Quality Account
2020/21

Proud to deliver high-quality, compassionate care to our community

Quality | People | Pathways | Ease of use | Sustainability

	Contents	Page
Part 1		
1.1	How we are accountable for quality	4
1.2	Statement from the Chief Executive	8
Part 2		
2.1	Priorities for improvement:	
	- Priority 1: Build ENHT Quality Improvement Capability & Capacity	9
	- Priority 2: Keeping our patients safe	21
	- Priority 3: Respect our patient's time through improving the flow through inpatient and outpatient services	36
	- Priority 4: Patient & Carer Experience	46
2.2	Statements of assurance from the board:	
	- Review of services	51
	- Participation in clinical audits	51
	- Research and development	58
	- Commissioner contractual requirements	60
	- Care Quality Commission	60
	- Data quality	64
	- Data security	66
	- Clinical coding	66
	- Learning from deaths	67
2.3	Reporting against core indicators:	
	- Mortality	71
	- PROMs	74
	- Emergency readmissions	75
	- Responsiveness to patient needs	75
	- Staff recommending the Trust	76
	- Patients recommending the Trust	77
	- Venous thromboembolism	78
	- Clostridium difficile	78
	- Patient safety incidents	79
Part 3		
3.1	Review against selected metrics:	
	- Patient safety	82
	- Clinical effectiveness	89
	- Patient experience	93
	- Staff	95

3.2	Performance against national requirements: - National standards - Freedom to speaking up / raise concerns - Rota gaps	 97 98 99
Annex		
1	NATSSIP documentation	100
2	Revised Treatment Escalation Plan	101
3	Research and development	102
4	Statements from stakeholders	103
5	Statement of directors' responsibilities	106

PART 1

1.1 How we are accountable for quality

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

Clinical strategy (2019-24)

2020/21 was the second year of the Trust's five year strategy to 2024. This was developed with input from our staff, patients, their families and carers, members and key stakeholders, including the Hertfordshire and West Essex Sustainability and Transformation Plan. The Trust's vision is to be "Proud to deliver high-quality, compassionate care to our community".

The Trust has identified five Strategic Priorities:

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

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

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

Quality Strategy (2019-2024)

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

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

Key objectives of the Quality Strategy include:

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

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

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

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

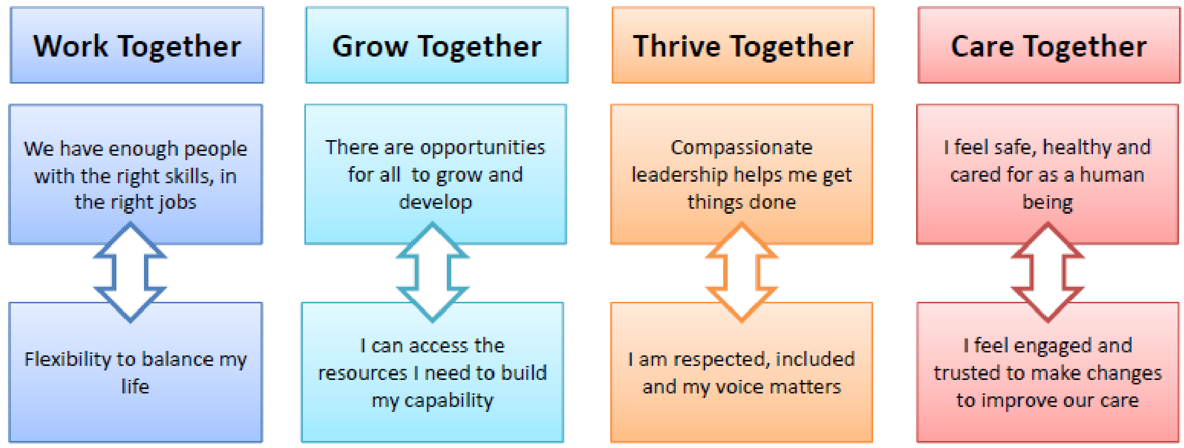
Five components of the Quality Strategy have been identified to provide a structure in which to focus our efforts of continuous improvement. These are:

Valuing the basics:	Keeping our patients safe:	Good Governance:	Patient experience:	Staff Capability:
Harm Free Care (VTE, Falls, TVS, Safer systems/ communcaion)	Deteriorating Patients (including sepsis)	Excellent Responsiveness to incidents	PACE programme	Digital Strategy
IPC	Invasive procedures	Learning from incidents	What matters to you programme	Pathways to Excellence
Medicines management	End of Life care	CQC	Excellent Responsiveness to complaints	Clinical leadership programmes
Safeguarding	Maternity	GIRFT/ NICE	Patient safety Partners	Staff Survey
Medical Devices	Mental Health	Compliance framework		Here to Improve
Documentation	Discharges	Informatics and reporting		Freedom to speak Up
		Efficient, simple reporting structures		People strategy
				Patient safety curriculum

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

People Strategy 2020

The Trust has continued to implement the People Strategy which was approved in January 2020, which is based on four ‘People Strategy Pillars’: Work Together, Grow Together, Thrive Together and Care Together, although the context of its implementation was different from that originally envisaged due to the pandemic.



Each of the pillars aim to improve the engagement and experience of our people and, clarifies the desired leadership behaviours to support the delivery of the Clinical Strategy and Quality Strategy.

However, 2020/21 was fundamentally different to the year the Trust had envisioned. The Trust was impacted by, and needed to respond to the COVID pandemic, with a complete change of focus for clinical and operational teams throughout the year. In March 2020 NHS England and Improvement wrote to all Trusts outlining ways for “Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic.” This included pausing some of the national programmes and data collections. For example, 7 day services, clinical audits and performance targets. This has impacted on the delivery of the quality priorities that had been originally planned, however, the challenges posed by the COVID pandemic also brought about opportunities for change and working together as an organisation and system in different ways to provide care safely.

The Trust responded to two waves of the pandemic; the first from March 2020 - June 2020; and the second from October 2020 – March 2021. A full summary of the Trust’s response is set out in the Trust Annual Report 2020-21 and the Quality Account sets out the delivery against the quality priorities.

Organisational Structure

The Trust completed an organisational redesign in 2020/21, reducing from four clinical divisions to two: Planned Care and Unplanned Care. Clinical leadership has been strengthened, with each division having a Divisional Medical Director, who is a senior clinician, a Divisional Nursing and Quality Director, and an Operations Director whom report to a Managing Director. This triumvirate structure is replicated at specialty level. This supports the delivery of the Trust’s strategies.

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

1.2 Statement from the Chief Executive

Our primary objective at the start of the COVID-19 pandemic was to keep our patients and staff safe. This 2020/21 Quality Account outlines how we did this, as well as demonstrating our commitment to continuous quality improvement and how we have been drawing on patient experience to inform this.

While the impact of COVID has meant some of our plans to build on our quality improvement capability and capacity has yet to be fully realised, we have made significant steps forward over the past year. In 2020, we launched ‘Here to improve’ – a model to develop quality improvement skills and knowledge across all our workforce groups at every level of the organisation. I am proud that the Trust is one of only 14 NHS trusts in England chosen to be part of the Pathways to Excellence ® international recognition of nursing and midwifery excellence.

The components of quality in healthcare are safety, effectiveness and patient experience. We are achieving, and indeed exceeding, our intentions in some areas such as improving mortality, reducing medication errors and maintaining our cancer performance. However we know there are other areas where further improvements can be made – with the pandemic posing unique challenges. These include earlier interventions around sepsis care, provision of seven-day service standards and decreasing wait times for operations.

We have welcomed working with our regulators on quality assurance and ever closer with system healthcare partners to provide high-quality care to our population. The pandemic has acted as a catalyst for this, with innovative new services such as virtual wards helping us to deliver care to those at home. We have also seen further improvements in identifying vulnerable families and earlier interventions, following the merging of our adult and children safeguarding teams.

