiac audit programme (NCAP) - National adult cardiac surgery audit (NACSA)
National cardiac audit programme (NCAP) - National congenital heart disease audit (NCHDA)
National cardiac audit programme (NCAP) - National audit of mitral valve leaflet repairs (MVLR)
National cardiac audit programme (NCAP) - UK transcatheter aortic valve implantation (TAVI) registry
National clinical audit of psychosis (NCAP)
National obesity audit (NOA)

Out-of-hospital cardiac arrest outcomes (OHCAO)
Paediatric intensive care audit network (PICANET)
Prescribing observatory for mental health (POMH) - use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services
Prescribing observatory for mental health (POMH) - monitoring of patients prescribed lithium
UK cystic fibrosis registry

Reviewed National Clinical Audit and Patient Outcomes Programme (NCAPOP) reports

Seventeen national clinical audit and patient outcomes programme (NCAPOP) reports were reviewed by the Trust during 2023/2024. The Trust intends to use the intelligence derived from participation in NCAPOPs to improve the quality and effectiveness of clinical care and ensure it is based upon nationally agreed standards of good practice and evidence-based care.

NCAPOP	Key successes, lessons learned and actions
National Paediatric Diabetes Audit (NPDA) Parent and Patient Reported Experience Measures (PREMs) 2021 (based upon 02/08/2021-02/01/2022 data)	Key successes: Trust conforms to 7/8 (87.5%) of the published national recommendations relevant to the Trust. Key actions: • To meet the recommendation of children and young people having access to a Psychologist with diabetes expertise, a second Clinical Psychologist has been recruited. This will reduce patient waiting times support the increased number of referred patients and reduce waiting times. • Additionally, ongoing action is being taken to improve the waiting area for transitional care patients
National Paediatric Diabetes Audit (NPDA) (based upon 01/04/2021 to 31/03/2022 data)	Key successes: The Trust conforms to 2/4 (50%) of the Trust relevant published recommendations. Key actions: • To ensure diabetes multidisciplinary team is adequate staffed to manage the increasing numbers of type 1 and type 2 diabetes patients a business case is being developed. Additional actions include: • Discussions about the roll-out of a new IT system across all diabetes services, supporting the collection of good quality data, ensure consistent healthcare checks in accordance with NICE and automatically submit data towards NPDA. • Although HbA1c is offered 4 or more times per annum, ongoing action is being taken to increase clinic capacity by increasing the number of Consultants to ensure children and young people are consistently offered 4 face to face clinics per year.

NCAPOP	Key successes, lessons learned and actions
UK Parkinson's Audit report 2022	Key successes: Trust conforms to 4/7 (57%) of the national recommendations Key actions: • Ongoing work is taking place in relation to Parkinson's patient referral access to community support occupational therapy, physiotherapy and speech and language therapy services in accordance with NICE quality statement 3 which was less than 100% (93.8-97.7%). • Ongoing action is being taken to ensure the recording of non-motor symptoms in clinics, Parkinson's UK risk and consent form to ensure they are used more frequently. • Ongoing work taking place to ensure the use of standardised guidance, assessments and outcome measures in occupational therapy, physiotherapy and speech and language therapy provided by Community support. • Ongoing work taking place to ensure all appropriate patients have access to Clozapine in accordance with NICE quality statement 5 for treating hallucinations and delusions provided by Psychiatry services. Additional actions include: 1) To address inpatient medicines management in terms of levodopa being administered within 30 mins of prescribed time in accordance with NICE quality statement 4 and outpatient clinic patients being asked about the development of side effects, Trust self administration policy is being reviewed and Trust's EPMA system has become helpful at deriving reports; 2) To ensure the Parkinson's service is part of an integrated delivery model ongoing pathway discussions and workshops with ICB and system partners are to take place.
National Joint Registry 20th Annual report on 2022 data	Key successes: • Trust awarded gold award for quality data entry. • Trust was a positive outlier for use of valid NHS number (Trust 98.2% vs National 95%) • Trust was in line with the national average for NJR consent submitted (Trust 82.4% vs National 90%) and time taken to enter data (Trust 40 days vs National 30 days) Key actions: • Dedicated NJR data manager is required to improve the rate of obtaining consent and entering NJR forms in a more timely manner.

NCAPOP	Key successes, lessons learned and actions
National Cancer Audit Collaborating Centre (NATCAN) – National oesophago-gastric cancer audit (NOGCA) annual report 2022 (based upon 01-04-2019-31/03/2021 data)	Key successes: Trust conforms to 5/7 (71%) of the national published recommendations. Key actions: • Local clinical audits and presentations will be used to address the need for reviewing stage 4 diseased patients and patients diagnosed after an emergency admission to identify opportunities for earlier detection.
Perinatal Mortality Review Tool (PMRT) (Fourth annual report)	Key successes: The Trust conforms to 4/5 (80%) of the national recommendations met Key actions: • To ensure adequate PMRT review team resourcing, a band 4 MSW job description is being developed and job matching to support data entry to PMRT. • In addition to in identify the needs of Asian and Black women, an equity and equality action plan has been developed and continued engagement will take place to ensure a better understanding of their reproductive needs.
Falls and Fragility Fractures Audit programme (FFFAP) – National hip fracture database (NHFD) The 2023 National Hip Fracture Database annual report based on data from 1 January 2022 to 31 December 2022.	Key successes: The Trust conforms to 7/10 (70%) of the national recommendations. Above national mean achievement of BPT despite system issues around beds, physio and theatre pressure. Key lessons learned: 2023 discussion focussed on procedures for inter-trochanteric fractures and audit results. Key actions: 1) Planned Trust wide initiatives to improve early ED assessment and bed availability will support patients being offered pain relief and admitted within 4h. 2) Discussions taking place around the development of a fast-track protocol in addition to specialist nurses liaising with peer units to support all patients reaching an appropriate bed promptly. 1) A peer unit is to be liaised with as to how they have been able to follow up patients after IV zolendronic acid infusions.
National Audit of Care at the End of Life (NACEL) Fourth round audit report 2022-2023 report	Key successes: The Trust was above the national summary scores for 6/7 identified areas. The Trust performed above the national average at discussing the possibility a patient may die with families and others (National mean = 96% vs Lister mean= 97.7%). The Trust conforms to 3/8 (37.5%) of the national recommendations. Key lessons learned: • Only two members of staff responded to the staff quality survey, which meant our responses were not featured in

NCAPOP	Key successes, lessons learned and actions
	the reports. Lack of conversations about nutrition and hydration options and the associated risks and benefits were noted. Also noted, the low numbers of conversations around the possibility that medications may make the dying person drowsy. Overall, the need for consistent documentation of the reasons why conversations have not been had. All these elements will be considered and factored into teaching and practice. Ongoing key actions: 1) Patient owned ReSPECT document has been launched, replacing the DNACPR forms. This is supported by the Trust's "Introduction to Planning Your Care" leaflet and introduction of the gold standards framework (GSF) which will encourage advanced care planning discussions and remain with patients upon discharge into the community. Three wards are being prepared for GSF training. ReSPECT is audited with the results influencing training. 2) The recent digitalisation of the Individual Care Plan for the Dying Person (ICPDP) has been mandated in the majority of areas to avoid areas being missed or not holding early discussions. Training in the use of the digitised ICPDP is being delivered and usage is being audited. Staff are being supported in having early advanced care plan conversations and raising the importance of having these conversations. 3) All current staff training opportunities are regularly reviewed and where possible new opportunities are identified 4) The team are working to educate and support nursing and medical teams to recognise and manage thirst and reinforce the need for conversations around nutrition and hydration options, in addition to the risks and benefits. 5) Bereavement has been identified as an area for improvement
National Audit of Dementia (National audit of dementia care in general hospitals 2022-20223 round 5 audit report)	Key successes: 1) Trust conforms to 2/2 (100%) of the national recommendations. 2) The Trust collects feedback from 2-3 people with dementia per month as recommended by NAD and the feedback is used to inform our improvement focus. 3) Completion of "This is Me" document enables staff to deliver person catered care. It is included in dementia training and audited on ward as part of the Clinical Excellence accreditation. 4) The Tier 2 dementia training program has been expanded to include simulation training and Tier 2 is delivered as a rolling program to all trainee Clinical support workers.

NCAPOP	Key successes, lessons learned and actions
	5) The dementia team now includes a dementia volunteer coordinator, 1-year fixed term post funded by ENHT charity. 6) The Trust now has a nutrition and hydration group creating the opportunity to incorporate the specific needs of the patients living with dementia during a hospital stay. 7) Refurbishment of ward 10A has followed Department of Health Dementia- Friendly health and social care environment guidance. 8) The Trust's incident reporting management system (ENHance) allows for the additional codification of patients living with dementia Key actions: 9) A quality improvement project is underway on an elderly care ward focusing on improving communication between carers and hospital staff. This builds on communication improvement activity already undertaken in other areas of the Trust. 10) Following review of the Lister hospital environment, recommendations have been made to ensure all areas have large clocks that display the date and time.
National Comparative Audit of nice quality standard QS138 (Published February 2022)	Key successes: Trust conforms to 2/2 (100%) of the national recommendations. Key lessons learned: The Trust continues to encourage the recording and promotion of iron supplementation for anaemia, liaising with the pre-operative assessment team.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) (Published March 2022)	Key successes: Neonatal team conformed to 5/5 (100%) of the relevant national recommendations.
National Prostate Cancer Audit (NPCA) (Published January 2024)	Key successes: 1) The Trust conformed to 2/4 (50%) of the relevant national recommendations. 2) The trust is a high-volume centre and the 5th largest prostatectomy centre in the country and have one of the lowest readmission rates in the country. Key lessons learned: More support is required to upload data to ensure we achieve full case ascertainment. Key actions: 1) Discussions are to take place with MDT data support teams to ensure performance scores from GP 2 week wait referrals, TNM and Gleason scores are captured and uploading, to support the achievement of a higher degree of key data items completeness.

NCAPOP	Key successes, lessons learned and actions
	2) In response to a GU toxicity post prostatectomy outlier notification, a full root cause analysis and audit was undertaken. In response to a slightly higher bulbar stricture rate identified, Surgeons have been advised related to some surgeons using a larger catheter and leaving them in for too long.
BAUS data and audit programme – muscle invasive bladder cancer at transurethral resection of the bladder audit (MITRE)	Key successes: The Trust conformed to the audit's standards.
Society for Acute Medicine's Benchmarking Audit (SAMBA) – SAMBA 2023 report: A national audit of acute medical care in the UK	Key successes: The use of the SDEC pathway has optimised admission avoidance/early supported discharge. Key lessons learned: Improvements are required to the time to first clinician review and Consultant review. Key actions: 1) ED planned improvements to improve patients being seen by a tier 1 clinician within 4h of arrival to hospital 2) Planned initiatives to decongest ED, supporting the achievement of 76% of ED patients being reviewed by a competent clinical decision maker within 4h of arrival across HWE. 3) Planned initiatives to improve unplanned admissions reviewed by a competent clinical decision maker within 4H of arrival in SDEC, include Nervecentre documentation trail for clinical review lag pending investigation results made available and enhanced SDEC staffing across 7 days. 4) Planned staffing and bed flow initiatives to improve percentage of unplanned admissions with Consultant review within target time 5) Improvements to support bed management for flow model via AMU to improve Consultant review of unplanned admissions arriving during the daytime within target time. 6) Improvements to staffing for post take ward rounds for overnight boarded medical patients, decongesting ED and single clerking to improve unplanned overnight admissions having a Consultant review within the 14h target time.
Learning from lives and deaths – people with a learning disability and autistic people (LeDeR) (published July 2022)	Key successes: 90.5% (19/21) of Trust SJR reviews concluded learning disability patient's care to be either adequate, good or excellent, comparable to national findings. Key lessons learned: 1) During 2022/23, 21 adults with a learning disability died in the Trust. The Trust's leading causes of death were

NCAPOP	Key successes, lessons learned and actions
	sepsis, respiratory failure, cancers or complications of cancer. In ENHT males accounted for 48% of the deaths and females 52% 2) In the Trust during 2022/23, 81% of patients with a learning disability had a DNACPR in place at the time of their death. **3)** Between the periods of June 2021 - May 2022 and June 2022-May 2023 the following trends were observed: • There was a 40% increase in the numbers of individuals with an LD referred to the Trust for an elective procedure or outpatient assessment whereas for the non-LD population this was 9.14% • There was a 7.17% increase in the number of registered learning disability patients registered on our EPR system • 20% of individuals with an LD waited six months or longer for an appointment or elective procedure, which was 4.7% higher than the general patient population (15.3%) • Potentially attributed to wider health care system inequalities pulled through from the COVID and industrial actions. The Trust intends to close the 4.7% waiting time gap difference between the LD and non-LD populations. The Trust is unable to determine whether inequality was a direct or indirect factor between the two time periods. Key actions: 1) Development of an LD nursing associate role. 2) Develop easy to read appointment letters. 3) Change individuals with LD alerts to 'was not brought'. 4) Changing places toilet facility. 5) In terms of the Trust's scheduling policy, develop a system for learning disability waiting list oversight (Specific system to monitor LD patients required particularly to monitor cancellations which may place individual at risk. 6) Trust to develop a hospital virtual tour to aid learning disability patients who are attending hospital appointments to be placed on the Trusts web site. 7) Revise LD complaints and patient feedback systems. Switch to 'Ask, Listen, Do', as favoured by NHSI/E. 8) TEPs and DNACPR Trust procedure and guidance for completion and decision making. 9) Develop a specific Trust forum on learning disabilities. 10) Implement Oliver McGowan training implementation.

NCAPOP	Key successes, lessons learned and actions
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) - Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20	Key successes: Trust conforms to 7/10 of the relevant national recommendations. Key actions: 1) To address the national recommendation of vulnerable and young women being overrepresented amongst those who have died from ectopic pregnancy, the team is currently reviewing its ectopic pregnancy guideline. This is in addition to existing measures of a detailed social and safeguarding history being taken at diagnosis and appropriate safety advice and phone numbers being given. Also, these patients are also put on the Trust's EPU database that is accessible to all doctors in the Hospital and personalised management plans discussed in multidisciplinary team meetings. 2) The thromboprophylaxis and termination of pregnancy guidelines are in the process of being reviewed. 3) The team is in the process of reviewing the antenatal care guideline to address the national recommendation of involving critical care teams in antenatal multidisciplinary team planning for women with serious morbidity who are anticipated to admission to intensive care postpartum.
MBRRACE perinatal mortality surveillance (Published September 2023)	Key successes: Funding received for placental histology at Addenbrookes (started Sept 2022), Aspirin for all women with a previous baby <10th centile (guideline updated 2022), management of jaundice – business case for more community bilirubinometers Key lessons learned: Documentation at the time IUD is diagnosed, Observations in triage at the time the IUD is diagnosed, Lab not processing Kleihauer, placental histology
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) Epilepsy (Published December 2022)	Key successes: Emergency department conforms to 4/11 (36%) of the relevant recommendations and the neurology department conforms to 9/11 (82%) of the national recommendations Neurology actions include • Nationwide portal to contact epilepsy specialists • To discuss with pathology the making all anti-seizure medication levels measured available • Develop a guideline for emergency staff to support the development of a core set of investigations for all patients who present with a seizure. • Develop a guideline/protocol for emergency staff that sets out the requirements for undertaking a CT scan of the head of patients with known epilepsy. • Need to have EEG available at the Lister Hospital for patients with suspected or treated status epilepticus to confirm diagnosis and monitor the effects of treatment. Emergency medicine actions include:

NCAPOP	Key successes, lessons learned and actions
	• Liaising with neurology department CD in relation to the arrangement of follow up plans before a patient is discharged from hospital following an admission due to seizure; ensuring there is specialist 24/7 neurology advice available for patients admitted with epilepsy; access to EEG for patients with suspected or treated status epilepticus to confirm diagnosis and monitor the effects of treatment; and having a system in place that enables emergency medicine or admitting clinicians to communicate with the patient's usual epilepsy clinical team • To add to the educational programme explaining to patients and their family members or carers the risks of sudden unexpected death in epilepsy, personalised risk reduction assessments; use all hospital presentations to reiterate the risks associated with epilepsy; documenting the discussions in case notes and discharge letters a; and provide resources to support these discussions

Local clinical audits

The Trust intends to continue improving the quality of healthcare by implementing actions from local clinical audit projects. Table 1 provides a sample of 17 the 100 completed local clinical audit projects with details of the key actions identified to improve the quality of the healthcare provided and table 2 provides the full list of completed projects reported during 2023-2024.

Table 1: Sample of projects completed during 2023-2024

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
Plastic and Reconstruction surgery	Audit and re-audit of LAOPS Safety checklist compliance *To prevent "Never Events" from happening in minor operations in plastic surgery, to improve patient care and outcomes* *(Audit n=75; Re-audit n=30)*	Key successes: Completion of lesion identification method section of the LAOPs checklist after the form's amendment increased from 97.3% to 100%, with at least one method selected Key lessons learned: The most frequent method of identifying lesions are drawing in patients notes and lesion identified by patients. WABA app was not used as a method of identification. Initially, LAOPS safety checklist compliance was not found to be 100%, but later it was modified and the compliance was found to 100% and no further zero events noted until now
	Animal bites management	Key successes: Antibiotics were known to be appropriately prescribed to the majority of patients (19 out of the 33 patients of known antibiotic outcome). Where known, the

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
	Assess ENHT antimicrobial prescribing for the management of animal bites in accordance with NICE NG184 (n=36)	choice of antibiotic was in line with NICE/local prescribing guidelines, apart from 2 patients, possible influenced by case-specific factors. Patients on IV antibiotics were typically considered for switching to oral within 48 hours. Key lessons learned: Careful consideration of whether antibiotics need to be prescribed, helping to minimise resource use and reduce the risk of promoting antimicrobial resistance. Some patients may have received antibiotics against recommendations (though assessment of skin break and blood drawn was not always explicitly documented): 7 who did not have any broken skin or blood drawn: 1 dog bite patient who had broken skin but no blood drawn: 4 dog bite patients who had broken skin and blood drawn but did not meet the additional criteria necessary for recommending antibiotic.
Ear, Nose and Throat	**Re-audit of ENT Emergency clinic** *Assess patients booked per clinic to ENT compared to UK guidelines, review the suitability of patients referred to emergency clinic and the patients seen more than twice over 2-month period. (n=66)*	Key lessons learned: • Optimize appointment scheduling by redistributing bookings across sessions based on availability, ensuring efficient utilization of all available slots. • Prioritize appointment bookings according to clinical urgency, allowing flexibility to defer less urgent cases to accommodate more pressing ones, such as recurrent epistaxis. • Reserve Monday AM sessions for overbooked appointments, while appropriately allocating less congested sessions for routine cases. • Establish guidelines for determining the suitability of acute clinic visits, with a focus on conditions like OE, recurrent epistaxis, nasal fracture, Bell's palsy, SSNHL, and ear foreign bodies. • Exercise discretion and seek senior input for patients requiring more than two visits to the acute clinic to ensure comprehensive management and appropriate follow-up. Key actions: Educate the ENT team about how many patients should be booked and which conditions are appropriate.
	Reducing ENT Follow-up appointments *Evaluate adherence to departmental follow-up guidelines, to reduce*	Key successes: Tonsillitis, hearing loss and post-op patients were followed up appropriately Key lessons learned: Some balance and non-polyp rhinitis patients were given unnecessary follow-ups.

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
	reduce unnecessary ENT follow-up appoitments (n=50)	In person educational sessions about the types of patients to be offered follow up appointments and those suitable for patient initiated follow up delivered
Cancer Centre	CK1 and CK5: Skull and X-sight spine re-audit *Reassess compliance with the procedures laid down in Cyberknife Technique Documents CK1 and CK5 for treatment to various sites including 6D Skull Technique and X-sight Spine technique (n=3)*	Key successes: The Cyberknife team are 100% compliant with the procedures Key lessons learned: Cyberknife Radiographers are thorough with all treatment checks laid down in the Cyberknife techniques
	CK 4 - Synchrony re-audit *Reassess compliance with the procedures laid down in Cyberknife Technique Documents for treatment to various sites including 6D Skull Technique and X-sight Spine technique and Fiducial Synchrony (n=3)*	Key successes: Cyberknife team are compliant with the procedures laid down in Cyberknife Technique. Key lessons learned: Each team member independently performs checks.
Gynaecology	Ovulation induction audit *To assess the management of ovulation induction against local policy and national standard (n=20)*	Key successes: Practice conformed 100% to local Trust guideline. Key lessons learned: Letrozole is effective now as 'first line' management for ovulation induction although still off-label. Clomifene +metformin are effective for patients with PCOS and insulin resistance. No clinical benefit of Tamoxifen. We need local resources to conform to the national recommendation of performing ultrasound follicular tracking at least for the first cycle of ovulation induction.
	Management of urinary incontinence management *Re-audit to determine service conformance to NICE Guideline NG123 (June 2019). (n=20)*	Key successes: There was an improvement in conformance to the following standards between the audit cycle in 2021 and reaudit in 2023 1) All urinary incontinence to be categorised at initial assessment (2021 and 2023– 100%) 2) All women have a digital assessment of pelvic floor muscles before treatment (2021 and 2023 all

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
		women had examination at initial appointment and were discussed in MDT prior to surgery) 3) All urinary incontinent women with symptoms of significant prolapse are referred to a specialist (100%) 4) Undertake urine dipstick as part of assessment (2021 – 95%, 2023 -100%) First line management should involve a trial of supervised pelvic floor training of at least 3 months (2021-95% vs 2023-100%) and lifestyle modifications (2021 – 95% vs 2023-100%) Key lessons learned: Trust practice conforms to NICE recommendations Key actions: Quality of life questionnaire used to evaluate therapy to be analysed by the clinician every quarter and audited annually.
Trauma and Orthopaedics	Management of Traumatic Meniscal Tears (locked knees) *Assess conformance to local and national guidance, compare Trust outcomes with published outcomes.* (n=40)	Key lessons learned: The significance of urgent MRI for these cases could be shared with Radiologists as well as the importance of urgent surgery could be shared with trauma coordinators/managers and theatre staff. Key actions: To ensure MRI for locked knees can be performed urgently we need more statutory slots for MRI each week exclusively for these cases. To ensure bucket handle tears care operated on within 6 weeks of injury need knee specific trauma lists on alternate weeks
	Audit on follow-up for proper documentation on consent form 4 (demented patients) with neck of femur fractures. *Evaluate adherence to trust guidelines, regarding obtaining proper documentation of consent for demented patients, diagnosed with neck of femur fractures. This evaluation seeks to enhance both patient safety and the quality of care provided by ensuring that consent*	Key lessons learned: Approx, 14% lacked procedure details, 68% only had dual healthcare professional sign, 23% lacked discussion with next of kin, and only 22.8% included Mental Capacity Assessment (MCA) forms. Key actions: 1. Improve awareness among the doctors/ junior doctors of filling consent form 4 by presenting the audit at a rolling half day meeting. Re-audit after 6 months to review improvement against the NICE guidelines.

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
	procedures align with established protocols. (n=22)	
	Audit on follow-up documentation of consent form 4 in neck of femur fractures patients- Re-audit and 2nd cycle. **Evaluate** the consent form process for patient lacking mental capacity with fractures of the neck of femur (NOF) and assess the compliance of completing the mental capacity (MCA) forms as part of the consent process.(**n**=31)	Key lessons learned: The department demonstrated enhanced compliance with RCA guidelines for consent Form 4. This was attributed to concurrent completion of the consent form in ED and preoperative checks by nurses in the ward. This led to improved MCA form completion and discussions with the next of kin. Key actions: The assessment encompassed the completion of Mental Capacity Assessment (MCA) forms, verification of signatures by healthcare professionals, engaging in discussions with the next of kin, and thorough documentation of procedure details.
Urology	Primary ureteroscopy at ENH *Assess Trust conformance to GIRFT guidelines for patients presenting ureteric calculi (n=32)*	Key actions: Of the non-infected obstructed system patients 4/23 (17.4%) received primary ureteroscopy and 0/9 (0%) of the infected obstructive system patients received ureteroscopy within 4 weeks.
Gastroenterology	**Large Non-Pedunculated Colorectal Polyps (LNPCP)** *Assess whether all complex polyps within ENH Bowel Cancer Screening Programme requiring endo-mucosal resection (EMR) Endoscopic Submucosal Resection (ESD) or surgical resection are managed in accordance with BSG guidance (34 polyp site checks carried out)*	Key lessons learned: • This audit remains ongoing, and data will be analysed year on year. • Within the local Endoscopy unit, a complex polyp MDT has been set up and is managed by the Bowel Cancer Screening Specialist Screening Practitioners and admin team. • This is held weekly and consists of all the Bowel Cancer Screening Accredited Gastro Consultants and a Colorectal surgeon. • This allows for any patients with large complex polyps to be discussed, and optimal management agreed. Key actions: Continue to monitor year on year via audit - all episodes of bleeding/perforation are reported to the screening quality assurance team and reviewd locally at RHD (Rolling Half Day)/team meetings
Obstetrics	Caesarean sections (CS) (n=32)	Key successes:

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
		1) Resident Consultants and embedded practice has resulted in 100% conformance to the standard of CS being appropriately classified and 2) 91% conformance to standard of Consultant Obstetrician being involved in emergency CS decision making. 3) 100% conformance to the standards of offering prophylactic antibiotics and thromboprophylaxis 4) 83.3% (n=10/12) conformance to the standard of emergency CS performed in </=75mins 5) 100% conformance to the standard providing appropriate care to mothers 24h post surgery Key actions: • Need to improve documentation for causes of Cat 2 delays and ensure CTG are reviewed as needed. Need to improve post CS discussions and advice
Pathology	**Comparison of Uro17 biomarker with thin prep cytology to identify malignant cells in urine cytological samples.** *Evaluate the reproducibility of the reporting categories in Uro17 biomarker.* *To compare the atypia rates in the Paris system reporting with the equivocal category of Uro17 biomarker. (n=50)*	Key successes: (50%) negative and 10/12 cases (83%) positive categories were reported in the equivocal category. Key lessons learned: The criteria of 5 or more cells with 2+ staining to define a positive result in 31 cases showed a lack of unanimity in 12/31 cases (39% of cases); In 2/12 of these cases (16%), one of the participants (same participant) called N result. Key actions: The Paris system has been widely practised across the country and the continent. It merely requires the use of the prefix "U" to describe categories. Action will be to raise this with the requesting Urologists and discuss this in their forum.
Anaesthetics	Patient handover in the post anaesthetic care unit (PACU)- Re-audit *Evaluate the transfer of mandatory information and patient safety (n=23)*	Key lessons learned: Using the patient handover checklist is beneficial as it ensures a more organised and higher-quality handover process. Encourage all anaesthetists to consistently utilise it for handovers. Additionally, recover nurses will actively remind anaesthetist to employ the checklist for every handover. Key actions: As this was a re-audit, there no actions, audit showed full compliance.
Child Health Acute	Audit of Peanut nut and tree nut allergy management *Assess primary and secondary care adherence to the BSACI*	Key actions: To follow the BSACI guideline

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
	guideline for the diagnosis and management of peanut and tree nut allergy. (n=264)	

Table 2: A list of 100 local clinical audit projects completed during 2023-2024 by specialty

Project title and reference	
Cervical Spine Fractures(17735)	Trauma and Orthopaedics
Osteoporotic vertebral thoracolumbar fractures at Lister hospital(18224)	
Analysis of rib fractures management and admission(18260)	
Completion rates of the Foot and Ankle Clinic Proforma(18263)	
An audit of post-operative prophylactic antibiotics following primary arthroplasty in the trauma and orthopaedics department in line with current trust guidelines of antibiotic prescription.(18297)	
Assessment of neurovascular status documentation of paediatric supracondylar humeral fractures in line with current British Orthopaedic Association Trauma Standards(18298)	
Compliance of elbow hemiarthroplasty for trauma with the BESS and GIRFT guidelines for Primary and Revision elbow Replacement – Re-audit of 18205.(18729)	
Audit of The Management of Shoulder Dislocations(18311)	
Re-audit - Evaluation of compliance of NJR policy and Trust policy of recording of data Reverse shoulder replacements performed for traumatic injuries(18712)	
Management of Traumatic Meniscal Tears (Locked Knees)(18746)	
Audit on follow-up for proper documentation on consent 4(demented patients) with Neck of femur fractures.(23/24_Trust_TandO_4)	
An audit on follow-up documentation of consent form 4 in neck of femur fractures patients- Re-audit and 2nd cycle.(23/24_Trust_TandO_5)	
Introduction of a New Protocol to Limit the Number of Cancelled Elective Orthopaedic Operations Due to Asymptomatic Bacteriuria (23/24_Trust_TandO_1)	
Audit to Improve Lister Hospital's Performance on National Hip Fracture Database (NHFD) in Regards to the Operative Management of Extracapsular Neck of Femur Fractures (23/24_Trust_TandO_6)	
Analgesic management of patients admitted with rib fractures.(18301)	Anaesthetics
Patient handover in the post anaesthetic care unit (PACU)- Re-audit of 18307(18709)	
Evaluating Intrathecal Bupivacaine's Impact on Unplanned Day Surgery Admissions(23/24_Anaesthetics_03)	
Post Delivery Neurological Injuries(23/24_Anaesthetics_04)	
Scaphoid referral sent to plastics department in Lister Hospital(18302)	Plastics

Project title and reference	
Assessment of wound management in Trauma and Orthopaedics(18306)	
Audit and reaudit of compliance of LAOPS Safety checklist(18705)	
Animal Bites Management(18752)	
Audit on management of hypothyroidism in pregnancy(18708)	Obstetrics
Postnatal Audit inc Postpartum Bladder Care(18713)	
Waterbirth Audit. Re-audit of 17748(18715)	
Caesarean Sections(23/24_Trust_Obstetrics_02)	
Antenatal care(23/24_Trust_Obstetrics_03)	
Maternity Hypertension Audit(23/24_Trust_Obstetrics_01)	
Sequential Operative Vaginal Delivery.(23/24_Trust_ Obstetrics_08)	
Audit of obesity in pregnancy guideline.(23/24_Trust_Obstetrics_09)	
SBAR handover audit .(23/24_Trust_Obstetrics_11)	
Antenatal Optimisation for babies less than 34 weeks.(23/24_Trust_Obstetrics_10)	
Newborn observations in a low risk setting - NEWTT(23/24_Trust_Obstetrics_14)	
Fresh eyes audit 2023 (from guideline 4.1.2 Fetal Heart Rate Monitoring)(23/24_Trust_Obstetrics_13)	
Conservative Management of CIN 2(23/24_Trust_Obstetrics_12)	
Breech, malpresentation and ECV Audit.(23/24_Trust_Obstetrics_15)	
Molar Audit (Gestational Trophoblastic Disease)(23/24_Trust_Obstetrics_06)	
Fetal heart rate monitoring - intrapartum caution checklist compliance(23/24_Trust_Obstetrics_05)	
Women who decline blood products(23/24_Trust_Obstetrics_04)	
Stillbirth Audit July 2021 - June 2022(23/24_Trust_Obstetrics_07)	
Audit of epidural observations during labour (23/24_Trust_Obstetrics_17)	
Admission of pregnant women to the ED and non maternity wards (23-34_Trust_Obstetrics_16)	
Safe handover within urology department(18733)	Urology
Re-audit of 18305 - Management of radiological investigation reports within the Urology Department(18737)	
Primary Ureteroscopy at ENH(18747)	
Ureteric stones conservative management audit(23/24_Urology_02)	
Non-surgical acute scrotum patient's follow-up(23/24_Urology_03)	
Measuring serum calcium in adults with renal stones (NG118) 2ND CYCLE (re-audit of 18271)(23/24_Urology_04)	
Completion of Discharge Letters in Urology (23/24_Urology_05)	
Reaudit of 18283- Are patients presenting with urinary tract calculi routinely given dietary advice?(23/24_Urology_06)	
CK1 and CK 5 - Skull and X-Sight Spine (re-audit of 18213 and 18214)(18740)	Cancer Centre
CK 2 - Cyberknife Fiducial Tracking (re-audit of 17058)(18741)	
CK 4 - Synchrony (re-audit of 18215)(18742)	
EPA - MVCC Radiotherapy IR(ME)R Patient Identification Compliance Audit Part 2 –Treatment (23/24_Cancer Centre_02)	

Project title and reference	
EPC - MVCC Radiotherapy Audit IR(ME)R Procedures Consent, Communication of risk and benefit of radiation exposure and Enquiries of individuals to establish pregnancy and breastfeeding status - Treatment 2(23/24_Cancer Centre_03)	
EPK - Reduction of probability and magnitude of Radiation Incident(23/24_Cancer Centre_08)	
EP J - Clinical evaluation of Radiation doses in Radiotherapy_Cyberknife (23/24_Cancer Centre_05)	
EP J - Clinical evaluation of Radiation doses in Radiotherapy_LINAC(23/24_Cancer Centre_06)	
EP J - Clinical evaluation of Radiation doses in Radiotherapy_Pre-Treatment(23/24_Cancer Centre_07)	
EPA - MVCC Radiotherapy IR(ME)R Patient Identification Compliance Audit Part 1 – Pre-Treatment (23/24_Cancer Centre_01)	
EPE - IR(ME)R - Assessment of patient dose and administered activity in relation to patient records.(23/24_Cancer Centre_04)	
EPL - IR(ME)R Procedure Incident Reporting(23/24_Cancer Centre_09)	
EPB2 - IR(ME)R Procedure Practitioner(23/24_Cancer Centre_10)	
EP B1 - Procedure Operator Audit - Radiotherapy Department(23/24_Cancer Centre_12)	
EP B4 - IR(ME)R Procedure for Justification and Authorisation of concomitant exposures V1, for treatment purposes(23/24_Cancer Centre_13)	Cancer Centre
EP B.4 Justification and Authorisation of concomitant exposures V1 for pre-treatment(23/24_Cancer Centre_14)	
EP D1 - Radiotherapy Dept Policy Developing Standard Operating Procedure Documents(23/24_Cancer Centre_15)	
MVCC Radiotherapy IR(ME)R EP B.3 - Referral Form Audit (23/24_Cancer Centre_16)	
EP F - IR(ME)R Procedure for Diagnostic Reference Levels Audit (23/24_Cancer Centre_11)	
Re-audit of PT 21 – VSIM Care Path(23/24_Cancer Centre_19)	
Re-Audit of GP 12 pt3 Hygiene in the Radiotherapy Department December 2023(23/24_Cancer Centre_20)	
Re-AuditGP 12 pt 3 Hygiene in the Radiotherapy Department December 2023 (23/24_Cancer Centre_18)	
Reaudit of GP33 Encounters Audit(23/24_Cancer_Centre_21)	
Re-audit of RT 4 Head and Neck(23/24_Cancer_Centre_23)	
Re-audit of RT 14 - MVCC Radiotherapy RT 14 Adaptive Bladder Treatment Technique Audit Month/Year(23/24_Cancer_Centre_24)	
GP35 - PLAN PREPARATION(23/24_Cancer_Centre_22)	
Reaudit of RT 16 Real Time Position Management(23/24_Cancer_Centre_25)	
Reaudit of GP23- Carepath Tasks for Radiotherapy Patients Month/Year(23/24_Cancer_Centre_26)	
RT25 - Oesophagus Radiotherapy Technique(23/24_Cancer_Centre_27)	

Project title and reference	
Reaudit of PC15- Care of Patient during Radiotherpy Treatment Month/Year(23/24_Cancer_Centre_28)	
Reaudit of RT11- Radiotherapy Non-adaptive Gynae Technique(23/24_Cancer_Centre_29)	
RT 12 MVCC Radiotherapy RT12 Lung Treatment Technique Audit (23/24_Cancer_Centre_33)	
RT 13 MVCC Radiotherapy RT13 Adaptive Gynae Treatment Technique(23/24_Cancer_Centre_34)	
Reaudit of RT 02 SINGLE ISO Breast tumours OCTOBER 2023(23/24_Cancer_Centre_31)	
Reaudit of PT 11 - CT Scanning with IV contrast(23/24_Cancer_Centre_30)	
Reaudit of RT 03 Prostate October 2023(23/24_Cancer_Centre_32)	
EPB.1 Procedure Operator Audit(23/24_Cancer_Centre_35)	
30 day mortality rate of palliative patients from treatment to death(23/24_Cancer_Centre_36)	
Reaudit Discrepancies in Clinical Details for CT requests form the Emergency Department (re-audit of 17718)(18717)	Radiology
Audit of Peanut nut and tree nut allergy management(18703)	Child Health Acute
Comparison of Uro17 biomarker with thinprep cytology to identify malignant cells in urine cytological samples(18245)	Pathology
Departmental adherence to gastric biopsy protocols for dyspepsia and suspected H.pylori infection(23/24_Trust_Pathology_01)	
Audit into clinician knowledge of antiplatelet and anticoagulant medications (23/24_Vascular Surgery_01)	Vascular surgery
Audit of handwashing and PPE use on general surgery ward rounds(23/24_Trust_General Surgery_01)	General surgery
Large Non-Pedunculated Colorectal Polyps (LNPCP)(18735)	Gastroenterology
Ovulation induction audit(18743)	Gynaecology
Management of urinary incontinence(18744)	Gynaecology
ENT Emergency clinic audit(18704)	Ear, nose and throat
ENT Emergency clinic - Re-audit (of 18704)(18707)	
Reducing ENT Follow-up appointments(18736)	

Participation in Research and Development

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***". Our research supports our values of include, respect and improve.

We work in partnership with the University of Hertfordshire, the life science industry and non-commercial research funders to enhance patient and experience through research and innovation.

The number of patients receiving relevant health services, provided or sub-contracted by the ENHT in 2023/24 that were recruited during that period to participate in research approved by a research ethics committee was 4,380.

This number is likely to be an underestimate as it has been obtained from a national data system (the Clinical Research Network East of England Open Data Platform) made on 15 April 2024 and the full 2023/4 data set will not be available until 27 April 2024.

The research activity in 2023/4 relating to studies adopted to the NIHR Portfolio is summarised below with research participation by service area.

Service area	Research participation
Maternity	2,235
Renal (Kidney)	710
Cancer	476
Anaesthesia	391
Cardiovascular	185
Gastroenterology	118
Ear Nose Throat (ENT)	81
Surgery	48
Dementias and Neurodegeneration	42
Children	27
Health Services	24
Critical Care	15
Metabolic and Endocrine	13
Hepatology	9
Diabetes	3

Some examples of embedding research into practice for the benefit of patients

- **Developing new knowledge:** Anticoagulants (blood thinners) are used in some patients to reduce the risk of clots forming which can lead to stroke. However, these medications can significantly increase the risk of bleeding. Our cardiology team were the highest recruiters for two research studies which identified the optimum use of a new anticoagulant (Asundexian) in patients with atrial fibrillation (irregular and often abnormally fast heart rate).
- **Development of new treatments (e.g. for breast cancer):** Thanks to the oncology research team, Mount Vernon became the first cancer centre in the UK to treat a patient with Trodelvy, a new treatment for metastatic triple negative breast cancer. Cancer patient Carly Francis, said: "*I'm incredibly grateful to the team who acted so quickly to enable me early access to this new treatment*."
- **Enhancing the delivery of a service:** Patients whose kidneys do not work properly have a procedure known as dialysis to remove waste products and excess fluid from the blood. Our renal research team found that the amount of

dialysis patients receive could be safely reduced for some people. This benefits patients because they have to spend less time in hospital. It also good for the environment because less dialysis means less patient travel and less electricity use.

- **Development of a new service:** Our gastroenterology team provide treatment to people with health issues of the digestive system including oesophagus, stomach and intestines). The team created a novel approach to detecting oesophageal cancer through the innovative Cytosponge approach - a 'sponge on a string' test that samples cells from the oesophagus without the need for gastroscopy (a tube into the stomach and previous standard of care). The use of Cytosponge can help with early detection and treatment of oesophageal cancer with improved health outcomes and cost savings.
- **Embedding research for all patients:** As a research active organisation we want to see research embedded as an expectation and we achieved this within our maternity services. Group B Streptococcus (GBS) is a bacterium present in the vagina of approximately 1 in 4 pregnant women. Giving women antibiotics in labour reduces the risk of their babies developing GBS infection but it is not routinely done. As part of a research study our maternity service offered GBS3 testing to every pregnant woman. A total of 3,610 women have taken up this offer, with 2,220 in 2023/4.

Update on Public involvement and research participation

We continually ask research participants about their experience using the standard National Institute for Health and Social care Research survey. During 2023/24 we had responses from 114 adults and their feedback is summarised below:

Questions	Response
1. The information that I received prepared me for my experience on the study	94% Agree or Strongly Agree
2. I feel I have been kept updated about the research	72% Agree or Strongly Agree
3. I know how I will receive the results of the research	74% Yes or Yes to some extent
4. I know how to contact the research team if I have any questions or concerns	92% Yes or Yes to some extent
5. The researchers have valued my taking part in the research	95% Yes or Yes to some extent
6. Research staff have always treated me with courtesy and respect	97% Yes or Yes to some extent
7. I would consider taking part in research again	90% Yes or Yes to some extent

The responses also provide data on ethnic group, summarised below:

Ethnic group (as described in the nationally designed survey questions)	Responses (n)	Responses (%)
White/English/Welsh/Scottish/Northern Irish/British	90	81.1%
White/Any other White background	7	6.3%
White/Irish	6	5.4%
Black / African / Caribbean / Black British/ African	3	2.7%
Asian/ Asian British/ Indian	2	1.8%
Asian/ Asian British/ Any other Asian background	2	1.8%
Black / African / Caribbean / Black British/ Caribbean	1	0.9%
Total (not all responded to this question)	**111**	**100.0%**

Although the information on the ethnic groups is based on a non-random sample of low overall number (i.e. 2.6% of the 2023/4 research participants) the ethnic composition of research participants is broadly similar to that of the populations served by the Trust.

Research participants also provided written comments, summarised below.

What was positive about your research experience?

- Welcoming and friendly practice nurse. The sense of being able to do something positive for the future healthcare of others.
- The research staff are excellent, caring and take the time to explain what is happening and are always available on the phone.
- Very grateful for my support and always thanked me for volunteering to take part in the study. I felt appreciated.
- Felt I was helping people in the future through my experience.
- Giving something back to help others in the future.

What would have made your research experience better?

- Access to a website about research programme.
- To have a newsletter (can be e-format to be kept updated about the programme note this might be available after completing the survey.
- Receive updates from the research team without me having to call every other day.
- That the research office was easier to find in the maze that is the Lister Hospital!
- Biscuits after the blood taking! No, in seriousness I don't know anything they could have done better.