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

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

Nick Carver, Chief Executive

PART 2

2.1 Priorities for improvement

Priority One: Build ENHT Quality Improvement Capability & Capacity

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

Link to the Quality Strategy: Staff Capability

Monitoring: Quality and Safety Committee

Reporting: Scheduled update to Quality and Safety Committee

Responsible Directors: Chief Nurse /Director of Improvement/ Medical Director

Theme	Measure	19/20	20/21	21/22*
1.1 Clinical and Non-Clinical staff are offered opportunities to gain knowledge on Quality Improvement theory.	Quality Improvement for all Theory & Practitioner level	Ascertain organisational readiness and set trajectory	QI introductory session for all staff on induction to the Trust. Adopt patient and carer experience information to focus 'what matters to you' design to training.	QI introductory session for all staff on induction to the Trust. Adopt patient and carer experience information to focus 'what matters to you' design to training.
	Quality Improvement for Leaders	Ascertain organisational spread and set trajectory.	Align continuous quality improvement leadership through: • Patient safety • Patient Experience • Clinical Leadership Programme priorities	Align continuous quality improvement leadership through: • Patient safety • Patient experience • Clinical Leadership Programme priorities
	Organisational wide quality learning events	Minimum one summer and one winter event.	Deploy 'virtual' summer celebration with assistance of Organisation Development (OD) and communications teams	Deploy 'virtual' summer celebration with assistance of Organisation Development (OD) and communications teams
	Measurement masterclass sessions	Deliver approx. 1 per quarter	Offer 1 virtual masterclass	Offer 1 virtual masterclass (inclusive of corporate and divisional leadership teams)
1.2 Staff are supported to	Establish 'quality clinics'	Deliver approx. 1 per	Offer a virtual clinic every week with a QI	Offer a virtual clinic every week with a QI

Theme	Measure	19/20	20/21	21/22*
practically apply Quality Improvement knowledge through QI coaching.	that will empower all staff to discuss quality, scope new ideas and think how they could work differently.	month	coach to explore a QI idea	coach to explore a QI idea
	Agree and deliver curriculum for Quality Improvement coaches	Ascertain organisational readiness and set trajectory	Train all of band 7's and 8's from the patient experience team to this level exploring the use of virtual training and coaching them while they run a project	Offer training to all band senior leaders (band 7's and 8's) from the corporate and divisional leadership teams to this level exploring the use of virtual training and coaching them while they lead improvement projects.
	Recruit to Quality Improvement Team	AIM: 4 WTE posts dedicated to QI capability building	N/A Action complete	N/A Action complete
1.3 Deliver organisational wide structured Quality Improvement continuous learning programme	Adopt 'Patient Safety Breakthrough Series Collaborative'	Successfully recruit approx. 10-15 improvement teams who contributing over 18 month programme.	Look at lessons learned from SIM teaching and COVID response and offer a virtual breakthrough series to build on this.	Look at lessons learned from the Trust-wide simulation team teaching and COVID response and offer a virtual breakthrough series.
1.4 Clinical Excellence Framework	Design and imbed ENHT Exemplar ward programme	Following published accreditation criteria, all adult in patient areas shall have undertaken accreditation assessment.	Scale and spread quality improvement plans to drive continuous improvement across pathway pillars	Scale and spread quality improvement plans to drive continuous improvement across accreditation pathway pillars.
1.5 Adopt a framework that reflects and values patient co-design	Patient co-design faculty shall be established	N/A	Following a 'what matters to you' model ENH QI & Engagement team shall continue to build new ways of working that promote meaningful patient involvement though continuous quality	Following a 'what matters to you' model ENH QI & Engagement team shall continue to build new ways of working that promote meaningful patient involvement though continuous quality improvement plans

Theme	Measure	19/20	20/21	21/22*
			improvement plans	

* Due to the impact of COVID the milestones from 2020/21 have not been able to progress in full and have been reviewed and rolled forward for 2021/22. The progress made to date is outlined below.