Looking forward

We are tremendously proud of our research this year. The UK government has set out a vision to improve the lives of patients all over the UK and around the world by putting clinical research at the heart of patient care across the NHS, making participation as easy as possible and ensuring all health and care staff feel empowered to support research.

The Trust is committed to delivering on this compelling and ambitious vision which will unleash the true potential of clinical research right across the UK, to address

long standing health inequalities and improve the lives of us all, both now and in the future.

Update on Commissioning for Quality and Innovation (CQUIN)
In line with national guidance for 2023/24, the CQUIN financial incentive (1.25% as a proportion of the fixed element of payment) will only be earnable on the five most important indicators for each contract, indicative by value/performance only, as agreed by commissioners.

All providers in scope for CQUIN will be required to report their performance against all indicators to the relevant national bodies where they deliver the relevant services. The Trust's income in 2023/2024 was conditional that CQUIN schemes were implemented and best endeavors on achieving quality improvement and innovation goals through the commissioning for quality and innovation payment framework.

Care Quality Commission
The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'requires improvement'. The CQC has not taken enforcement action against the Trust during 2023/24.

On 20 and 21 June 2023, the CQC carried out an unannounced inspection of acute services at the Lister hospital including urgent and emergency services, medical care, surgery and maternity services. This was followed by an announced 'Well Led' inspection which was carried out on 2 and 3 August 2023. The Trust submitted evidence of completion of 'must do actions' at the end of the year and are now focussing on the 'should do actions'.

In 2023/24 the inadequate rating for maternity services (previously rated inadequate in 2022) was lifted. The maternity service continued on the national improvement programme throughout 2023/24 and following the learning from the inspection, priority actions have been undertaken and delivered to address the identified must and should do actions.

The Trust has participated in other planned reviews by the CQC during 2023/24 relating to the following areas:

- IR(ME)R on 27 November 2023. CQC inspectors conducted a virtual announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the radiotherapy service at the Mount Vernon Cancer Centre.
- InHealth mobile van CT service on 7 August 2023.

During 2023/24 the Trust has continued to review the quality assurance framework. Actions to embed cultural change in good governance standards include the review of reporting requirements and reach of shared learning platforms where good practice is identified.

Reporting to Secondary Uses Service (SUS)

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. The Trust submitted records during 2023/2024 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics and these have been included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number were as follows. The numbers in brackets represent the national average across the same period.

99.9% (99.7%) for admitted patient care
99.9% (99.7%) for outpatient care
99.4% (97.0%) for accident and emergency care

The percentage of records in the published data, which included the patient's valid General Medical Practice code, was:

99.0% (99.7%) for admitted patient care
100.0% (99.5%) for outpatient care
100.0% (98.9%) for accident and emergency care

Update on data quality

The data quality team focusses on the quality of data captured on the Trust's patient administration system, Lorenzo, relating to patient information, activity recording and performance management. During 23/24, the team continued its focus on improving the quality of our performance data.

Good quality data feeds into all areas of the trust and the data quality team ensures that the Trust's data is accurate, valid and is recorded in a timely manner. Good quality data is essential for Trust reports, ensuring that the data supports the decisions that are made for the local community that we serve.

The team is taking the following actions in 24/25 to improve the quality of the Trust's data:

- Raising awareness of poor data quality, focussing attention on areas which need support through the monthly data quality steering group
- Reviewing the data quality KPI dashboard in line with the Trust objectives

Update on Information Governance Toolkit (IGT)/ Data security

All health and care organisations are expected to implement the 10 National Data Guardian (NDG) standards for data security. These standards are designed to protect sensitive data, and to also protect critical services which may be affected by a disruption to critical IT systems (such as in the event of a cyber-attack).

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that enables the Trust to measure their compliance against the NDG standards, and

demonstrate and that sensitive information is protected from unauthorised access, loss, damage and destruction.

The DSPT 2022/23 submission achieved “approaching standards” status. In quarter 3 2023/24 a new cyber and information governance function was established in the Chief Information Officer’s directorate led by a new role of Head of Information Governance and Cyber Security. A review of all DSPT assertions is underway to provide an improved level assurance for the 2023/24 DSPT cycle.

A baseline publication was made on March 7, 2024, and the outcome of an internal audit is pending but expected in advance of DSPT submission at the end of June 2024. The Information Governance Steering Group continues to monitor progress ahead of DSPT submission.

In the current DSPT year, 11 incidents have been reported on DSPT. Two of these incidents met the threshold for disclosure to the Information Commissioner’s Office. The increase in incidents reported on the previous DSPT cycle, demonstrates improved awareness within the Trust regarding GDPR regulations to report personal data breaches and maintain data confidentiality, integrity and availability.

Update on clinical coding

The Trust undertakes annual and regular clinical coding data quality audits to determine how accurately our coded clinical data reflects documented diagnoses and procedures in the patient record. This is part of the Data Security Standard 1, Personal and Confidential Data. Clinical coding also regularly undertakes clinical coding validation in both the admitted patient spell and outpatient attendances. The table below are the results for the Admitted Patient Care (APC) audit.

	2023/24	Previous year (2022/23)	Standards Exceeded
Primary diagnosis	97.5%	95.5%	>=95%
Secondary diagnosis	97.0%	98.0%	>=90%
Primary procedure	97.1%	96.1%	>=95%
Secondary procedure	98.5%	98.5%	>=90%

Update on 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 maximise learning from our learning from deaths work.

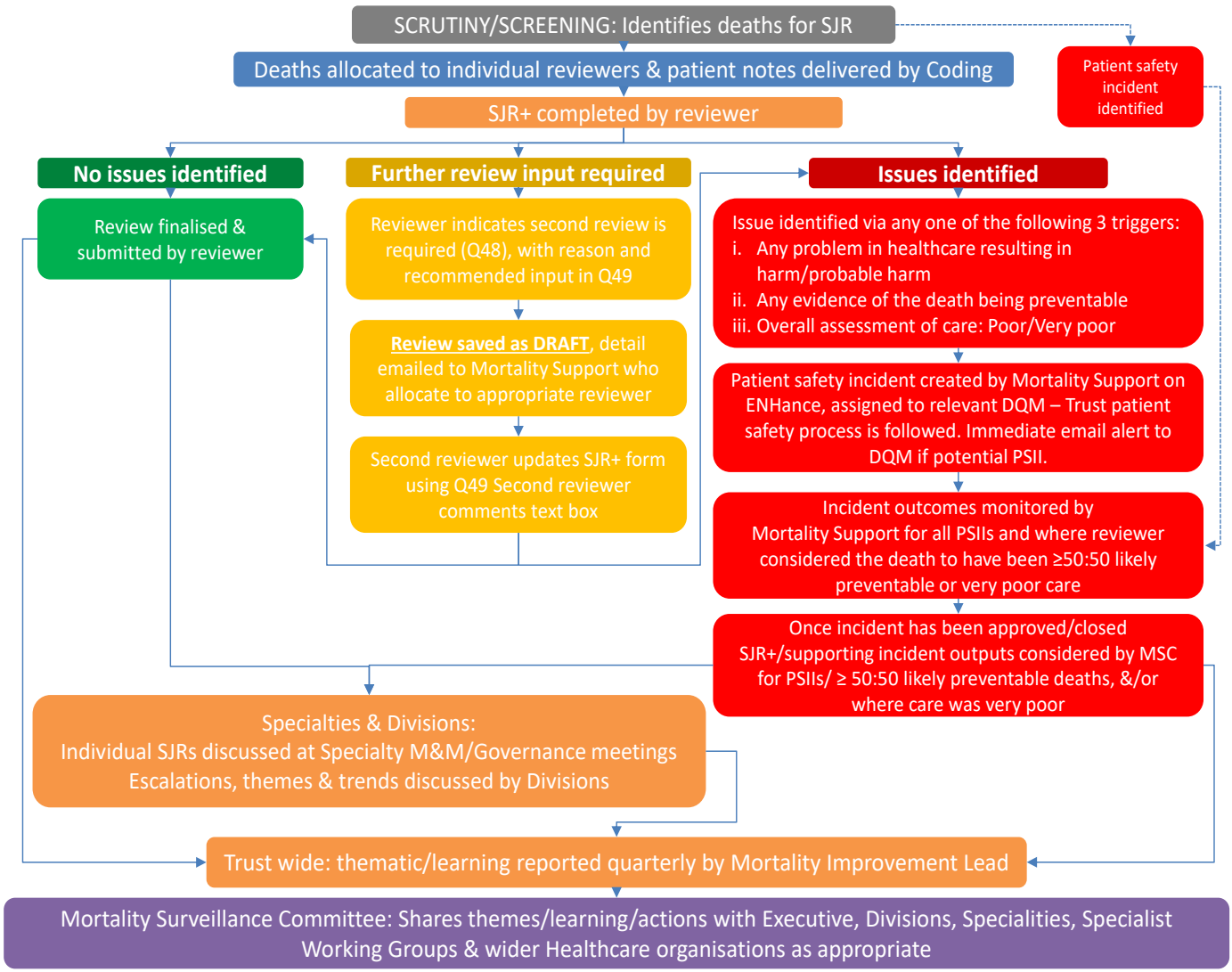
The Trust is committed to seeking ways to continuously strengthen our governance and quality improvement initiatives to support the learning from deaths framework. While our mortality rates have remained strong, it is increasingly recognised that while monitoring these rates has a role to play in mortality governance, there is limited correlation between them, and the quality of care provided by organisations.

To learn from deaths and improve the quality of the care we provide; 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. In recent years we reviewed our processes and introduced several reforms which we believe have built 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 was the adoption in July 2022 of the Structured Judgement Review Plus (SJR*Plus*) format for review, developed by the “Better Tomorrow” team. This collaborative initiative was developed as part of the FutureNHS platform and has since transferred to Aqua (Advancing Quality Alliance). Its aim has remained the same, “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.

Currently learning from our mortality review process, whether specific cases or themes, is shared across the Trust with clinical staff via clinical governance and quality forums such as mortality and morbidity meetings, rolling half days and divisional quality and safety meetings. It may also be shared with relevant working groups such as those focussing on deteriorating patient and end of life care. Where appropriate, thematic review outcomes are also shared in the wider healthcare community, including with the ICB and community trust. We continue to seek ways to build on our existing processes to make our learning even more accessible to the staff who can make a difference.

Mortality review process
The below chart provides an overview of the mortality review process at the Trust using the SJR*Plus* review format.



Some of the key themes identified in the course of our learning from deaths work are detailed below.

Themes and Current Issues Identified to Inform Future Improvement Planning
Findings from Thematic Reviews **Factors contributing to excellent care:** • early recognition of end of life • appropriate/timely communication with patient and family • patient and family involved in decision-making • creating a supportive environment • clear documentation of discussions • appropriate escalation and timely withdrawal of treatment • excellent MDT and joined-up decision-making • comfort for the patient • compassion. **Factors contributing to poor/very poor care:**

- issues with patient management; EoL care; errors and omissions; pathways, processes, policies; documentation including:
- patient cared for by wrong specialty
- multiple bed/consultant transfers
- unconscious bias
- failure to review test results prior to discharge
- pressures/overcrowding in ED
- insufficient specialist care for high numbers of MH patients in ED
- delay to acting on scan findings
- COVID pandemic
- appropriate drug to treat seizure not available on ward.

Learning from Deaths Strategy – Ongoing Objectives

- improvement against NHFD KPI target for #NOF patients to receive a nerve block and be admitted to an orthopaedic/orthogeriatric ward within 4 hours
- stroke: Improve the percentage of patients who are thrombolysed within 60 minutes of arrival
- reduce the number of inappropriate CPR attempts
- improve the conduct of Advanced Care Planning (ACP) discussions
- work with the ICS to reduce the number of in-patient deaths of medically optimised patients with delayed discharges
- improve case ascertainment for the national emergency laparotomy audit
- improve the delivery of ABX within 1 hour for In-patient and ED in those with septic shock or a high likelihood for sepsis.

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	2023-24 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 2023-24, 1379 of ENHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 317 in the first quarter; 301 in the second quarter; 391 in the third quarter; 370 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 2024, 327 case record reviews and 3 investigations have been carried out in relation to 1379 of the deaths included in item 27.1. In 2 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:

		93 in the first quarter; 96 in the second quarter; 92 in the third quarter; 47 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.	3 representing 0.22% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 1 representing 0.32% for the first quarter; 1 representing 0.33% for the second quarter; 1 representing 0.26% for the third quarter; 0 representing 0% for the fourth quarter. These numbers have been estimated using the Trust's Mortality Review process. Since 1 July 2022 the Trust has used the SJR*Plus* review format. Based heavily on the original Royal College of Physician's SJR model, this was developed by the 'Better Tomorrow' initiative, which was initially hosted on the Future NHS platform and has since transferred to Aqua (Advancing Quality Alliance). Included in the review, is an assessment by the reviewer of the preventability of death. It must be remembered that the question of the preventability of a death is the subjective assessment of an individual reviewer on the basis of a SJR desktop review. While not definitive, the assessment by them that the death was more likely than not due to a problem in healthcare (more than 50:50% preventable) triggers a patient safety incident, enabling further in-depth investigation of the case in line with current patient safety processes.
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.	In the first case the key concern related to the fact that the Hyperacute stroke unit is not staffed like an HDU in accordance with guidelines and this had a negative impact on patient's care. The

		reviewer concluded that if Nursing resource had been comparable to an HDU the outcome may have been different. In the second cases the reviewer could not find evidence of adequate VTE assessment and prophylaxis in the patient notes. This incident is now being investigated as a PSII under the new PSIRF regime. Final outputs and analysis awaited. In the third case, while there were no concerns relating to the final admission, the reviewer identified that in a prior ED attendance there was a failure to act on abnormal test results, with possible missed diagnosis, which potentially affected the patient's outcome.
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).	Case 1: The HASU staffing issue sits with the Chief Nurse and DNandQ Unplanned Division. A business case is in progress, with one of the areas being addressed being an increase in staffing levels for the HASU to align with the new Stroke Guidance. The matter has been reviewed as part of ongoing collaborative East of England Integrated Stroke Delivery Network initiative. Case 2: Final outputs and analysis awaited from the PSII incident investigation. Case 3: A Roundtable was considered the most appropriate learning event for this incident. At this it was agreed that ED consultants need to document ECG findings directly into NerveCentre and that Nursing Staff should be encouraged to document any findings noted by doctors regarding a patient's ECG onto this system.
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.	Insufficient time has elapsed to enable an assessment of the actions detailed above.

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.	76 case record reviews and 15 ACON investigations completed after 1 April 2023 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 76 case record reviews and 15 ACON investigations reported in 27.7 above]* representing 0% of the patient deaths before the reporting period *[ie 2022-23]* 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.	9 representing 0.65% of the patient deaths during 2022-23 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]*.

2.4 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 Trust's performance is reported together with the national average and the performance of the best and worst performing trusts, where applicable.

2.4.1. 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 12 months to November 2023 is 0.9194, positioned within the 'as expected' Band 2 category. SHMI is generally available six months 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 21st out of all acute non-specialist trusts (119).

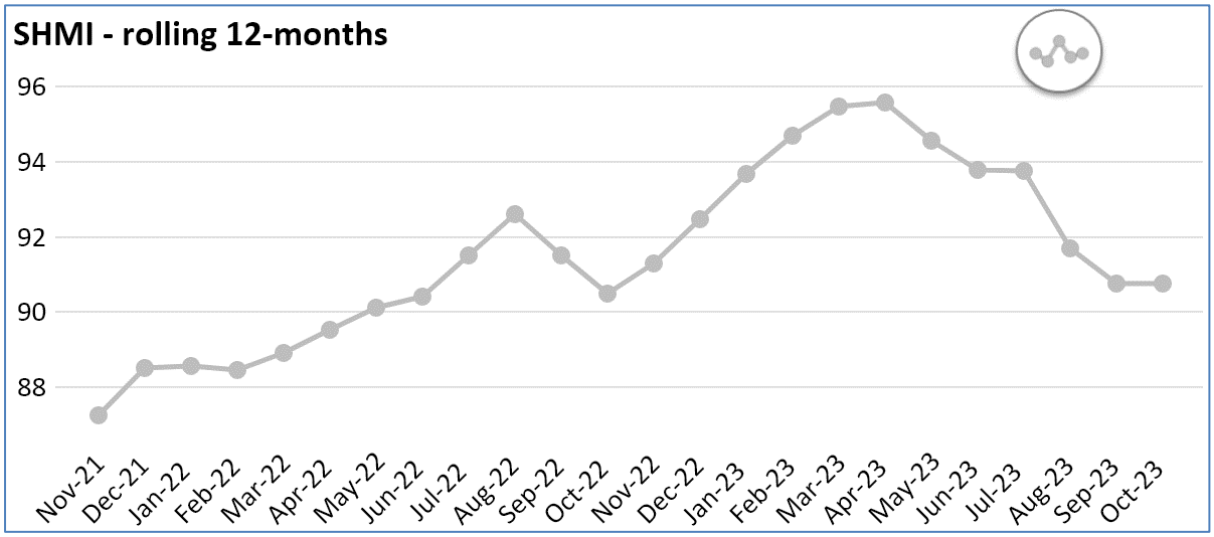
NHS Digital has excluded COVID-19 activity from the SHMI metric. Of note is that the fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, which provides some assurance that our response to COVID-19 has not generally 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	0.9194	Dec-22 to Nov-23	0.9113*	0.7195	1.2654	1.0
	Banding	2		2	3	1	-
% deaths with palliative care coding	Percentage	44.0		41.0	66.0	16.0	42.0

** Time period: December 2021-November 2022*

Rolling 12-month SHMI: December 2022 to November 2023

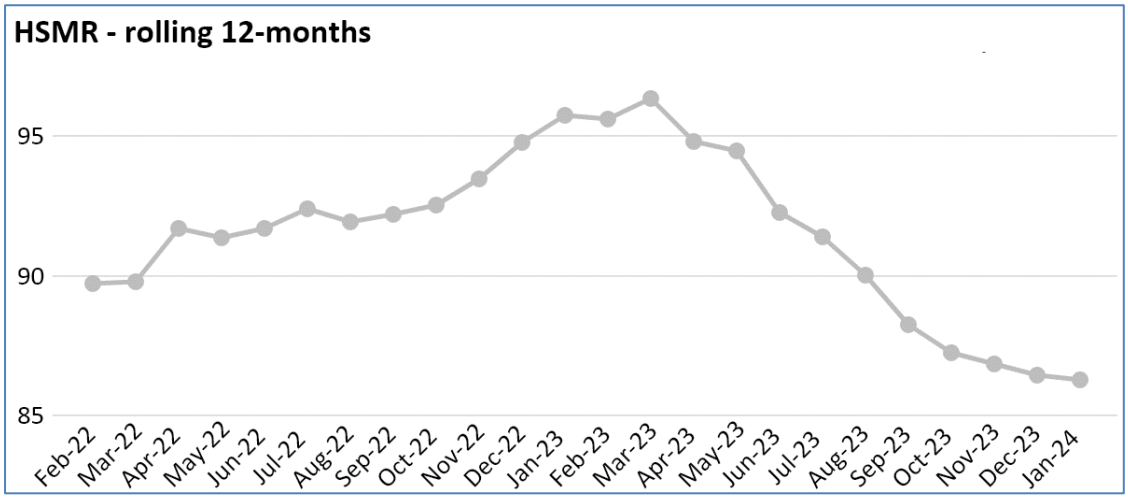


Note: In the chart above the observed to expected deaths have been multiplied by 100 (comparable to HSMR methodology) so that '100' and is comparable to the '1' as described above, where the number of observed deaths exactly matches the number of expected deaths.

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, for a basket of 56 diagnosis groups, which account for approximately 80% of all deaths.

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). Generally, this means that a figure below 100 indicates a 'lower than expected' number of deaths. However, unlike SHMI, our informatics provider CHKS, do not rebase the HSMR metric monthly. They currently rebase every one to two years. This should be borne in mind when assessing performance. Our performance is currently within 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 2024 is 86.3 against a national average of 92.8.

Rolling 12-month HSMR: February 2023 to January 2024



The Trust 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 Trust 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.

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.

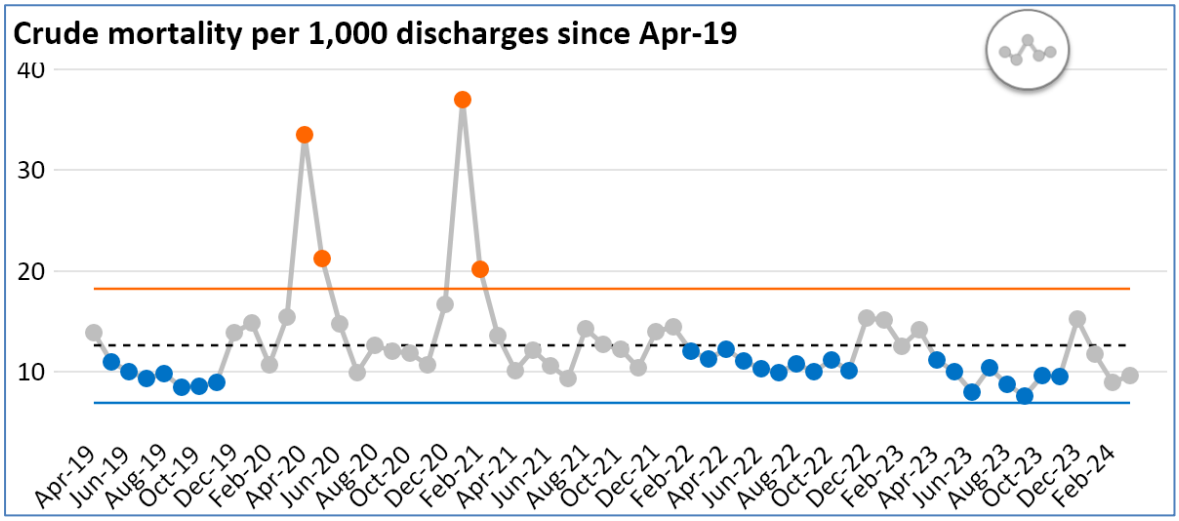
This measure is available the day after the month end and is the factor with the most significant impact on HSMR.

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.

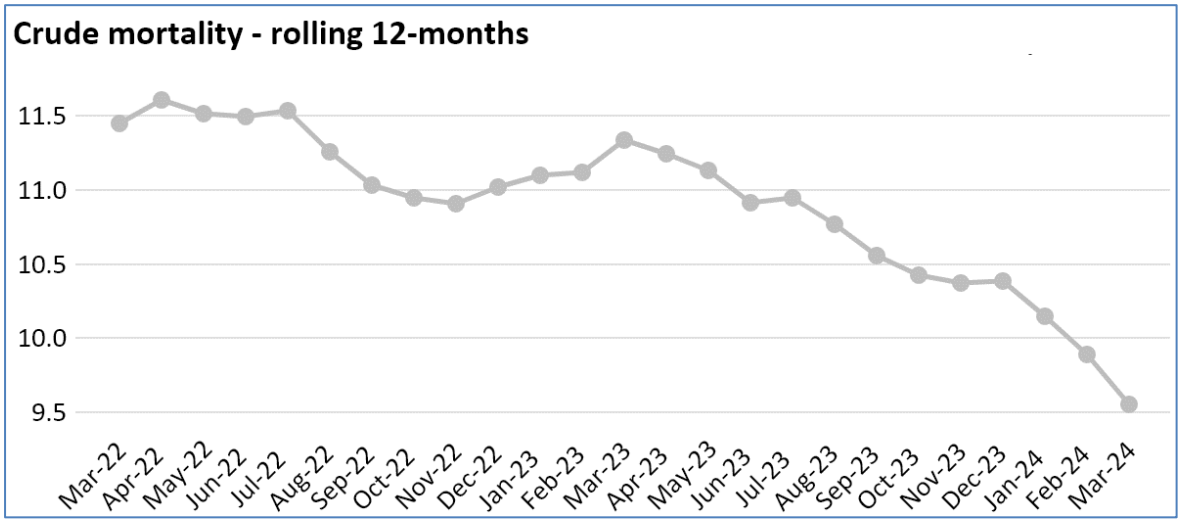
While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line

with, the national average, with rolling 12-month crude consistently tracking below national.

Crude Mortality per 1000 discharges since April 2019



Rolling 12-month Crude Mortality March 2022 to March 2024



2.4.2 Covid

The multi-layered effects of the Covid pandemic made meaningful analysis and comparisons regarding mortality data challenging. For example, in-patient numbers and case-mix have varied during the pandemic. While the WHO downgraded its status from an emergency to a threat in May 2023, signalling the end of the pandemic, the effects continue to impact data analysis, and Covid deaths will continue. The below chart provides the latest high-level detail covering most of the 2023-24 year.

Our reported number of deaths for the year 2023-24 are as follows:

Covid Deaths 1 Apr-23 to 31 Mar-24	Definition
105	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.
73	Patients who had a laboratory confirmed positive COVID test and died within 28 days of the first positive specimen date. This is the Public Health England national reporting definition.

2.4.3 Patient Reported Outcome Measures PROMs (EQ-5D Index Score)

PROMs use a standardized tool as a measure of health outcomes. It is applicable to a wide range of health conditions and treatments and provides a simple descriptive profile and a single index value for health status; the health gain index is primarily designed for self-completion by respondents and is ideally suited for use in postal surveys, in clinics and face-to-face interviews. It is cognitively simple, taking only a few minutes to complete. Instructions to respondents are included in the questionnaire.
For the reporting year 2023/24, the Trust did not participate in PROM collections.

2.4.4. 30 Day/ Emergency readmissions

Readmissions data is only available until Jan 2024 and hence the data below is comparison of data from Apr - Jan period.

30 Day Readmissions	Apr 21 - Jan 22			Apr 22 - Jan 23			Apr 23 - Jan 24		
	0-15	16 and over	Total	0-15	16 and over	Total	0-15	16 and over	Total
Discharge	9377	84370	93747	10533	86496	97029	8544	95657	104201
30-day readmissions	1304	5326	6630	1317	4856	6173	894	5621	6515
30-day readmission rate	13.91%	6.31%	7.07%	12.50%	5.61%	6.36%	10.46%	5.88%	6.25%

*Data up to January 2024

We consider the above data as described because it is extracted directly from CHKS, which is an established and recognised source of data nationally.

2.4.5. The Friends and Family Test (responsiveness to patient needs)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the

opportunity to provide feedback on their experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.

Friends and Family Test	2022 -23			2023-24	
	A and E	Inpatient		A and E	Inpatient
Response rate	0.49%	21.75%		0.48%	18.19%
% would recommend	88.10%	96.37%		92.61%	96.45%

*data as at March 2024

The Trust considers that this data is as described for the following reason: the data has been extracted directly from the NHS England, which is an established and recognised source of data nationally.

2.4.6. Venous Thromboembolism (VTE)

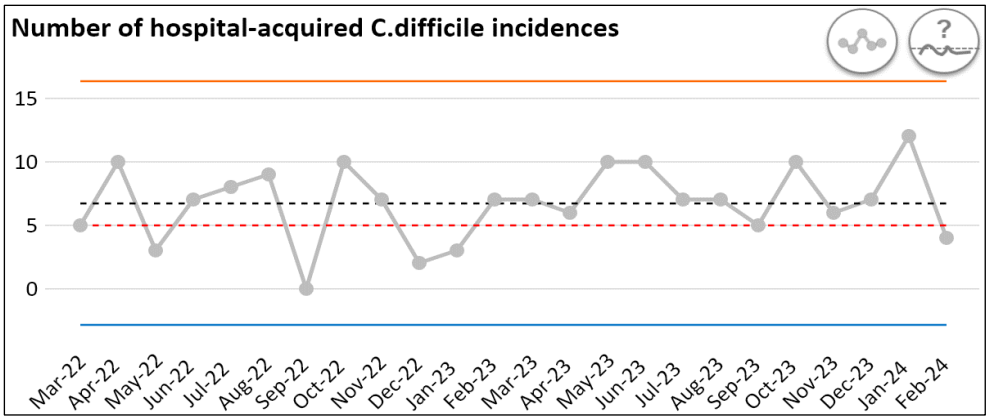
The national bench marking data collection has been reinstated for April 2024 with the first submission scheduled for July 2024. Since the quality improvement work began in July 2021 the following changes and improvements have been made:

- 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
- 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%
- Transformation of the HAT process 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 re-launched
- Established regular clinical engagement to share VTE data, improvement work and learning from HATs
- Reporting in real-time on the ‘patient safety at a glance’ (PSAAG) board to provide a ‘prompt’ as a visual reminder.
- Digital reporting at the ward, speciality and consultant level to support targeted improvement projects.
- Engaged in a patient information quality improvement project with patient partners to alert to signs and symptoms of VTE on Trust wide discharge letter given to patients on discharge.

2.4.7. Clostridioides difficile

Trust-allocated cases of *Clostridiodes difficile (C diff)* infections – 91 against the threshold of 58 for the financial year 2023/24. Post infection reviews remain the

process to ascertain timely learning, with the Infection Prevention and Control (IPC) team supporting education and training needs highlighted. The reviews have demonstrated that the intrinsic risk factors of our patient demographic increase the likelihood of certain patient groups developing *C diff* infection during their hospital stay or shortly after. The microbiology consultants and the IPC team worked with the pharmacy team, and relevant medical clinical leads to review the micro guide according to body systems, with the aim of providing appropriate treatment regimen and reducing C diffogenic antimicrobials, if clinically safe to do so. Regular IPC team engagement with the divisions to support timely sample taking and isolation in order to prevent cross transmission remains a focus.



The C.diff improvement programme started towards the end of 2022/23. The multidisciplinary approach in tackling the risk of developing C.diff was significantly recognised and focus on antimicrobial stewardship was strengthened. Recently, the programme has gained momentum having the Medical Director and Chief Nurse/DIPC inviting treating teams into a post infection review to identify where improvement can be made from the lessons learned. Progress on actions and improvements is monitored regularly.

Non-Covid related key infection control performance indicators for 2023/24

Month	***C.difficile* 23-24**	**MRSA BSI 23-24**	**MSSA 23-24**	***E.coli BSI* 23-24**	***Pseudomonas aeruginosa* BSI 23-24**	***Klebsiella spp BSI* 23-24**
April	6	1	1	1	2	0
May	10	0	1	3	2	2
June	10	0	3	6	0	3
July	7	0	2	6	0	0
August	7	0	2	7	0	2
September	5	0	1	2	0	1
October	10	0	5	6	1	4
November	6	1	1	4	1	3
December	7	0	3	7	0	0
January	12	0	2	3	1	2

February	4	0	2	8	0	2
March	7	0	2	3	4	1
	Total	**Total**	**Total**	**Total**	**Total**	**Total**
	91	2	25	56	11	20
	Threshold numbers 2023 -2024					
	58	0	N/A	44	10	18

Despite a significant increase of 10.7% in the number of patients who have had inpatient stays during 2023/24 compared to 2022/23, there is a reduction in Blood Stream Infection (BSI). MSSA and *Pseudomonas spp* incidences are lower compared to the previous financial year, and a slight increase of one case in MRSA BSI and two cases of *Klebsiella BSIs*. The IPC team have continued to support the Trust by delivering the '3Cs' (clean hands, clean equipment, clean environment) to all inpatient and outpatient areas, and renal satellite units, which emphasises aseptic technique principles as essential skills in preventing BSI. Fundamental IPC measures, based on the guidance from the National Infection Prevention and Control Manual (NIPCM), have been taught and re-emphasised Trust wide. Transmission based precautions have been widely encouraged to support patient care, following a return to pre-Covidpractices. Moreover, hand hygiene competency training continues to be delivered by the IPC team to all staff groups, both clinical and non-clinical. To date, well over 3,500 staff have completed the hand hygiene competency; significantly positively influencing patient safety throughout the organisation.

2.4.8. MRSA bacteraemia

The Trust reported a total of two healthcare associated MRSA bacteraemia (blood stream infections) which is above the threshold of zero. Both cases had intravascular indwelling devices. The first case was a renal dialysis patient in April 2023, who had shared care between our Trust and the neighbouring acute trust. The second case in November 2023 was an oncology patient, with numerous healthcare visits requiring repeated access to their intravascular line. Both patients were known to be colonised with MRSA from admission screening. Post infection reviews were held to ensure actions from the learning were carried out and sustained.

2.4.9 Patient safety incidents

In November, the Trust transitioned from investigating incidents under the Serious Incident (SI) Framework to the Patient Safety Incident Response Framework (PSIRF). The PSIRF is the national approach devised by NHS England to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and continuously improving. It replaces the SI framework and removes the classification of an SI.

The PSIRF embeds patient safety learning responses within a wider system of improvement and prompts a significant cultural shift towards systemic patient safety management. It focuses on proportionate responses being deployed to patient safety incidents with the focus being on learning and continuously improving whilst also engaging and involving those affected. The Trust developed a Patient Safety Incident Response policy and plan which were approved by the board on 5 July

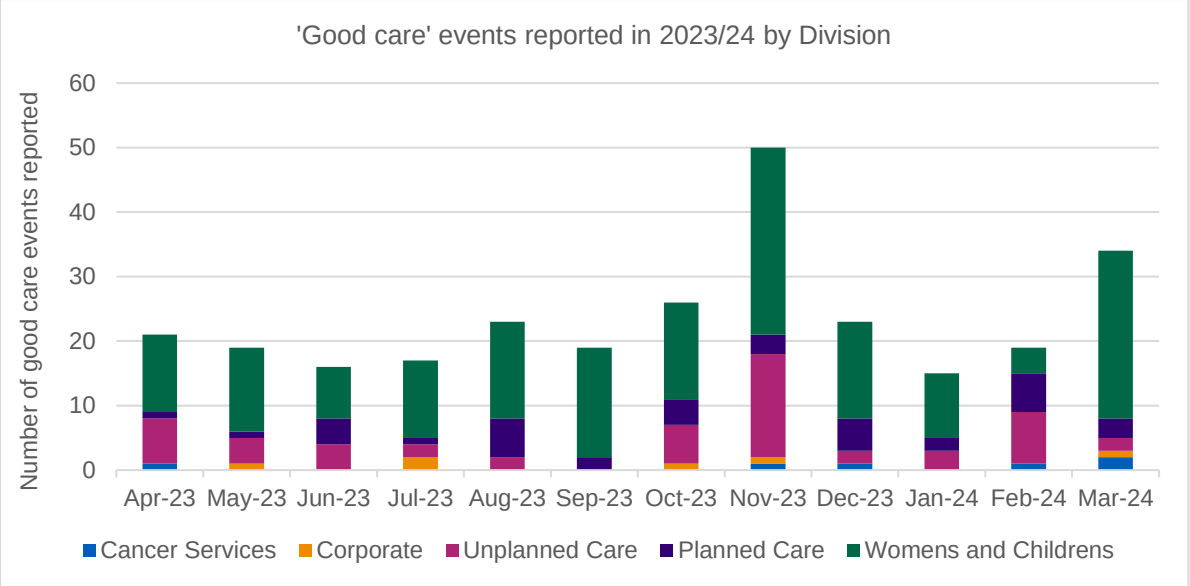
2023. Within our plan we identified our top local priority areas as communication, early recognition and management of deteriorating patients, reducing avoidable harms, recognition and management of challenging behaviours and reducing patient safety risks from long waiting times. There were defined more specifically in the table below which also details the planned learning / improvement response.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Improving safety communication through building a culture of safety and co- production	Learning response pathway	Create local safety actions and feed these into the safety improvement plan
Early recognition, reliability and managing acutely unwell/deteriorating patient	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts
Reducing avoidable harm for pressure ulcers, critical medications, falls, medication errors and VTE	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts
Recognition and management of challenging behaviours/ Violence and aggression	Learning response pathway	Create local safety actions and feed these into the safety improvement plan
Reducing patient safety risks from long waiting times from admission to discharge	Learning response pathway	Create local safety actions and feed these into the safety improvement plan

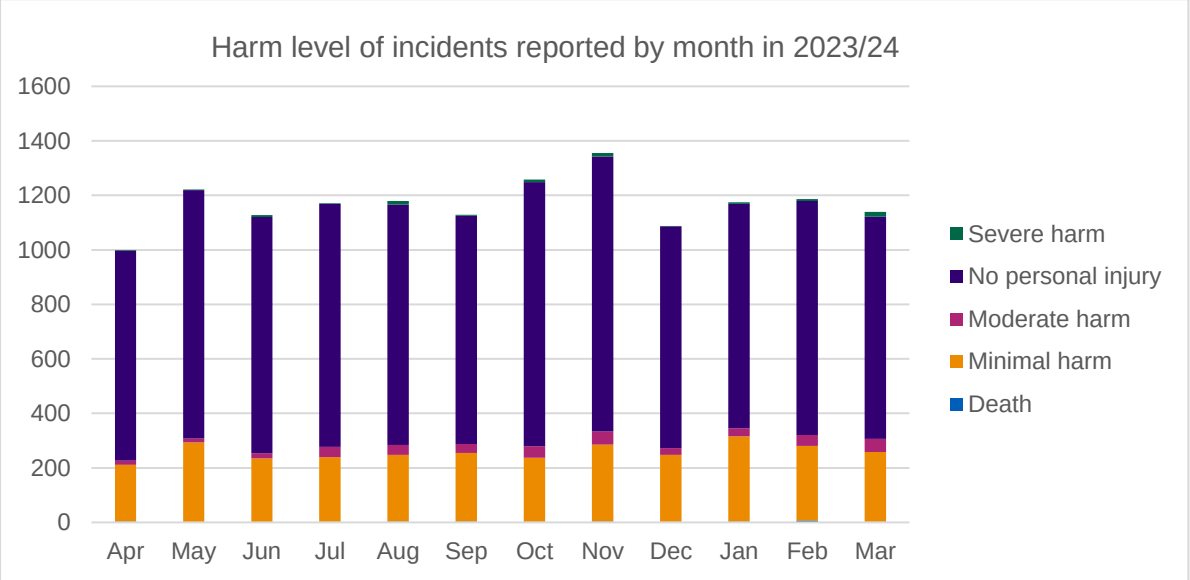
Learning From Patient Safety Events (LFPSE) – incidents and good care

The Trust encourages all healthcare professionals to report incidents on its electronic incident reporting system (ENHance) as soon as they occur, with timely reviews to support learning reflective of a positive safety culture. It also supports divisional oversight of incidents to ensure proportionate responses are being deployed alongside oversight of themes and trends (both existing and emerging).

Through our adoption of the new national NHS learning from patient safety events service (LFPSE), this allows central recording and analysis of patient safety events in healthcare across the country by NHS England. Under the LFPSE service the Trust now has functionality to record ‘good care’ events alongside reporting incidents. Recording good care allows us to both recognise individuals and teams’ positive impacts and in addition allows us to learn from excellence. The graph below shows the ‘good care’ events reported by month by each division. The Trust has recently revised our ‘good care’ reporting form to include further detail of the categories to allow for easier analysis of themes and trends.



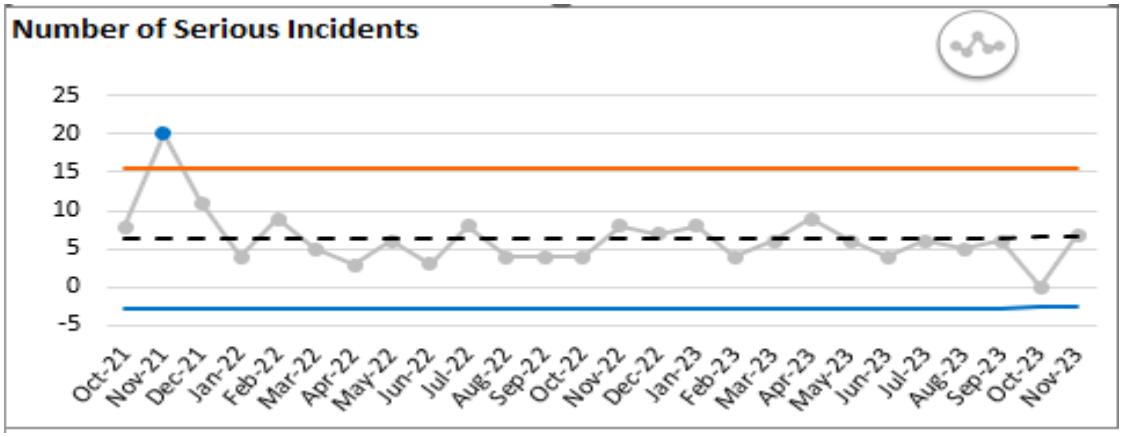
Between 1 April 2023 – 31 March 2024 there were 14,028 incidents reported. Of those, 96% reported resulted in no or minimum harm. Of the total incidents reported, 78% relate to patient safety incidents and 11% relate to staff. Within staffing incidents, the top themes are violence and aggression, staffing, communication and health and safety / security incidents.



As part of our transition to the PSIRF, local divisional incident review meetings have been established to co-ordinate weekly local incident reviews and support the deployment of proportionate learning responses. The Trust continues to hold serious incident review panels, chaired by either the Medical Director, Director of Quality, Associate Director of Patient Safety and/or Chief Nurse. The role of this panel is changing to reflect the organisation's journey into the PSIRF. Whilst it continues to review individual incidents of concern that have been escalated from divisions, it is also expanding into its oversight role to include themes and trends from divisional reviews and the associated learning. It also maintains oversight of the key milestones of the ongoing Patient Safety Incident Investigations (PSIIs).

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. The ENHance system provides greater oversight of incident data and management and will facilitate easier triangulation moving forward. It will also provide a standardised platform to enable oversight at care group, divisional and corporate level.

Serious Incidents (SI) / Patient Safety Incident Investigations (PSII)
Prior to our transition to the PSIRF, between April - November 2023, whilst operating under the SI framework, the Trust formally declared 43 Serious Incidents (SIs).



Of those SIs declared between April – November 2023, the top three themes were violence and aggression (8), treatment (8) and diagnosis (6). These were also common themes that were seen in SIs declared the previous year (2022-23). In 2022-23 the top theme of SIs declared was 'care'. When the Trust moved incident reporting system from Datix to ENHance in February 2023 the incident category of 'care' was consciously removed as it was considered too broad and non-specific. Thus it is not used in the 2023-24 data. Of the SIs undertaken between April – November 2023 there were two large thematic reviews; one focussed on paediatric audiology services and one focused on the management of patients with challenging behaviour / mental health concerns. It is of note that of the SIs declared between April – November 2023 there was only one obstetric related incident that met the criteria for HSIB investigation.

Paediatric Audiology Services
Following an NHSP (Neonatal Hearing Screening Programme) national peer review in March 2023, 799 patients were reviewed. From this review several concerns were raised regarding the service at East and North Hertfordshire.