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

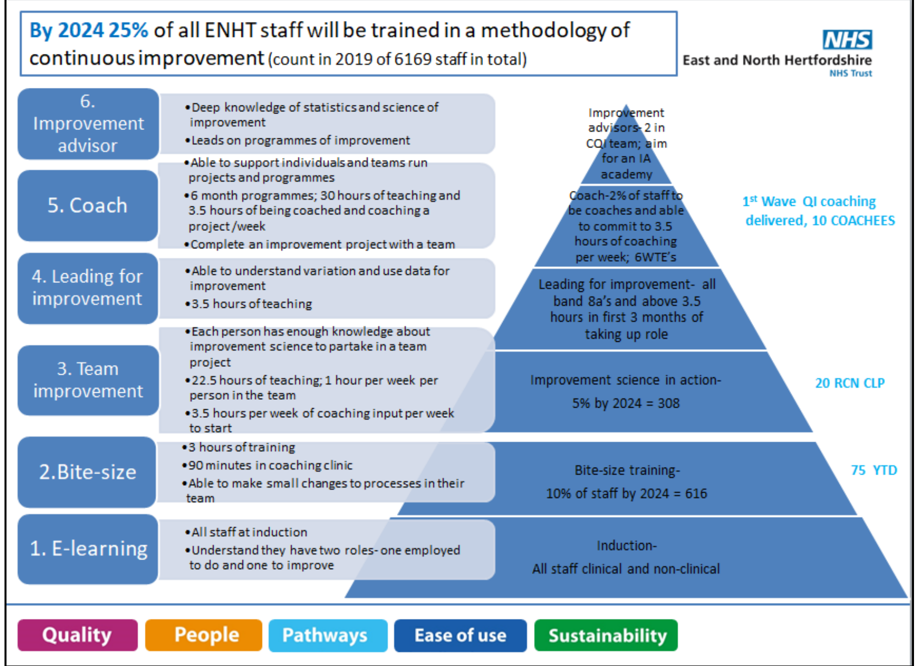
The quality improvement team was set up in September 2019 and restructured in 2020. The team have worked alongside our transformation, education, organisational development and digital teams to develop the East and North Hertfordshire model for a cohesive '7 steps for improvement', known as the 'Here to improve' model (figure 1.1.1).

Figure 1.1.1

The Trust is committed to develop skills and knowledge across all workforce groups, this will drive a saturation of staff successfully having achieved different levels of skill required within their roles. A saturated 'tipping point' in the organisation shall produce a shared language and understanding of how to apply and drive improvement tools and knowledge.

Reaching our organisational saturation point will be achieved through adoption of an evidenced based, tiered dosing formula of skills required at each level of the system. Our progress against each level of skills and knoweldge can be seen in figure 1.1.2 below.

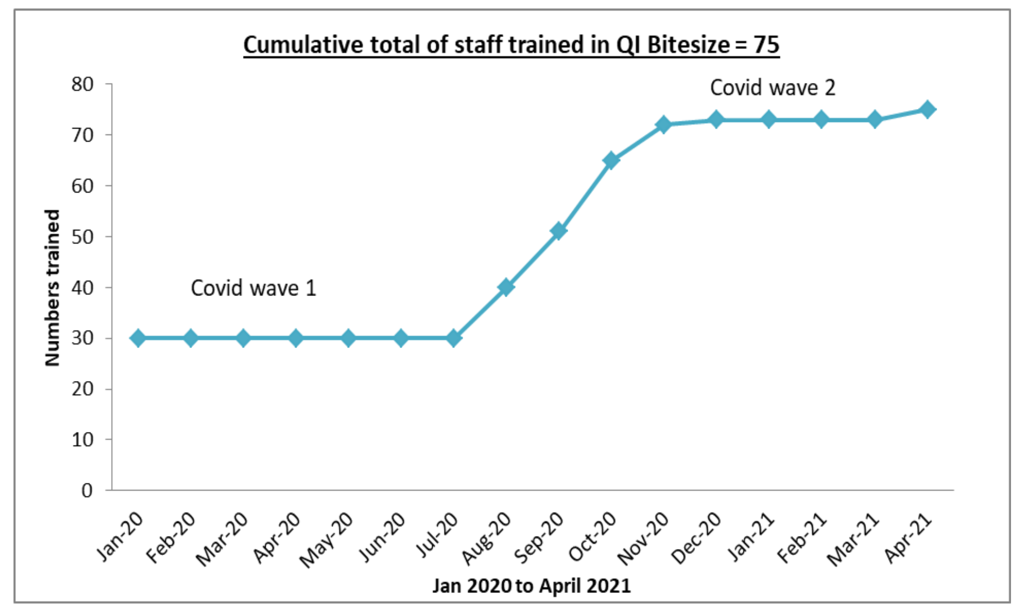
Figure 1.1.2



Level 1 shall target all staff in the Trust to have a basic understanding of key principles to improvement. While recent induction and on-boarding mandatory training has required adjusting due to the pandemic, quality improvement level 1 material and content has been designed and is ready to be launched on the new Trust learning system as a key induction and essential training modules throughout 2021/22.