Concerns related to quality of data submitted, processes for identification of risk and follow up arrangements. These concerns were escalated and reviewed through the Trust Serious Incident Review panel in March 2023. A serious incident investigation was commissioned, with systems sharing of the incident with external partners and regulators. Executive oversight and management of safety actions are reviewed weekly through an ENHT Paediatric Audiology improvement committee, chaired by the Trust Chief Nurse, and attended by ICB colleagues.

The Trust invited the United Kingdom Accreditation Service (UKAS) proactively to undertake an on-site assessment of ENHT Audiology service. These findings were published on 16 June 2023, and highlighted significant areas of concern for the quality and safety of the service, specifically the paediatric audiology service.

A risk-based approach was undertaken to pause the delivery of the paediatric audiology service due to concerns related to potential patient harm, however the service continued to receive paediatric referrals. (This decision was made collaboratively with the ICB and the Regional Chief Scientist)

Whilst the service is paused, the Trust has been reliant on mutual aid to carry out paediatric audiology services, with external providers working in the Trust, as well as accessing the independent sector. In some instances, families have had to travel to other Trusts. Mutual aid has been on a clinically prioritised basis and has been limited, due to the national shortage of available and accredited centres of expertise.

The service continues to require mutual aid across key pathways to deliver care safely, this has been escalated via the oversite committee. In July 2023, the Trust partnered with Guys and St Thomas's (GSTT) paediatric audiology service to benefit from their subject matter expertise, namely in the reviews of ENHT clinical pathways. The Trust improvement plans have six key organisation improvement drivers, with detailed actions and reporting oversight in progress. These priorities include:

1. Quality and safety
2. Environment and equipment
3. Digital
4. Operational
5. Workforce
6. Communications

Mount Vernon cancer centre (MVCC)
An incident occurred in Q2 23/24 and was investigated under the SI framework. A commissioned external peer review showed that ovarian patients treated at MVCC had a 30-day Systemic Anti-Cancer Therapy (SACT) associated mortality that is almost 3 standard deviations greater than the UK average. The final report concluded that immediate changes to the pathway were required to reduce the excess risk to patients and thereby reduce the 30-day SACT associated mortality.

Radiology
There were four patients with delay in formal reporting of chest x-rays, with harm associated. The index incident occurred in Q2 23/24 and was investigated under the SI framework. Following this incident, the unreported SDEC chest X-ray images were reviewed and reported. The subsequent cases were discussed and raised during the transition stage to PSIRF in Q3 23/24 and a round table discussion was agreed. An oversight group continues from divisional level, which reviews the ongoing management of radiology reporting.

Renal services
This incident was raised in Q4 23/24 under PSIRF. Several symptomatic patients presented with low haemoglobins, shortness of breath and fatigue, possibly due to changes in water quality. The dialysis unit was closed pending outcome of investigation, however, has now reopened. At the time patients were relocated to other dialysis units. A PSII is currently ongoing.

Update on Patient Safety Incident Response Framework (PSIRF)
Under the PSIRF a PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning and is aligned to both a national and local criteria. The aim of a PSII is to provide an understanding of how an organisation's systems and processes contributed to a patient safety incident. They examine systems factors and use human factors methodology to identify areas for improvement and systems learning.

Since adopting the PSIRF, between November 2023 and 31 March 2024 the Trust has commissioned five PSIIs.

Never Events
The Trust reported two Never Events between 1 April 2023 and 31 March 2024.

	2020/21	**2021/22**	**2022/23**	**2023/24**
Wrong site surgery	2	4	3	2
Total	2	4	3	2

It is of note that both of the Never Events were classified as minimal or no harm and occurred in different specialties and different areas of the hospital.

The first incident was a wrong site surgery/procedure involving a nerve block (local anaesthesia) in main theatres which occurred in Q1 23/24. This was reviewed under the SI framework and the findings informed a range of learning and actions including; reminder and refresh of 'stop before you block posters' and when the site of block insertion is away from site of surgery, additional marking (e.g. on the patient's back) to serve as visual reminder.

The second Never Event was an injection in the wrong eye in Ophthalmology. This occurred in Q3 23/24 and thus was investigated under PSIRF as a PSII. All Never Events are nationally mandated to be reviewed as a PSII. The learning review is being undertaken by a 'learning response team' comprising of a Patient Safety Manager, Divisional Quality Manager, Deputy Divisional Medical Director and Matron. The learning response is ongoing and is using SEIPS framework (Systems Engineering Initiative for Patient Safety) and also human factors methodology. In addition, the team have had discussions with staff, reviewed audits, undertaken observational work in the area and engaged with the patient affected to capture their insight. Whilst the review is still in progress, some early areas for improvement include lack of LoCSSIP, lack of site marking, and multiple interruptions in the clinical area. In addition, notable good practice has been identified including patient identifier checks including allergies, ease of documentation in paper records

regarding laterality and good pre-procedure laterality checks prior to the patient entering the treatment room.

Duty of Candour (DoC)
The Trust is committed to being open and honest with our patients. The Duty of Candour is a legal requirement that for all safety incidents recorded as 'moderate' or 'severe' harm, a formal apology to the patient and/or family involved is carried out and an investigation into their care is undertaken; the responsible clinical team undertakes this. We feedback in writing the findings of our review and any actions we are taking to prevent a similar incident from reoccurring.

Inpatient falls
In 2023-2024, the Trust's average falls rate per 1000 bed days is 4.1. This is an improvement from the previous year's rate of 4.3. The Trust's falls rate per 1000 bed days remains below the national average of 6.6 (NHSE).

In 2023-2024, we recorded 767 Inpatient fall. This is 3.8% lower than the previous year. Falls with serious harm were also lower this year (16) compared to the previous year (18).

We have seen an increase of inpatient falls resulting in a neck of femur (NOF) fracture. This will be the focus of quality improvement in the coming financial year.

Quality improvement remains the focus surrounding falls, targeting areas with the highest incidence. The digitisation of falls documentation was embraced by the Trust and yields a positive outcome where we have now a sustaining average of 92% completion, compared to 72% at the start of the digitisation program. We are also transitioning to the Patient Safety Incident Response Framework (PSIRF) and how apply a range of system-based approaches to learning from patient safety events. Reducing avoidable harm (including falls incidents) is one of the Trust's local priorities identified in our Patient Safety Incident Response plan. Our focus will be on sustaining current improvement workstreams and embedding effective change to reduce harm from falls.

Inpatient pressure ulcers (PUs)
The Trust is committed to the prevention of hospital acquired pressure ulcers (HAPU). All HAPU are investigated via Root Cause Analysis (RCA) to capture any learning. HAPU identified by ward staff are reported to the Tissue Viability Team (TVT) via ENHance. These incident reports 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 reported 146 HAPU for 2023-24.

	2021-22	**2022-23**	**2023-24**
Number of reportable HAPU	205	210	146

Due to the reporting changes introduced in 2018, the data for 2019-2022 shows more categories of damage were reported as compared to previous reporting periods. The TVT have supported the digital transformation of documentation and its impact has also been noted within the Trust's ongoing surveillance. Since April 2023, new National Wound Care Strategy Programme (NWCSP) recommendations were implemented which resulted in a decline of our PU reported numbers.

PU Categories

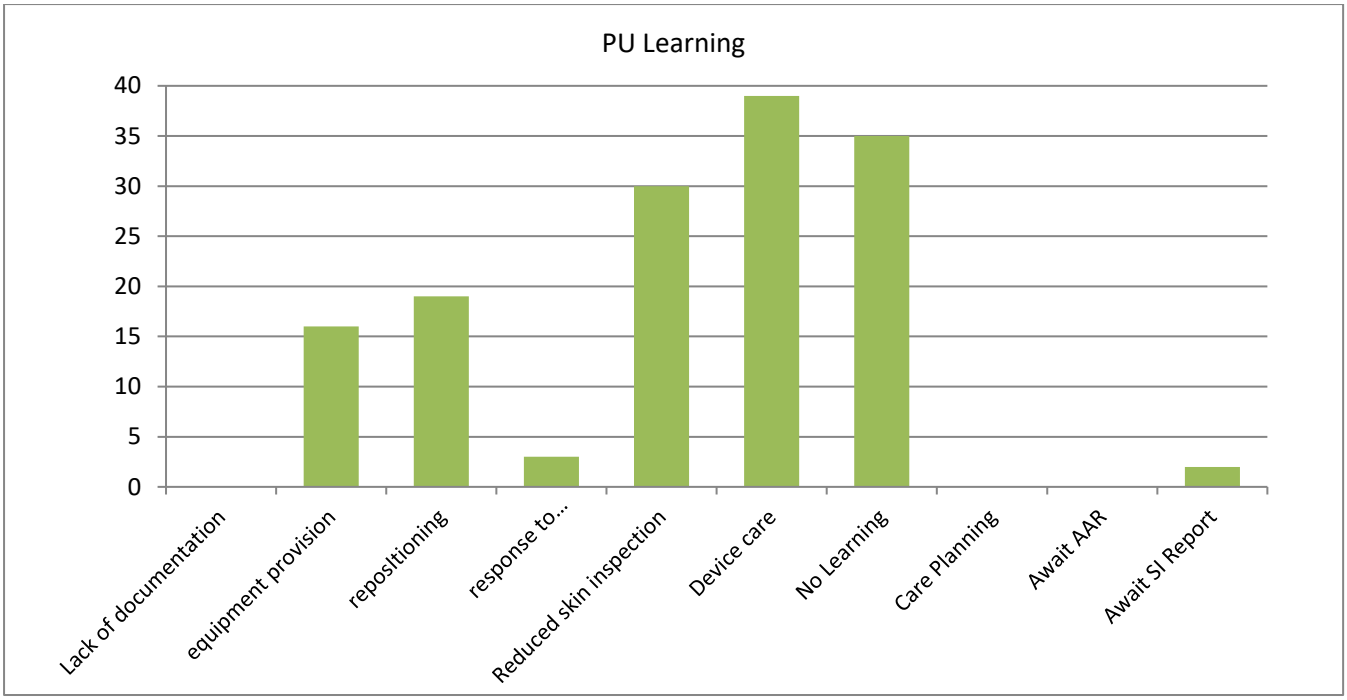
The most prevalent category for 2023-24 has been PU2 accounting for 61.6% of total reportable ulcers. 28% of these PU2 were directly related to the use of a medical device. There is a new rise in trend for PU3 and PU3 (device related) as the NWCSP recommendations have changed the way Suspected Deep Tissue Injury (SDTI) and unstageable PU are reported and validated as likely PU3, and all are documented under PU3.

PU RCA Themes

Every HAPU is investigated by a TVN to enable identification of gaps in care so that learning can be identified and improvements delivered, a Root Cause Analysis (RCA) is performed at the time of validation and outcomes are fed back directly to ward staff. The RCA is also attached to the incident reporting the skin damage to ensure transparency of cause of PU. All category 4 and significant PU3 (with considerations to the NWCSP recommendations), and any PU with significant gaps in care identified at RCA are escalated via the Serious Incident Review Panel for consideration and possible serious incident investigation. The chart below details the themes associated with this year's PU data. Our most prevalent themes are device care (26%), skin inspection (20.5%) and repositioning (13%).

Three PUs have been investigated as serious incidents this year and the TVT have been actively involved in the investigation and recommendations. The safeguarding team were involved in all three of the reviews of these incidents. The main care delivery problem (CDP) associated with each escalation is captured in the RCA theme data below.

In compliance with the NHSI PU recommendations the terms 'unavoidable' and 'avoidable' are no longer used in reporting, however, in 35 ulcers (23.9%) we were unable to determine any learning for ward staff as all care was delivered and documented as per Trust standards.



Transitioning to the Patient Safety Incident Response Framework (PSIRF) 2024/25

Reducing avoidable harm for pressure ulcers is one of the Trust's local priorities in our Patient Safety Incident Response Plan. HAPU Incidents are well understood and so it is necessary for the service to take an improvement approach. Quality Improvement (QI) programmes focusing on our three identified causes will be led by the service in collaboration with wards Trust wide. Improvement outcomes will be monitored by the Harm Free Care group.

QI methodology will be utilised to guide teams to identify and assess potential change ideas. Previous years HAPU data will be interrogated to identify which ward areas shall be the focus of initial improvement work. Successful programmes of change will be adopted and spread Trust wide.

Patient Experience

Complaints and Compliments

All complaints data is sourced from the Trust's internal quality management system ENHance. The Complaints and PALS Department records and responds to complaints, concerns, comments and compliments received from all areas of the Trust, which are triaged to identify the most appropriate method of handling.

It is the Trust's ambition for complainants to have their concerns resolved as swiftly as possible, by offering a formal or informal method to resolution. The Trust captures and monitors any concerns raised by our patients and their families to introduce high impact actions and improvements across the organisation.

In 2023/24 763 formal complaints were received across all services (from 746 in 2022/23) within the Trust, and 4657 informal PALS concerns (from 3496 PALS

2022/23) were received. The Trust has a current 28 day turn around on all non-urgent PALS enquiries.

Complaint themes were mainly around communication and medical care.

Indicator	**21/22**	**22/23**	**23/24**
Number of formal complaints	777	746	763
Number of PALS concerns	3614	3496	4657
Number of PALS concerns closed within 5 days/ % performance	2529 78%	1951 55%	2508 54%
Complaints – response within agreed timeframe	72%	50%	48%

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

Since starting to embed the PHSO standards framework, to ensure that we are offering early resolution meetings to complainants, we have seen an increase in the number of delays for complaints being responded to within the allocated timeframe. This is likely due to the time taken to arrange and hold meetings due to patient/carer and staff availability.

Plans for 2024/25:

- A pilot will take place within one of the Trust's divisions to try a new process within the formal complaints procedure, which will involve having independent investigators who have full ownership of the entire complaint and will gather the evidence around this. This will allow for a timelier investigation and conclusion.
- The Trust is introducing a new quality oversight framework which will clarify a group of core standards and governance arrangements across the Trust departments and services. This framework will be implemented over the next year and will require iterative testing and learning to sustain operational change.
- A business case has been submitted for the PALS and complaints department to improve staffing resource within both teams.
- We will be providing new Trust wide PALS resolution training to train and empower staff to identify and resolve issues in real time.

Parliamentary and Health Service Ombudsman complaints

In the reporting year, nine were assessed by the Parliamentary and Health Service Ombudsman (PHSO). Three complaints were closed with no further investigation, four remain under investigation, one upheld and one with learning for the Trust.

The Trust received 295 compliments last year, which has been seen an amazing improvement alongside the ability to log on the Trust wide quality management

system ENHance. All compliments are shared with the Chief Executive, divisional leads and the staff member in question.

2.5. Other Quality Information

2.5.1. Operational performance appraisal summary

In 2023/24 we welcomed 184,926 patient attendances to our emergency departments; we cared for 52,012 inpatients and saw 610,180 patients in our outpatient settings. Unfortunately, due to the high incidence of industrial action this year there were higher than average levels of cancellations and longer waits for elective care.

- The focus in 2023/24 has been on elective recovery and work towards the achievement of elective and non-elective operational performance targets. This includes the development of and delivery against the elective recovery plan, including eradication of patient waits over 104 weeks from referral to treatment. The Trust delivered on this metric with the exception of community paediatrics. For this specialty the Trust is working with system and national leads to develop new community pathways with the aim of providing a more consistent and shortened pathway with particular reference to those with neurodiversity. During this year, the Trust delivered waiting times of 78 weeks from referral to treatment for the majority of patients, where the patient was available and fit for treatment with the exception of some Trauma and Orthopaedic patients.
- The Trust has continued to incrementally improve its performance against the four-hour non-elective wait time standard. Nationally the target was set at 76% for all patients by March 2024 and the Trust achieved 73.18%. Despite the underperformance this is 10% higher than the Trust's performance against the four-hour standard this time last year, against the backdrop of 13.5% more attendances to ED in-month. This has been delivered through a large Urgent Treatment Centre (UTC) improvement programme and significant investment to include operationalisation of an Urgent Treatment Centre, Surgical Assessment Unit and greater use of community models such as the virtual hospital.
- There has been a real and sustained improvement in ambulance handover times due to an acute focus reset, increased Same-Day Emergency Care (SDEC) direct admission and improved system working. By March 2024, the target was to not have any ambulance delays over 30 minutes. The Trust achieved 66.1%
- Delivery against the cancer targets has continued as a priority and remains a strong performer for the organisation. The Trust continues to focus on the reduction of the proportion of patients waiting over 62 days and working with system partners to reduce delays due to late referrals into the Trust. This year saw a change in focus of cancer operational standards away from two week waits and a focus on faster diagnosis. The Trust has been nationally recognised for its early adopter work on the timed pathway analyser which has enabled a sustained compliance against the faster diagnosis standard of 75%.

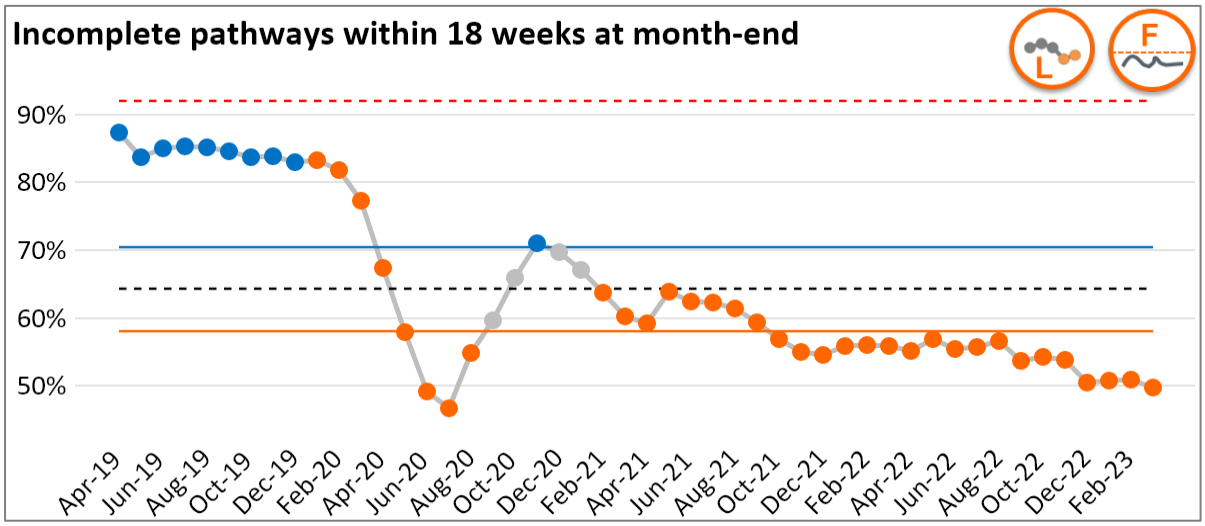
- Diagnostic turnaround times remain a challenge for the organisation across all modalities. Additional pressure has been experienced due to an increase in both cancer referrals and urgent and emergency care (UEC) demand requiring imaging. Detailed capacity and demand modelling has been completed at Trust level which sees all modalities, except MRI, deliver DM01 compliance by March 2025. Community Diagnostic Centre (CDC) performance has been on track with agreed trajectories for 2023/24 across all the radiology areas of CDC. Cardiology CDC fell below trajectories as a result of poor GP uptake, workforce pressures and delays in commencement of the service.
- Stroke performance nationally is monitored on the calendar year rather than the financial year. The Trust has improved on its performance and is now at a B rating due to the amount of work and attention to detail by the teams. The Trust will continue to work on actions with the aspiration to achieve an A rating.

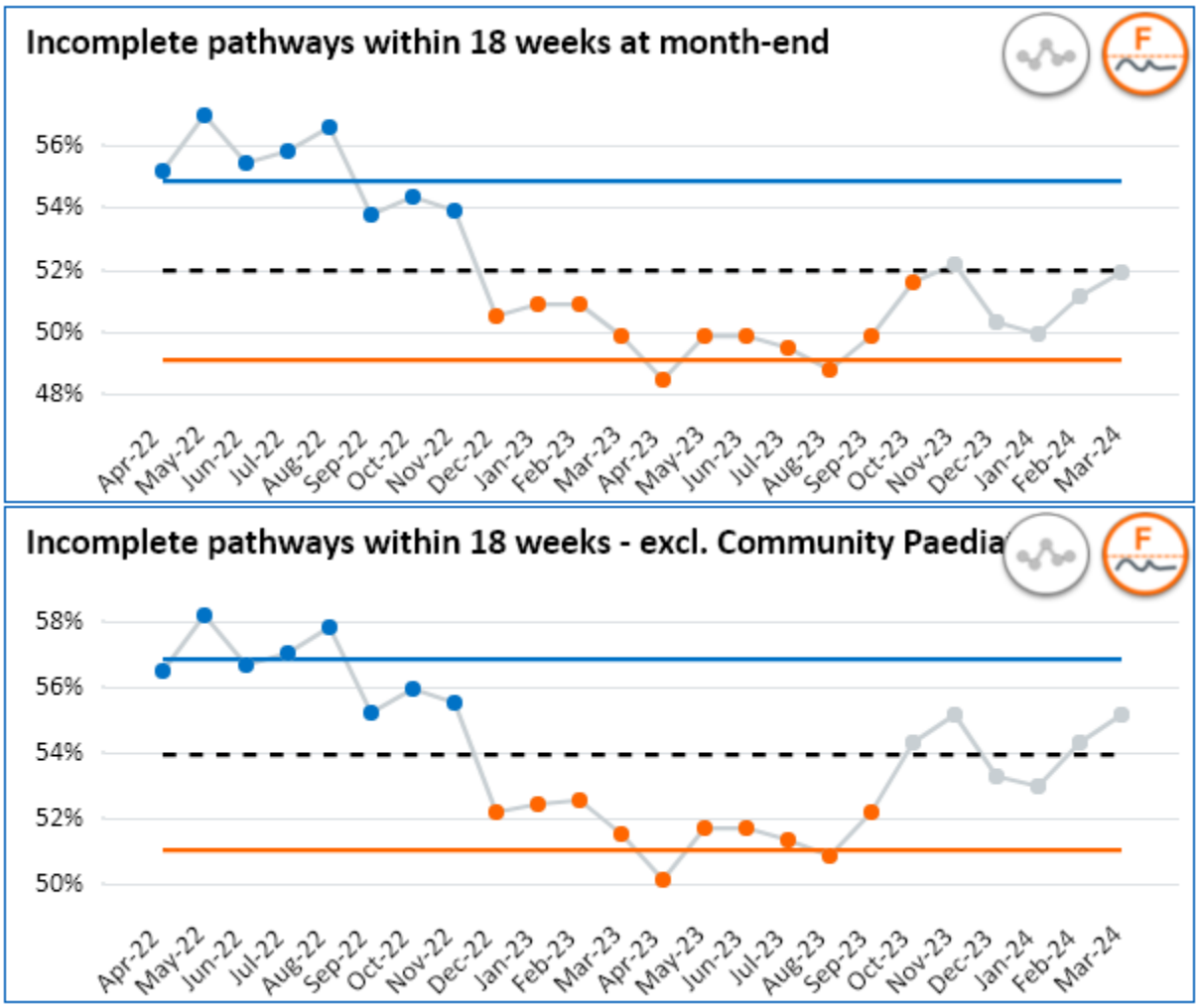
2.5.2. Performance Analysis: In-depth performance review

Operational Performance
A summary of performance against the key metrics is provided below:

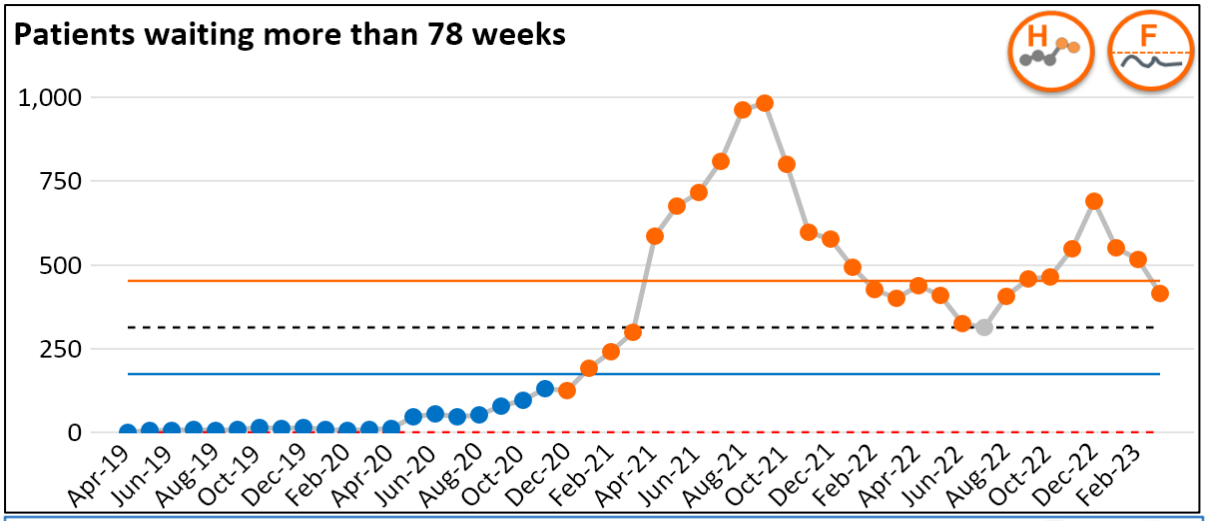
Referral To Treatment (RTT)
Nationally the drive was to eradicate any patient waiting over 78 weeks with a push to getting waiting times below 65 weeks. The Trust through a variety of actions including recruitment, efficiency gains, additional waiting lists, contact, validation and robust waiting list management has seen a dramatic improvement in waiting times.

Community paediatric waiting times has nationally remained a concern with a clear gap between demand and capacity. The Trust has been working closely with system partners to really understand the demand and the reason for the increase, impact of covid and streamline the pathways to ensure equitable access for all children within the region.





The Trust ended the year with 29 patients (of which 22 were in Trauma and Orthopaedics) waiting over 78 weeks due to patient choice, complexity or capacity. These will be treated by the end of May 2024.


Patients waiting more than 78 weeks
H
F
1,000
750
500
250
0
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
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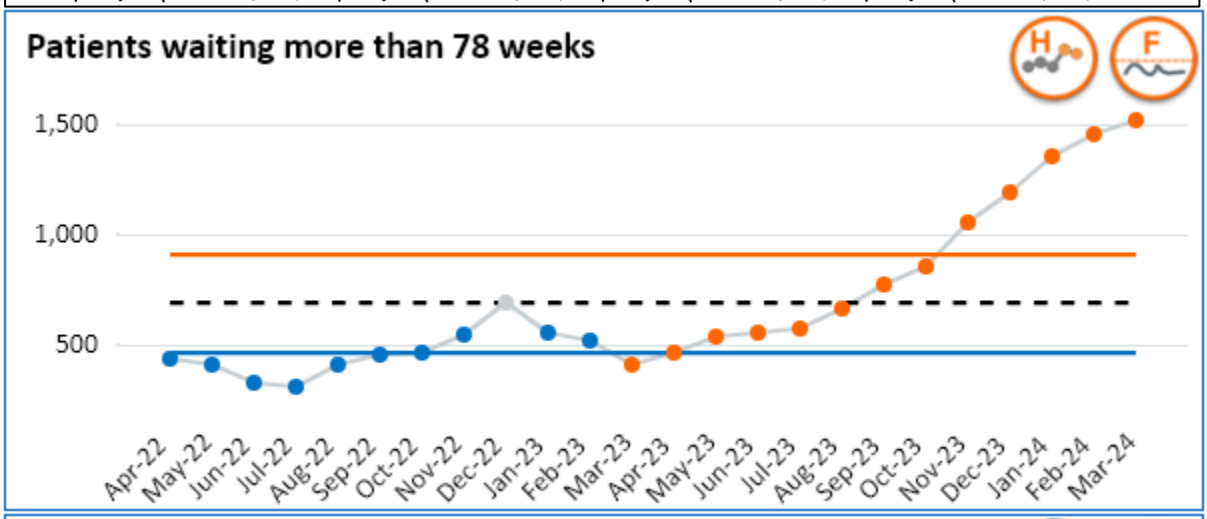
Patients waiting more than 78 weeks
H
F
1,500
1,000
500
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
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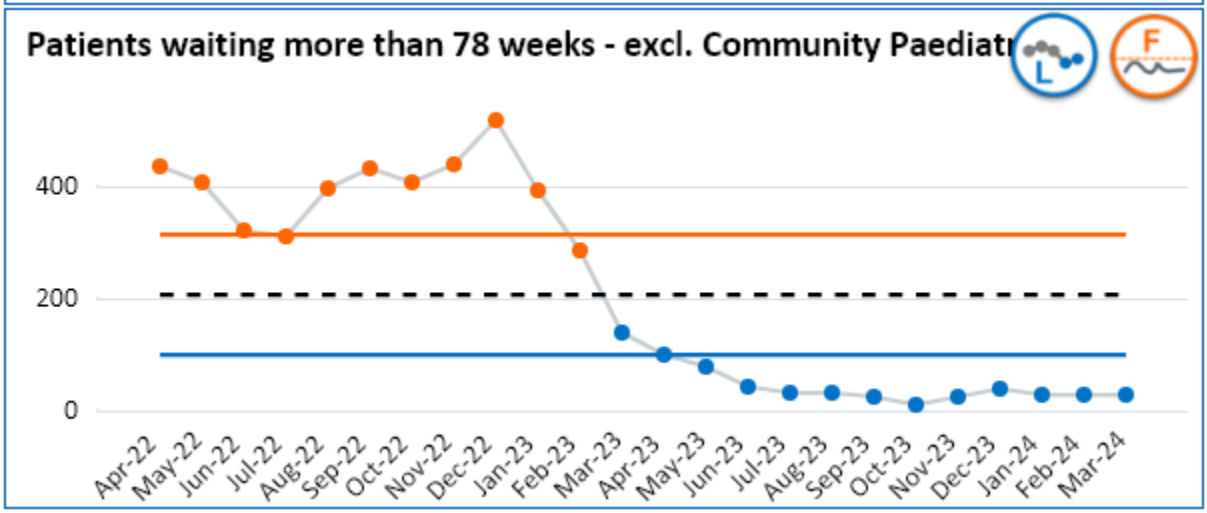
Dec-23
Jan-24
Feb-24
Mar-24


Patients waiting more than 78 weeks - excl. Community Paediatr
L
F
400
200
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
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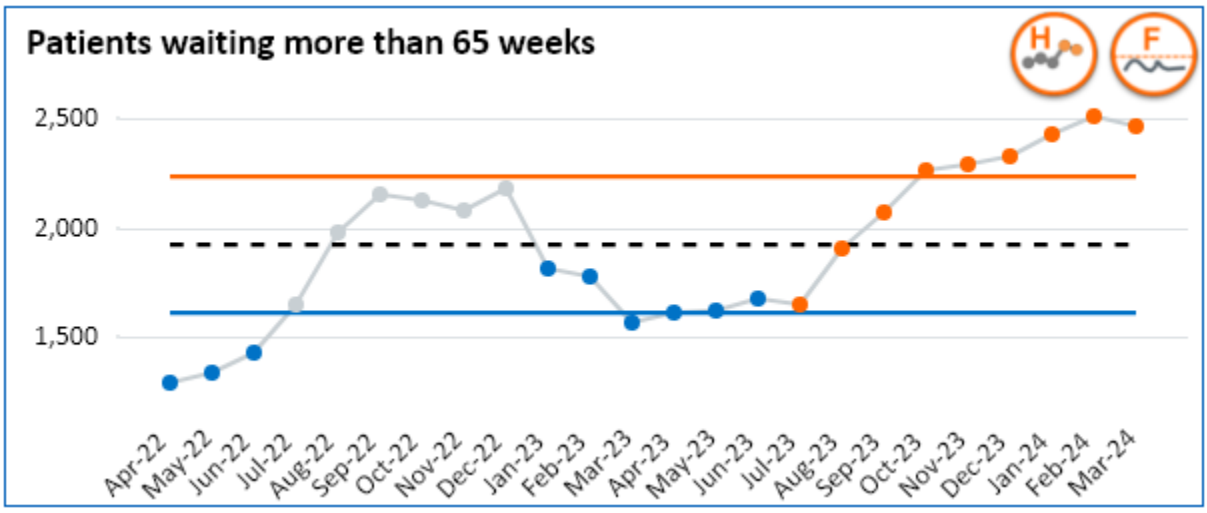
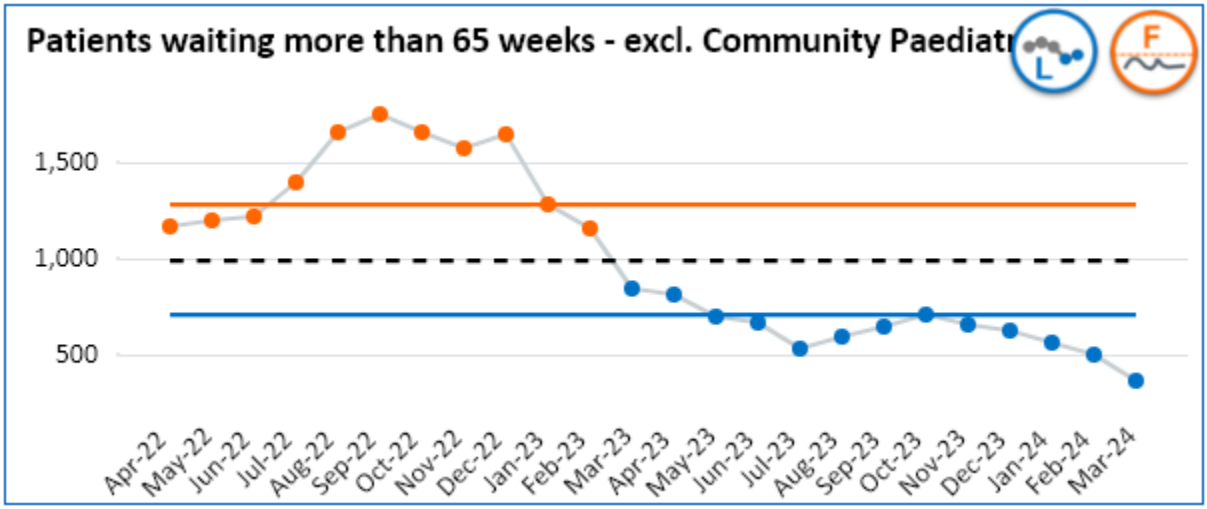
Mar-24





With the exception of Community Paediatrics and T and O, the Trust managed to treat the majority of patients within 78 weeks unless the patient chose to delay their treatment, or their treatment was delayed due to a clinical condition. Trauma and orthopaedic capacity has been challenged due to a combination of industrial action, clinically urgent patients taking priority and sub specialisation capacity pressures. It has been agreed T and O will deliver this target by the end of May 2024.

At the end of the 2023/24 financial year, the majority of services were able to meet the new target waiting time of 65 weeks. However, capacity remains challenging in trauma and orthopaedics, gastroenterology, pain management, ophthalmology, oral surgery and urology and there is agreement to be compliant with the 65-week target from the beginning of September 2024 for these services.

To support the delivery of the contact and validation target of 90% of patients waiting over 12 weeks who have not had an appointment in the last 12 weeks and don't have an appointment booked in the next four weeks, 72,500 text messages were sent asking if patients wanted to remain on the waiting list. The response rate was 75% with almost 5,000 patients requesting discharge (6.8%).

In addition, as part of national patient choice requirements, 3,069 patients who were waiting more than 40 weeks for treatment and who did not have a future booking

were invited to sign up to the national Patient Initiated Digital Mutual Aid System (PIDMAS) in October 2023. The Trust received 125 responses (4.1%) confirming they would be happy to potentially go elsewhere for treatment. However, 90 of these patients had treatment at the Trust before they could be offered an appointment elsewhere, 22 were not suitable for PIDMAS, and the ICB could not find suitable capacity within the region for the other 13 patients.

Urgent Care Pathways
To improve performance against the four-hour standard, the Trust embarked on a multi-project programme to develop a new emergency care model.

The national four-hour standard still remains at 95% with a recovery trajectory set at 76% of patients arriving at the Emergency Department (ED) to be admitted to hospital, transferred to a more appropriate care setting, or discharged home within four hours by the end of March. In April 2023 the Trust's 4-hour performance was 64.2% and the Trust achieved 73.8% in April 2024

The ambition of the programme was to transform emergency care pathways to provide alternative(s) to the ED where appropriate, thereby reducing the volume of patients in ED and improving patient flow and experience.

With the support of Hertfordshire and West Essex Integrated Care Board (HWE ICB) funding, a new Adult Urgent Treatment Centre (UTC) opened in January 2024 on the Lister Hospital site. The service is open from 8am to 10pm 7 days per week and can treat a range of minor illnesses and minor injuries for adults aged 16 years and over that would otherwise have gone to ED. In the first seven weeks of opening, the UTC treated more than 2500 patients, with the average time from arrival to discharge of 1 hour 43 minutes. Plans are in development to expand the service to include children (under 16 years) which will enable the Lister UTC to fully mirror the successful model at the New QEII Hospital.

Medical SDEC opening hours were also extended until 10pm to provide additional capacity for patients who had either been directed to the medical team by their GP, or who were identified as requiring medical team intervention by the ED.

A Surgical Assessment Unit (SAU) was formally re-established in January 2024 having been stood down during the COVID-19 pandemic. This is a dedicated service for the assessment of emergency surgical patients who may be referred directly by their GP or who have presented to the ED and referred to surgical specialties for further assessment and possible inpatient admission. Since opening the SAU has cared for over 1000 patients. The service also supports a Surgical SDEC which will continue to expand its capacity in line with recruitment of workforce.

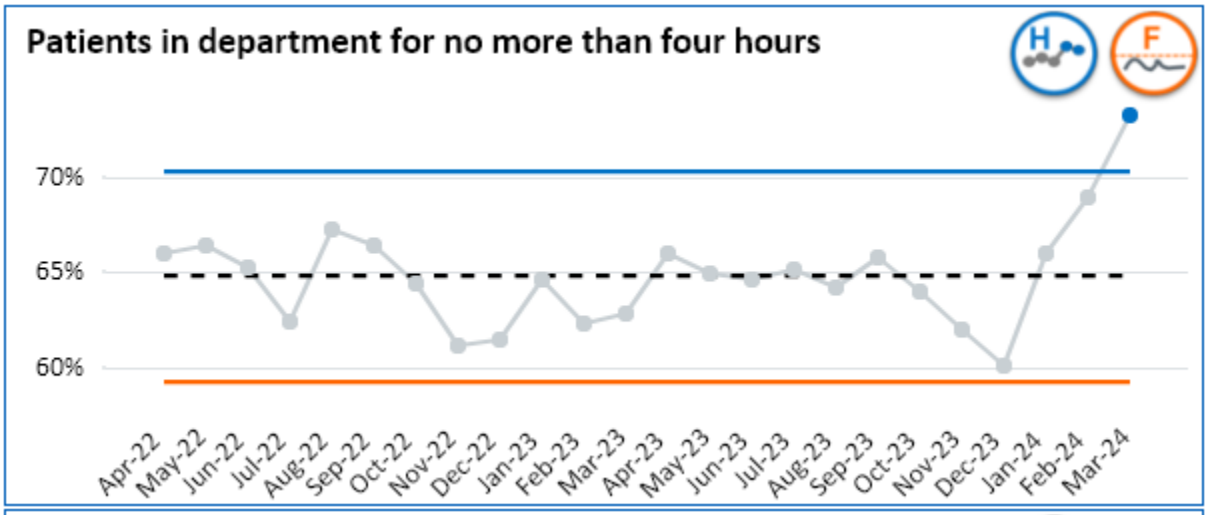
In addition to alternative services, the ED has revised nursing and medical workforce rosters to ensure the staffing model aligns with expected peak times in patient arrivals to the department. The new rosters came into effect in January 2024 and continue to be embedded across all staffing groups, providing more support during peak hours. Work is also ongoing to increase diagnostic capacity with an additional CT machine expected to open for ED patients and inpatients from April 2024.