Level 2 has been targeted to staff that have some basic quality improvement knowledge and would like to learn specific subject topics in a little more depth. These sessions have successfully been delivered through the design of short, targeted 'Bite-size' sessions. This teaching is offered to anyone in the Trust and includes 3 hours of training in the 7 steps for improvement e.g. how to design an improvement aim, how to analyse data for improvement, how to innovate and test new ideas. This has been successfully delivered to 75 staff across 2020/21.

Figure 1.1.3



Level 3 has been targeted to more ‘team’ leadership and wide commitment to adoption of quality improvement. Staff attending these sessions has been more submersed in many more aspects of quality improvement; and are expected to drive an improvement project over a moderate period of time. Through partnering with the Royal College of Nursing Clinical Leadership Programme 20 ward leaders undertook 12 months of study together and successfully delivered improvements in quality within their services e.g. staff experience, patient experience, waiting time, medication safety. These projects were celebrated and presented at a shared learning event online in November 2020.

Below in figure 1.1.4 demonstrates an example of the ward leader’s projects.

Fig 1.1.4

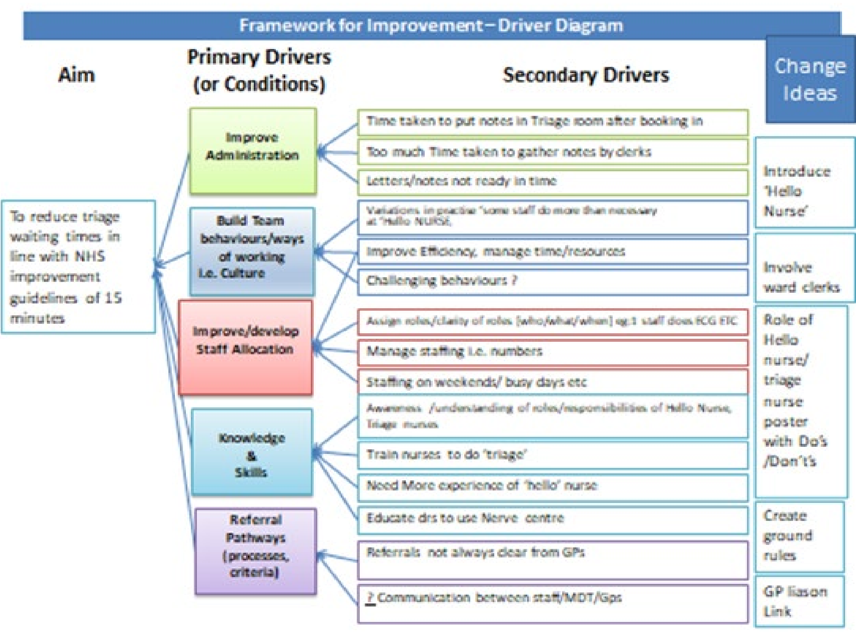
Project: Improve the triage process within ambulatory emergency care to improve patient flow, safety and experience

Background:
In November 2019, Ambulatory Emergency Care was transformed, and a higher percentage of patients attending would be ‘emergency patients’ either from GP or Emergency Department. This required improvements to key aspects of the service. The team set an aim to align with ED standards that all patients would be assessed within 15 minutes of arrival.

The baseline performance demonstrated that for the period December 19- January 20 the initial triage times were between 20 and 75 minutes.