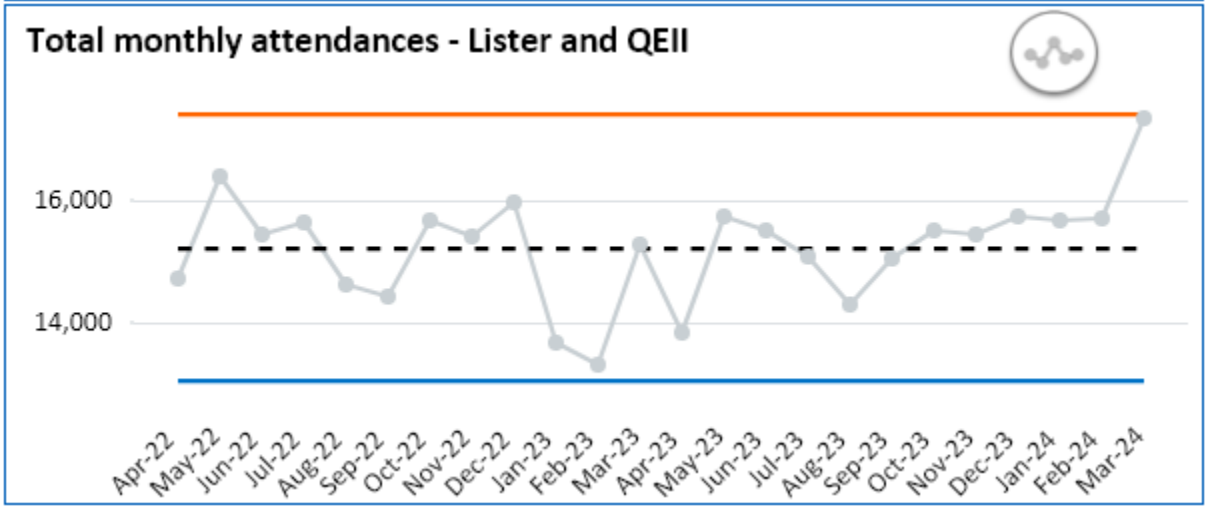
Paediatric ED has also been part of the ED improvement programme and further focus on new space for time to triage during peak times, development of the CDU

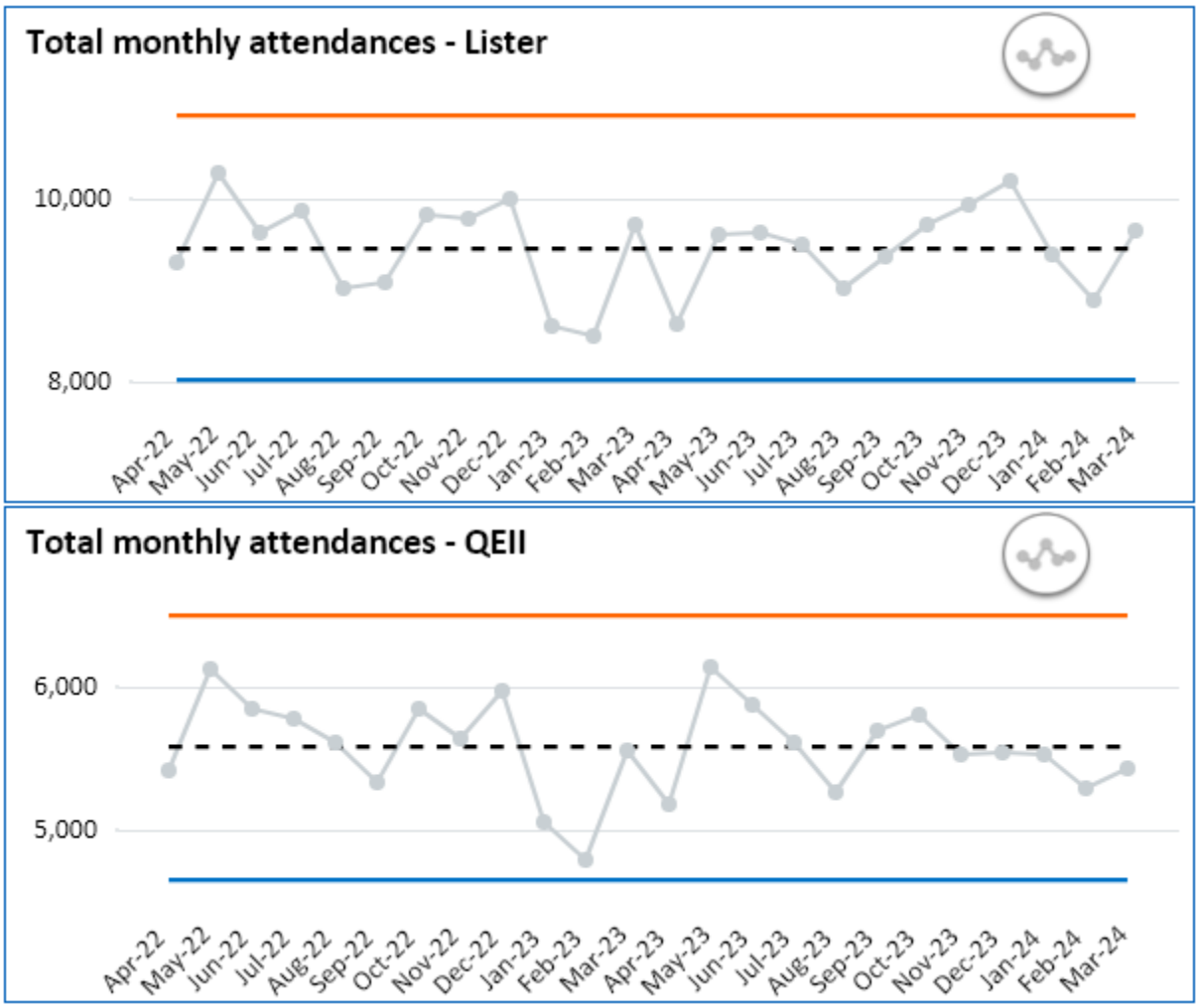
and redesign of the medical workforce to align with expected peak demand is forecast to improve paediatrics ED four-hour performance further in 2024/25.

All Urgent and Emergency Care (UEC) services are operating under a model of continuous improvement with processes constantly reviewed to identify areas of opportunity. The ED has reviewed and refined their streaming and triage models to ensure patients are directed to the most appropriate service at the earliest opportunity. Further areas of development and improvement will be identified and driven in 2024/25.

In March 2024, the Trust's four-hour performance standard increased to 73.18%. Many of the improvement initiatives did not commence until January 2024 therefore it is anticipated that as new pathways and services embed performance will continue to improve in this area in-line with the target of 78% for 2024/25 but will remain under close observation.

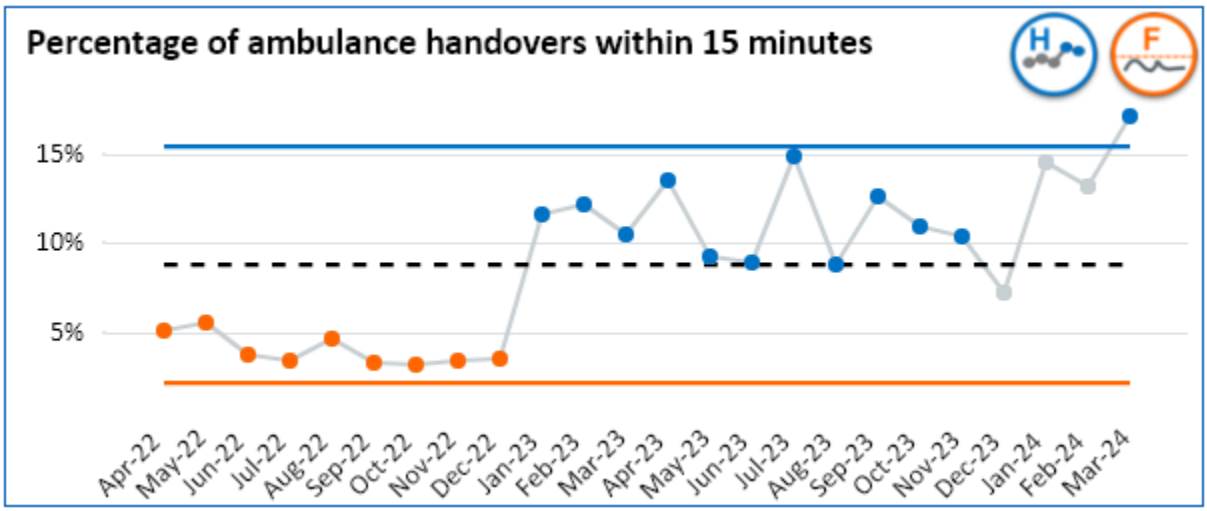


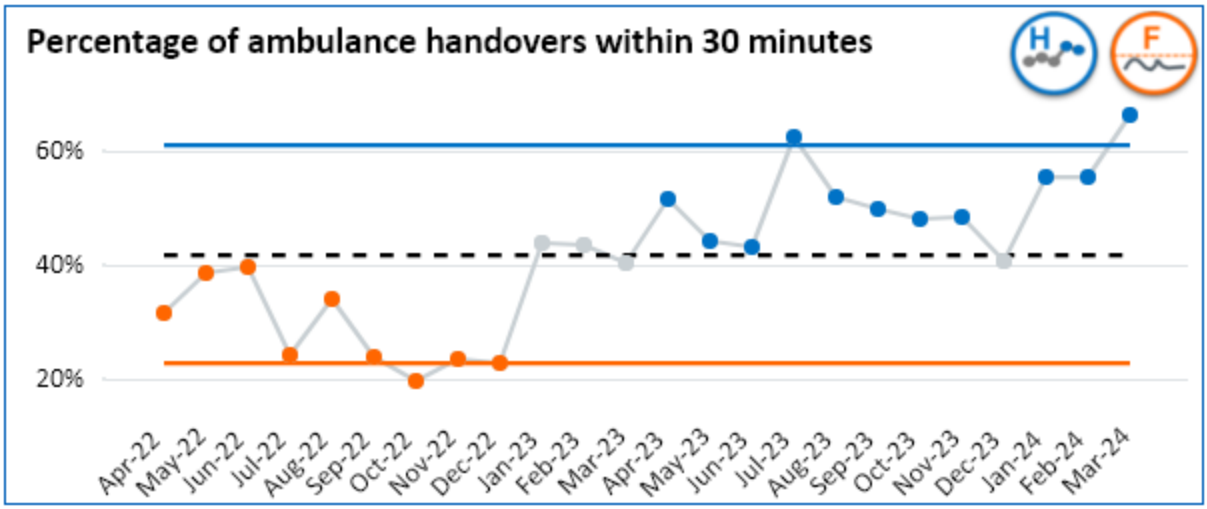




Ambulance handover

The Trust with the East of England Ambulance Service NHS Trust (EEAST) and other partners such as Hertfordshire Community Trust and the other acute providers, worked hard to significantly reduce handover time for those patients bought to the department by ambulance. Despite the number of conveyances, the Trust through its actions and work on the urgent care pathways, has significantly improved handover time therefore enabling ambulances to get back out into the community and patients arriving to the department getting the care they require in a quicker timeframe.





Cancer performance

In the 2023/24 financial year, the national Cancer Waiting Times standards were streamlined from eight separate to three combined standards. These new standards are:

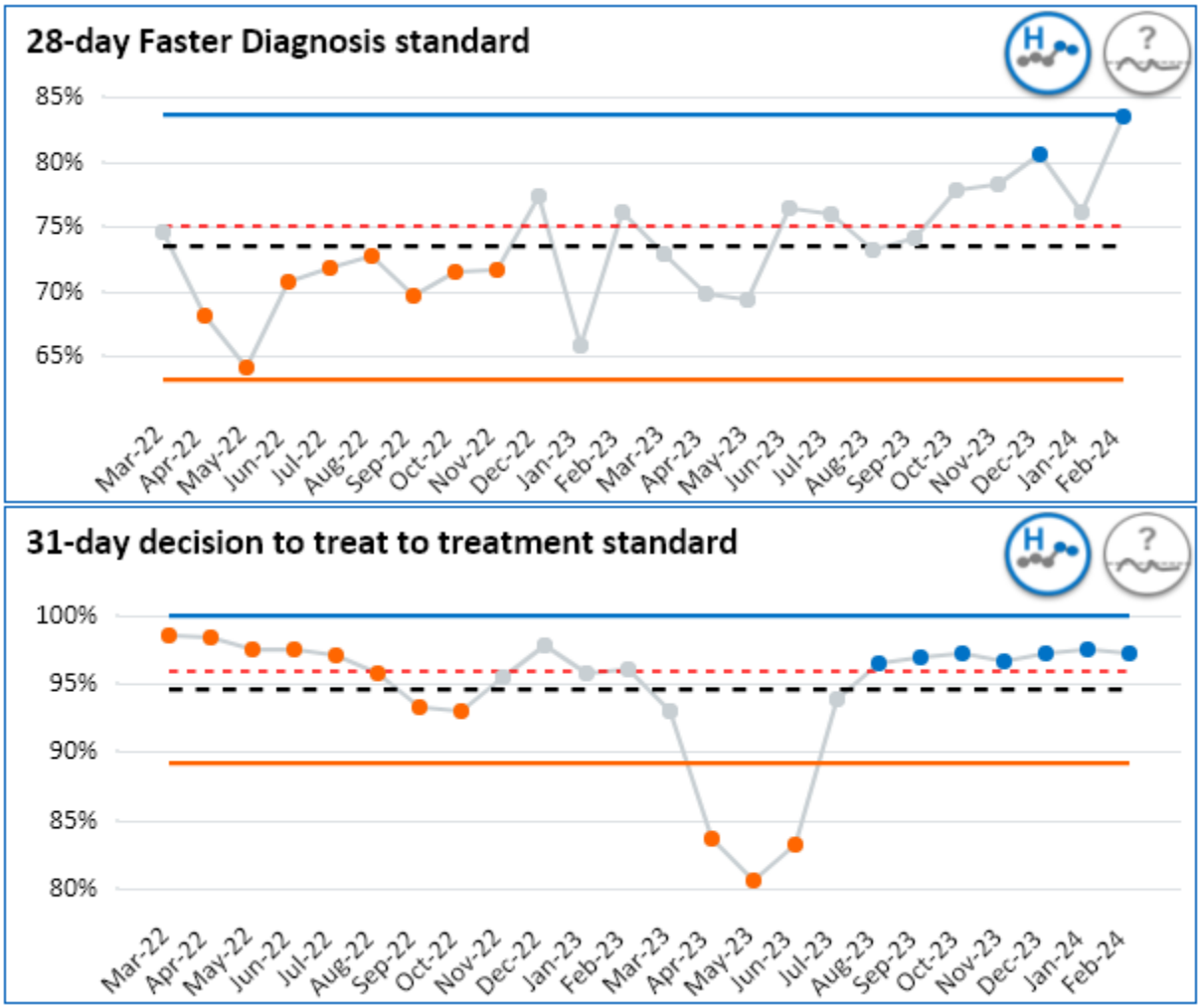
- the 28-day faster diagnosis standard,
- the 31-day decision to treat to treatment standard,
- the 62-day referral to treatment standard.

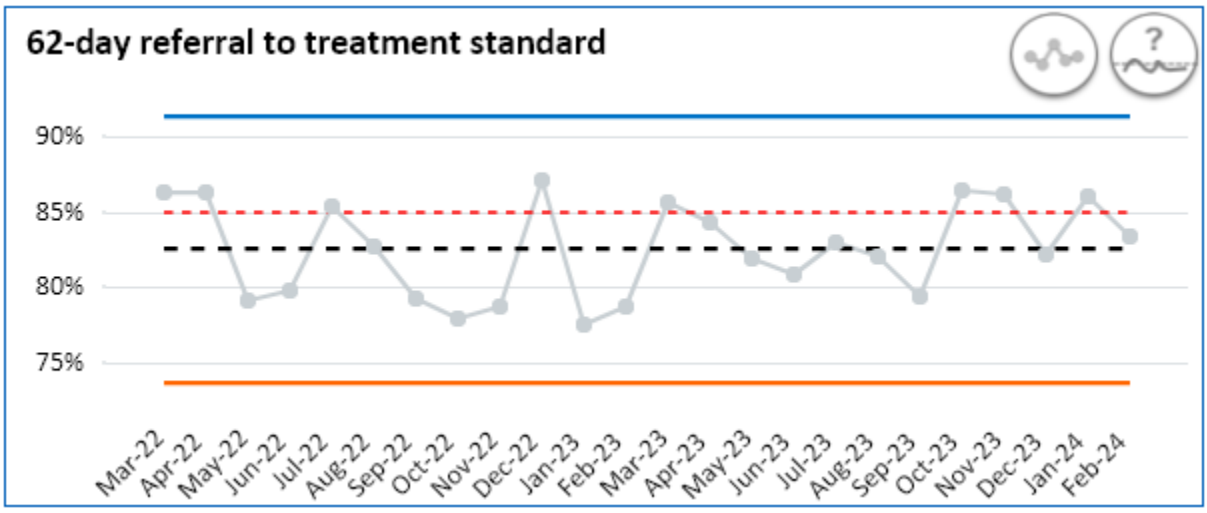
Whilst cancer performance was not sustained fully over the course of the first 6 month for 2023/24, the 62-day cancer target was achieved for three out of six months, and our performance against this standard remains one of the best regionally. Across all the cancer standards, the year-end position was compliant with three of the eight standards and within 1.0% of achieving the 62-day standard. Factors for this underperformance include high numbers of two week wait referrals putting substantial pressure on the Trust capacity in endoscopy, radiology and histopathology, late referrals from other local providers, patient choice and industrial actions have caused delays in the cancer pathways; these all have remedial plans in place to prioritise all cancer pathways to avoid delays in 2024/25.

31-day subsequent performance for chemotherapy and radiotherapy was consistently sustained for the year, despite a few months' dip in performance for radiotherapy as a result of increased downtime from aging linacs, coupled with workforce shortages. The new machines have now been replaced with new Ethos technology and staffing is fully established.

The Trust's 28-day faster diagnosis standard has remained consistently high during 2023/24. The Elective Intensive Support Team has supported pathway analysis for all tumour sites so the Trust can clearly identify delays and make changes to improve the end-to-end pathway. The Trust's early adoption of the pathway analyser work has been recognised nationally and the cancer team has been asked to share good practice with other trusts.

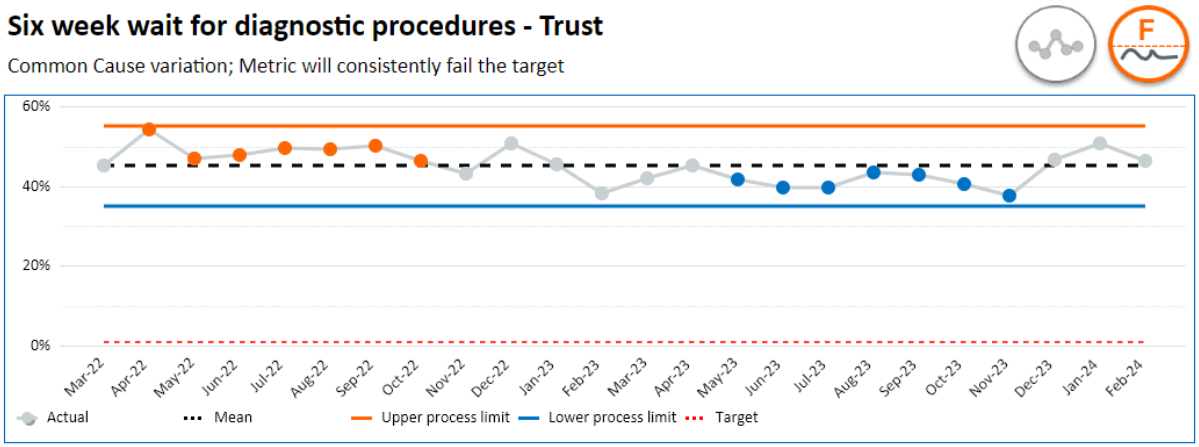
Cancer performance for the three new standards was sustained fully over the course of the first six months for 2023/24. The 62-day cancer target was achieved for four months out of six months, and our performance against this standard remains one of the best regionally.

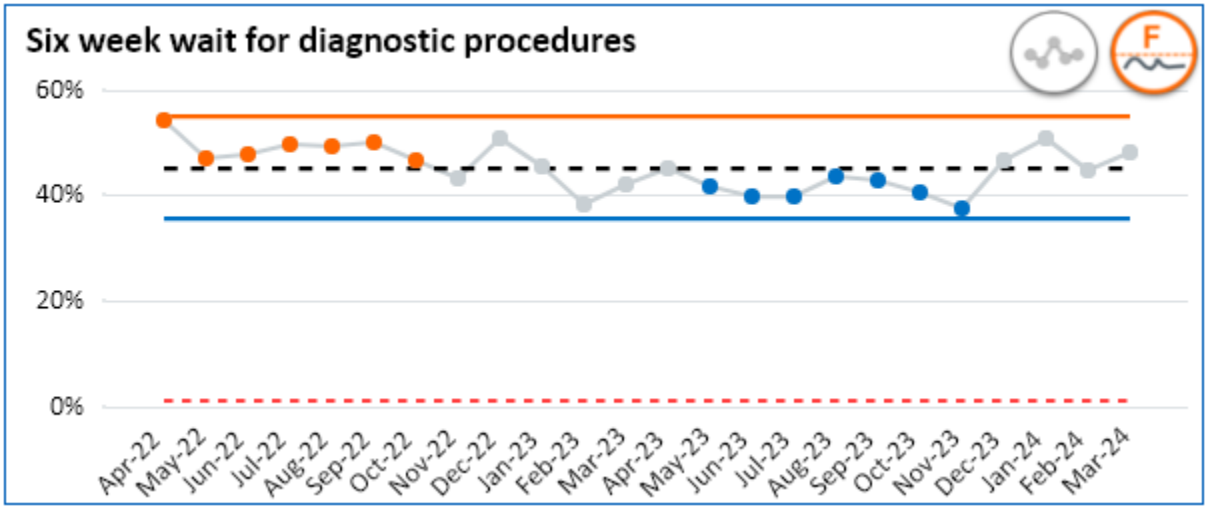


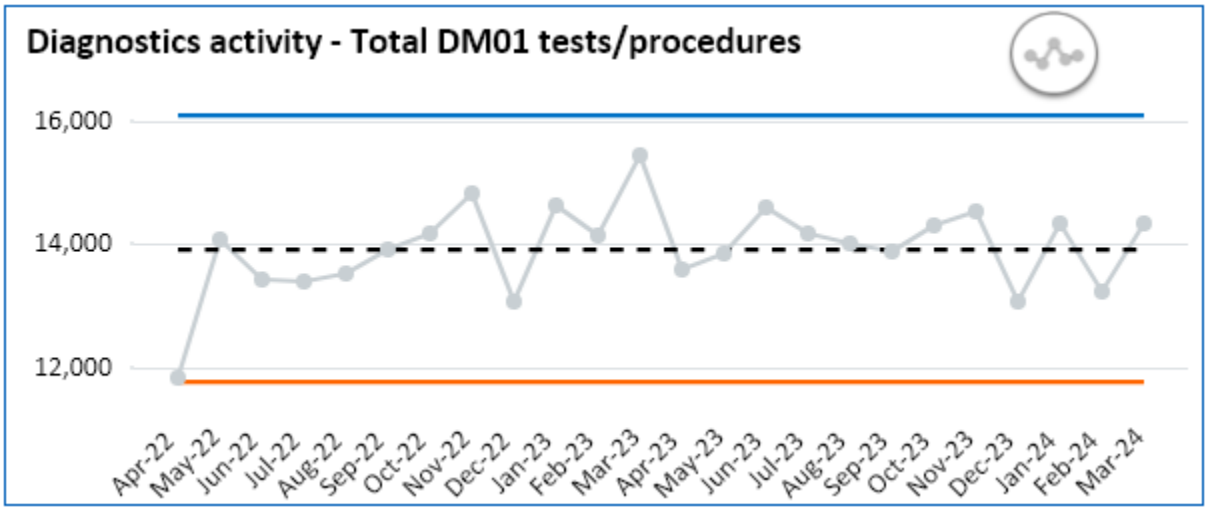


Diagnostics (DM01) (less than 1% of patients should wait 6 weeks or more for a diagnostics test)

As mentioned previously in the report, the demand on services has exceeded capacity plans for the majority of 2023/24 as a result of urgent and cancer referrals. This has resulted in an inability to meet DM01 performance this year. The Trust has undertaken detailed capacity and demand modelling with recovery trajectories that will deliver DM01 compliance for all modalities other than MRI by March 2025 as agreed.