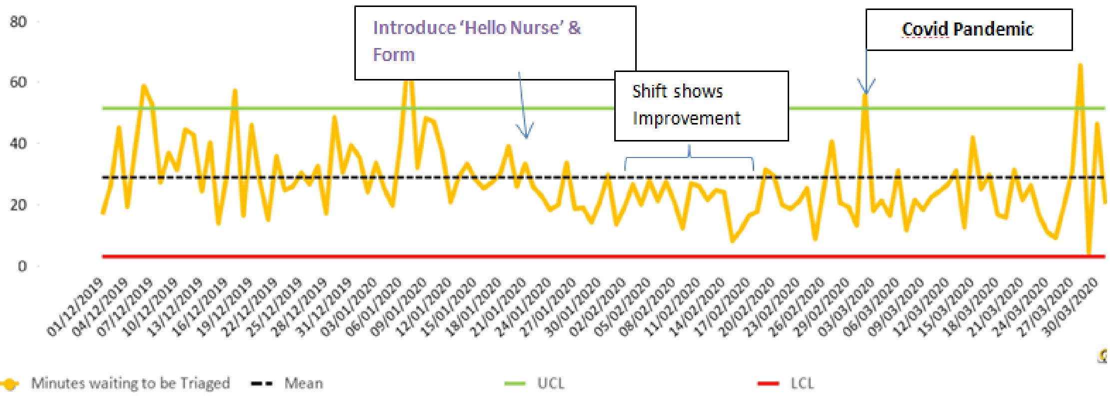
The driver diagram below shows the team aim to improve all triage times to 15 mins and the identified primary and secondary drivers to target to achieve this improvement. The Trust has since redesigned front door services and ambulatory care is no longer a clinical area however, while the project was being carried out before COVID significant improvement was achieved. The work was celebrated at a shared learning event in November 2020.

Driver Diagram



New idea tested:
Following consultation with the wider service team members and medical leaders, the team introduce a new 'Hello Nurse' at point of triage. With continuous review of current and new processes of steps the team worked together to re-design assessment and escalation steps to ensure a safe and more timely triage of patients.

Outcomes:
Patients are now being assessed within 15 - 30 minutes of arrival. This has seen triage times improve from January 2019 at 40-60 mins to March 2020 at 15-25 mins.



Staff feedback included that they were 'Proud to be part of a team' that could successfully drive service improvements, with ward clinical leaders feeling more accomplished and more confident.

Patient feedback included "The service was well timed, with friendly staff who knew what they were doing and explained everything". The project also demonstrated an improvement in Friends and Family feedback, with an increase in the number of patients that would recommend the service from 94.49% Sept 2019 to 100% in February 2020.

Level 5 - The quality improvement team co-designed an inaugural wave of a QI coaching course for the Trust. This course is designed to enable people to develop skills in coaching others to carry out improvement projects and was successfully delivered to 10 leaders within the organisation with leading improvement as a part of their role.

Capability and capacity building next steps:

- Current strategic plans include the ongoing development and co-designing of the Trust 'Here to improve' curriculum. This educational offer shall enable faster scaling of our capability and capacity building programme by working with colleagues in education, transformation and organisational development.
- The Trust has adopted a quality improvement project platform, recommended by our regional Academic Health science Network and NHSE/I called 'LifeQI'. This sharing system enables staff to easily collaborate across teams and, follow a structured approach to driving quality improvement. It shall accelerate regional sharing of improvement efforts and improve local reporting on projects and programmes within the Trust.
- The development of more in-depth knowledge (level 2 and 3 skills) shall be supported through ongoing access of externally accredited learning products such as Institute of Health Care Improvement open school licenses and lean six sigma training modules.

These are proved packages to provide scale and submersion of quality improvement skills.

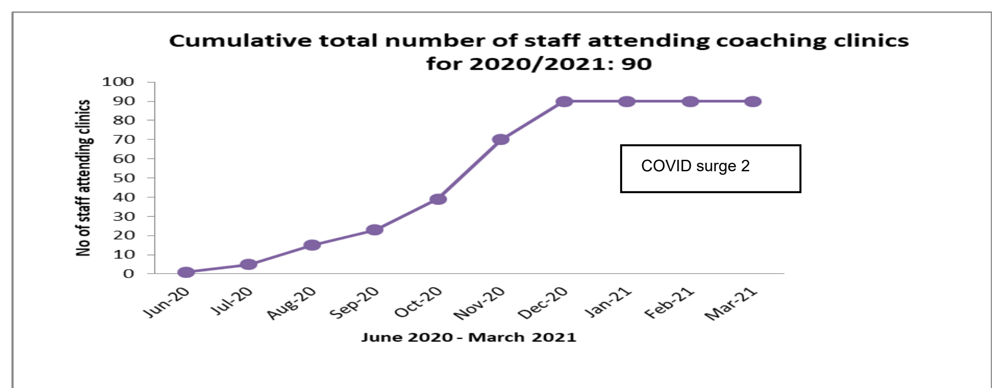
- The Trust has committed to a second cohort partnership with the RCN Clinical Leadership programme. A further 20 clinical leaders are enrolled and ready to undertake a new 2021/22 twelve month programme, commencing May 2021.