Stroke performance

The Trust's performance continues to improve and is now at level B for the second consecutive quarter. Stroke cases continue to increase over the average baseline set on SSNAP of 63. Most recently in Feb 2024 we saw 91 confirmed strokes. A high number of patients are requiring care at Addenbrookes and Charing Cross – these patients make up a high number of our breach reasons alongside winter pressures such as stroke beds being occupied by medical patients which reduces flow through the pathway.

Further work is required to protect dedicated stroke beds during peak times in ED and manage repatriation of out of area referrals.

There have been improvements in the provision of both occupational therapists and physiotherapists in this area, but further Trust investment is needed to sustain level B for the organisation and progress to level A. A business case has been submitted with this in mind.

Speech and language therapy input continues to be an area of concern and the Trust alongside its system partners are reviewing different models of care delivery to mitigate staffing shortfalls.

The initial scanning of patients with suspected stroke remains at the highest score meaning that stroke can be diagnosed, and appropriate treatment commenced as early as possible.

SSNAP Scoring Summary	Team Type	Routinely admitting team
	ISDN	East of England (South)
	Trust	East and North Hertfordshire NHS Trust
	Team	Lister Hospital

	Time Period	Jan-Mar 2023	Apr-Jun 2023	Jul-Sep 2023	Oct-Dec 2023
	SSNAP level	D	C	B	B
	SSNAP Score	57.0	65.0	70.3	75.0
	Case ascertainment band	A	A	A	A
	Audit compliance band	A	A	B	A
	Combined total key indicator level	D	C	B	B
	Combined total key indicator score	57.0	65.0	74.0	73.0
Number of records completed:	Team-centred post-72h all teams cohort	204	206	215	252

Other positive developments to note

- Thrombolysis in Acute Stroke Collaborative (TASC) project underway from January 2024 in partnership with NHS Elect, to support improvement in thrombolysis performance rate to 14% and additional benefits in supporting overall flow within the stroke wards, due to positive impact on simple discharges.
- Stroke video triage pilot; positive feedback on the benefits to the clinical pathways.
- Digital Nerve Centre project is ongoing to support MDT working and goal setting to improve SSNAP data collection.
- Radiology is consistently meeting targets set against scanning patients within 1-hour of clock start. However, progression to achieve scanning under 15 minutes will enable thrombolysis with a median time of less than 40 mins, which is currently a challenge.

Seven Day Service

The national Seven Day Hospital Services (7DS) Programme is a quality improvement initiative providing acute provider organisations with a framework to work to reduce variation in outcomes for patients admitted to hospitals in an emergency and at the weekend across NHS trusts in England. There are four priority standards:

Standard 1: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission. An audit undertaken in 2023 identified that approximately 66% of patients were reviewed within 14 hours of admission by a consultant.

The table below details the schedule for on-site consultant cover for our acute specialties:-

Specialty	7-day Consultant on-site rota cover
Acute Medicine/General Internal Medicine	0800-2100
Anaesthetics	0800-1800
Critical Care	0800-1800
Emergency Department	0800-2200
General Surgery	0800-1800
Obstetrics	0830-1715
Paediatrics	0830-2100
Respiratory	0830-1800
Trauma and Orthopaedics	0800-1800

Standard 5: inpatients must have scheduled 7-day access to diagnostic services.

The table below details our compliance with standard 5 regarding access to these emergency diagnostic tests

Emergency diagnostic test	Available at weekends
USS	Yes
CT	Yes
MRI	Yes
Endoscopy	Yes
Echocardiography	Yes
Microbiology	Yes

Standard 6: inpatients must have timely 24-hour access to key consultant -directed interventions. The table below shows compliance regarding access to emergency consultant-led interventions:

Emergency Intervention	Available on site at weekends	Available via network at weekends	Not available
Intensive Care	Yes		
Interventional radiology	Yes		
Interventional endoscopy	Yes		
Surgery	Yes		
Renal Replacement Therapy	Yes		
Radiotherapy		Yes	
Stroke Thrombolysis	Yes		
Stroke thrombectomy		Yes	
PCU for MI	Yes		
Cardiac pacing	Yes		

Standard 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. An audit during 2023

identified that approximately 60% of a sample of patients were reviewed within 14 hours of admission.

The nationally recommended board assurance framework for 7-day standards will be used when reporting to the Trust's Quality and Safety Committee during 2024/5.

Rota Gaps

We recognise that increased number of vacancies, resulting in rota gaps, puts increased pressure on doctors in training (DiT), locally employed (LED) and SAS doctors also working on the rota. Whilst all attempts have been made to recruit to these gaps, recruitment can be delayed and at times unsuccessful. Acknowledging this, the following action plan is in place to alleviate pressure created by rota gaps.

As part of the annual review, all departments are requested to review their rotas for resident doctors, ensuring they meet both requirements of the service and the requirements for all doctors in training, outlined by their terms and conditions, and educational requirements outlined by Health Education England. The review of rotas ensures that where there are changes to numbers of doctors on the rotas, the rotas are amended, to avoid unnecessary rota gaps.

Table 1

Month	Total vacant trainee posts	Number filled with SCF/JCF	% Filled
Jan-24	22	9	41%
Feb-24	22	9	41%
Mar-24	21	9	43%

As soon as vacancies that create rota gaps are identified, the recruitment process is started to ensure that the vacancy is filled as soon as possible. As indicated in table 1 above, this recruitment is not always successful. We are therefore looking at ways to make these roles, particularly Senior Clinical Fellow roles, more attractive. Currently, a paper is being written with the focus of LED's being employed on the 2016 terms and conditions, rather than the 2002 terms and conditions that they currently are. The principle behind this is to create parity between DiT and LEDs, with a focus on rota commitments and educational opportunities. The idea being that offering greater educational opportunities will aid recruitment to these roles. There is also a focus on providing full and thorough inductions for these doctors, enabling them to join the full rota sooner.

The Trust has recently undergone a restructure, with a focus on leadership. The restructure in leadership allows for greater ownership of the service, therefore ensuring the identified rota gaps are filled.

With regard to improving short term rota gaps, the Trust's management, in liaison with the junior doctor forum, have been working to finalise a new process for out of hours to fill rota gaps. The new process, which is yet to be implemented, as discussion is ongoing, will highlight responsibilities of each party, and at what point escalation is required. It also highlights the need to prepare for options other than

bank and agency fill, to mitigate risk and pressure on the resident doctors present for the specific shift.

Staff/ National staff survey
For 2023/24, we will focus primarily on themes around the following and continue work in other areas:

- We are compassionate and inclusive
- 'Morale'
- 'Voice that counts'

Our overall scores shown below indicate improvements in all categories:

People Promise elements	**2022 score**	**2023 score**	**Statistically significant change?**
We are compassionate and inclusive	7.07	7.13	Not significant
We are recognised and rewarded	5.67	5.83	Significantly higher
We each have a voice that counts	6.51	6.56	Not significant
We are safe and healthy	5.78	5.99	Significantly higher
We are always learning	5.14	5.55	Significantly higher
We work flexibly	5.97	6.17	Significantly higher
We are a team	6.55	6.65	Not significant
Themes			
Staff Engagement	6.71	6.80	Not significant
Morale	5.58	5.78	Significantly higher

The key survey areas of focus include 'morale', 'voice that counts' and 'compassionate and inclusive'. The survey results show improvement in people being clear about their objectives in work, with this helping them improve doing their job and we can see more staff progressing their careers, through undertaking learning activities and staff taking advantage of flexible working opportunities. Increases are also seen in the percentage of staff recommending the Trust as a place to work.

We have developed and launched our EDI strategy and our EDI commitments and actions are informed by our survey results with areas such as the development of mentoring and coaching, supporting staff with disabilities and long term conditions, including supporting our staff networks to facilitate change.

The Trust continues with consistent approaches to improve culture including embedding our refreshed values and development of staff values charters. We

continue to support interventions that encourage safer and more inclusive environments for our staff, including improvements to our onboarding processes to ensure they are values driven.

Veterans covenant

The Trust has committed to the Veterans' Covenant Healthcare Alliance (VCHA) which is an organisation for healthcare providers aiming to provide the best standards of care for the armed forces community. The aim is for veterans not to experience disadvantage as a result of their service compared to other citizens. This includes ensuring family members retain their place on NHS waiting lists if moved around the country and that veterans receive priority treatment for a service related health condition/injury, subject to need.

As part of our inclusion agenda, we will be establishing a staff network for service personnel.

Freedom to Speak Up / Raise Concerns

The National Guardian's Office (NGO) and the role of the freedom to speak up guardian were created in response to recommendations made in Sir Robert Francis QC's report which investigated failures in care at the Mid Staffordshire NHS Foundation Trust. These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result. The NGO leads, trains and supports speaking up strategy within the NHS including monitoring the number and themes of concerns raised by NHS staff.

The Trust has 1.0 WTE freedom to speak up guardian who supports staff with speaking up five days/ week. The executive lead for freedom to speak up is Theresa Murphy, Chief Nurse and the non-executive lead is Val Moore. Governance is provided by the People Committee, providing assurance in relation to process and clear connectivity to the People Priorities and People Promise.

40 speak up champions across all staff groups, specialities and sites support the freedom to speak up function by addressing barriers to speaking up, signposting staff and influencing positive culture within their department.

In line with the Trust values (Include, Respect and Improve), all staff are encouraged and supported with speaking up. Both confidential and anonymous speaking up is welcomed with several avenues available to our people.

Speaking up confidentially: Staff can speak up to their line managers, divisional directors, Trust executives (including ask.adam email to raise concerns directly with CEO), and the freedom to speak up guardian.

Speaking up anonymously: Staff can speak up anonymously via Work in Confidence (external service provider) or our incident reporting system (ENHance).

This increased investment in supporting our colleagues to speak up demonstrates a positive shift within our Trust to building an open, transparent, and psychologically safe work environment.

Assessment of issues
Total number of concerns raised this year (2023/24): **270**

	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Total
Total Cases	54	69	68	79	270

Themes
This is in line with the NGO's recommended themes. The breakdown is as follows:

Themes	Number	Percentage
1. Worker Safety or Wellbeing	93	34%
2. Patient Safety/ Quality	49	18%
3. Bullying and Harassment	13	5%
4. Inappropriate attitudes or behaviours	115	43%
5. Disadvantageous or demeaning treatment because of Speaking Up	0	0%
Total	270	100%

Achievements
A new speak up policy, in line with NHS England policy, was approved by the board and introduced in September 2023

A five- year speak up strategy was discussed and approved at the board seminar in October 2023

The speak up guardian regularly visits all sites to provide cross- site cover.

Freedom to speak up and support for speaking up is a standing agenda item for all inductions including corporate induction, junior doctors' induction, and student inductions.

NHS Staff survey: 3 percentage point increase in staff reporting that if they spoke up, they have confidence that the organisation would address their concern.

Learning and Improvement
Ongoing improvements are being made to support staff to improve 'speaking up''. This is supported by an online skills training on the Trust's training academy.

Speak up cases are reviewed through the lens of learning and improving, ensuring meaningful actions and sustained improvement.

Part 3: Other information

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) response to the Quality Account of East and North Hertfordshire NHS Trust for 2023/2024.

NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) welcomes the opportunity to provide this statement on the East and North Hertfordshire NHS Trust (ENHT) Quality Account for 2023/24. The ICB would like to thank ENHT for preparing this Quality Account, developing future quality priorities, and acknowledging the importance of quality at a time when they continue to deliver services during ongoing challenging periods. We recognise the dedication, commitment and resilience of staff, and we would like to thank them for this.

HWE ICB is responsible for the commissioning of health services from ENHT. During the year the ICB has been working closely with ENHT in gaining assurance on the quality of care provided to ensure it is safe, effective, and delivers a positive patient experience. In line with the NHS (Quality Accounts) Regulations 2011 and the Amended Regulations 2017, the information contained within the Quality Account has been reviewed and checked against data sources, where this is available, and we confirm this to be accurate and fairly interpreted to the best of our knowledge.

During 2023/24 the Nursing and Quality Team have worked closely with the Trust, meeting routinely to review a range of areas related to both quality and safety, for example regarding paediatric audiology services. The ICB worked in partnership with the Trust to undertake Partnership Quality Visits obtaining assurances regarding the quality of care provided, and where identified improvements were highlighted, provided relevant support to embed the changes required.

The Trust's Care Quality Commission (CQC) rating has remained as 'Requires Improvement'. The Trust has provided a transparent account of the CQC inspections they have had in year, including the CQC improved grading for the Maternity Service to Requires Improvement and the removal of the Section 29A notice. The Trust continues to focus on their CQC Improvement Plan and progress is regularly reported to the ICB as well as the Trust Board and CQC.
During 2023/24 ENHT achieved a range of results in areas regarding quality, patient safety and patient experience, and the ICB is pleased to see the progress so far in

relation to Quality Improvements in these areas. This is particularly pertinent in relation to the recognition of deteriorating patients and the Harm Free Care programme. The ICB also welcomes the progress made by the Trust with the Clinical Excellence Accreditation Framework.

The ICB notes the sepsis pathway compliance continues to be an improvement priority and will continue to seek assurance that this, alongside venous thromboembolism (VTE) risk assessments, continues to move in the required direction and that related performance is sustained.
The Summary Hospital-level Mortality Indicator data reported throughout the year is positioned in the 'as expected' range. Where outliers are identified the Trust has worked pro-actively to identify any improvements required. It is also encouraging to see the work undertaken to reduce mortality and ensure learning and robust processes are in place.

In relation to Infection Prevention Control, the Trust reported two MRSA bacteraemia cases for 2023/24 with post infection reviews held to ensure actions from the learning were carried out and sustained. Cases of Clostridium difficile have been above the annual ceiling and all cases have undergone a review, to support learning and improvement, and the aligned work undertaken by the IPC team in providing education, training and support is also noted. The ICB will continue to have oversight and seek assurance regarding Clostridium difficile cases for 2024/25.

During 2023/24 the Trust reported 2 Never Events; a decrease from the three reported the previous year. The ICB are pleased to note the ongoing actions and identified learning related to these incidents to prevent similar incidents in future. The ICB would like to recognise ENHT for their readiness and successful implementation of the Patient Safety Incident Response Framework (PSIRF), which sets out a shift in approach for how the NHS responds to patient safety incidents for the purpose of learning, improving patient safety and outcomes for our population. The ICB looks forward to working in partnership with ENHT and across the system as we collectively take forward PSIRF and the National Patient Safety Strategy.

The timeliness of complaint responses has seen a decrease in performance during 2023/24. The ICB acknowledges the added pressures that have impacted on this, and the work planned by the Trust in 2024/25. The ICB looks forward to seeing continued improvements in this area and in ensuring that patients and families receive prompt responses to concerns raised.

The Trust has undertaken a significant amount of work to improve the quality and timeliness of discharge summaries. Whilst the ICB recognises the strong focus in this area, it is aware that ongoing work is needed to achieve the Trust standard. The ICB expects this to be an ongoing focus for 2024/25 and looks forward to seeing a continued focus on the timeliness of both discharge summaries and clinic letters sent to primary care to support patient care.

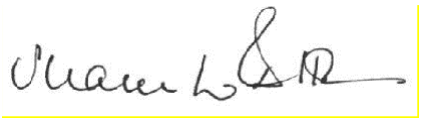
In 2023/24 the national cancer waiting times standards were consolidated into three combined standards. For the 28-day faster diagnosis standard, the Trust has met the target threshold of 75% every month since October 2023 and for the 31-day treatment standard the Trust has also met the target threshold of 96% every month

since October 2023. For the 62-day treatment standard, the Trust met the target threshold of 85% for three out of the six months between October 2023 and March 2024, and the Trust's performance against this standard remains one of the best regionally. The ICB is pleased to see that improvements continue to be made in this area and would encourage the Trust to sustain a strong commitment and focus in this area.

The Trust has embarked on a multi-project programme to develop a new emergency care model. In March 2024 the Trust's four-hour performance standard increased to 73.2%. The Trust's Urgent and Emergency Care services are operating under a model of continuous improvement and further areas of development will be identified in 2024/25.

The 2023 annual national staff survey results for the Trust showed areas of progress as well as those requiring action for improvements and the ICB recognises the ongoing work and commitment within the Trust in progressing these.

During the year the ICB have been working closely with ENHT gaining regular assurance on the quality and safety of provision to ensure a positive patient experience. Looking forward to 2024/25, the ICB supports ENHT's quality priorities and we look forward to a continued collaborative working relationship, including through building on existing successes and collectively taking forward needed improvements to deliver high-quality services for this year and thereafter.



Sharn Elton
Place Director, East and North Hertfordshire
Hertfordshire and West Essex ICB

Healthwatch Hertfordshire values the relationship with East and North Hertfordshire NHS Trust and has welcomed the regular updates on quality improvements, in particular to maternity services and urgent and emergency care.

The Trust has also been very supportive in arranging for us to meet with their internationally recruited midwives to understand their experiences. Retaining and supporting staff to provide high quality care is crucial to ensuring patient safety and a good patient experience and we look forward to sharing the outcomes from this research with them.

We look forward to continuing to work closely with the Trust to help enhance opportunities for patient voices to be heard and services to be improved including supporting the quality priorities outlined in this Quality Account.

Neil Tester, Chair Healthwatch Hertfordshire
May 2024

Statement from Social Care Health and Housing Overview and Scrutiny Committee

Central Bedfordshire Council's Social Care Health and Housing Overview and Scrutiny Committee holds decision-makers to account for improving outcomes and services for the residents of Central Bedfordshire. As a critical friend to the Trust, we are pleased to have an opportunity to provide feedback on the Trust's Quality Account for East and North Hertfordshire NHS Trust.

We would like to start by acknowledging the many highlights and achievements delivered by the Trust during the last year.

We make specific reference to the 'respect our patient's time' priority within the patient experience quality domain – this focus on the patient experience is welcomed. We also welcome the focus on improving discharge within this priority, although we note the slight decline in midday discharges compared to last year and the work undertaken to focus on tackling delayed discharges.

Waiting times at AandE services are often raised as a concern of residents and so it is encouraging to see that the Trust's performance against the national 4 hour wait target has improved and we hope to see further improvement on this in the coming year in order to meet the recovery trajectory.

We highlight the following area of concern and for improvement;

- the lack of awareness amongst the public about the new Urgent Treatment Centre (UTC) at the Lister Hospital. We would like to see this more widely publicised so that residents are aware that they can use this facility rather than having to travel further afield to other health facilities.

We note that only 48% of complaints to the Trust received a response within the agreed timeframe, in comparison to the Trust KPI of 80%. We are concerned that the business case submitted for Patient Advisory and Liaison Service (PALS) and Complaints department may not come to fruition given financial challenges and wish to see a clear plan for improving response times to complaints.

In conclusion we welcome the opportunity to consider and comment on the report and we look forward to working constructively with the Trust to support the scrutiny process and our residents.

Cllr Emma Holland-Lindsay, Chair, Central Bedfordshire, Social Care Health and Housing Overview and Scrutiny Committee

Statement of adjustment following receipt of written statements required by section 5(1) (d) of the National Health Service (Quality Account) Regulations 2010

There are no major adjustments to be made following the receipt of written statements.

Annex 2: 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

28 June 2024 Date  Chair

28 June 2024 Date  Chief Executive

Glossary

Acronym	Meaning
AKI	Acute Kidney Injury
AMS	Antimicrobial Stewardship
C-DIFF	Clostridium difficile
CLD	Criteria-led discharge
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSW	Care Support Worker
DSPT	Data Security and Protection Toolkit
Enhance	Trust's Risk and Incident Management System
ENHT	East and North Hertfordshire NHS Trust
ENH PS	East and North Herts Production System
ED	Emergency Department
ePMA	Electronic Prescribing Medicines Management
EOLC	End of Life Care
FFT	Friends and Family Test
GDPR	General data protection regulation
GP	General Practitioner
H@H	Hospital at Home
HAT	Hospital acquired thrombosis
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
IPC	Infection Prevention and Control
KPI	Key Performance Indicator
LocSIPPs	Local Safety Standards for Invasive Procedures
MRSA	Methicillin-Resistant Staphylococcus Aureus
NELA	National Emergency Laparotomy Audit
NHS	National Health Service
NIHR	National Institute for Health Research
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
PROM	Patient Reported Outcome Measures
PST	Patient Safety Team
PSIRF	Patient Safety Incident Response Framework
PSAAG	Patient Status At A Glance
QI/P	Quality Improvement/Project
RCA	Root Cause Analysis
PIFU	Patient initiated follow up
RTT	Referred to Treatment
SDEC	Same day Emergency Care

SHMI	Summary Hospital Level Mortality Indicator
SJR	Structured Judgement Review
SJRPlus	Structured Judgement Review Plus
StEIS	Strategic Executive Information System
SUS	Secondary Uses service
TOCH	Transfer of care hub
UTC	Urgent treatment centre
VTE	Venous thromboembolism
WHO	World Health Organisation
WMTY	What Matters To You