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

Coaching support for staff is provided from qualified improvement coaches, of which the Trust as two full time coaches and who are supported by the Head of Continuous Improvement and Associate Director for Quality and Safety. Coaching staff has been provided through two main forums – coaching clinics and the RCN Clinical leadership programme.

1. Coaching clinics are available twice a week for anyone with an interest in improving any aspect of quality. Staff are encouraged to come along to the clinic and be coached to take the next step in their QI project. Each project is scored and resource allocated on the basis of key aspects of QI being considered, for example co-design with patients.
2. Coaching clinic attendance has progressively supported 90 staff in total since June 2020.

Figure 1.1.4



3. Each candidate within the RCN Clinical leadership programme had an identified coach to support practical application of QI skills and knowledge. In the formal classroom learning session staff expressed positive feedback on the support from the coaches towards them successfully achieving results. The coaches supported 16 projects to completion, 8 of which focused on improving patient safety, 7 focused on staff and patient experience and one focused on efficiency.

Project progression is tracked through an Institute for Healthcare Improvement (IHI) scoring scale, allowing staff and coaches to track project progress over time using a scale between **0.5 - 5.0, see figure 1.1.5.** All projects reached improvement scores between 2 and 5 on the IHI project score rating scale with a mean of 3.

Figure 1.1.5

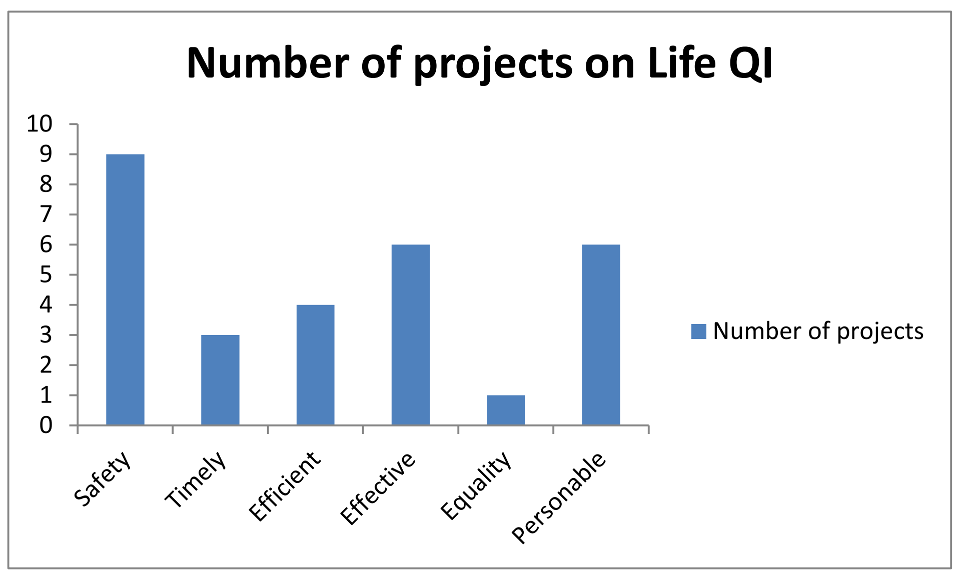
IHI Standard Assessment Scale (2003)

0.5 - Intent to Participate
1.0 - Forming team
1.5 - Planning for the project begun
2.0 - Activity, but no changes
2.5 - Changes tested, no improvement
3.0 - Modest improvement
3.5 – Improvement
4.0 - Significant improvement
4.5 - Sustainable improvement
5.0 - Outstanding sustainable results

Note: Specific definitions of assessment scale developed for each project

The coaches have supported staff to adopt the recording of their quality improvement projects and programmes on sharing platform LifeQI. There are currently 16 active and 11 completed projects. Each project contributes to a quality priority and in some cases more than one.

Figure 1.1.6



1.3 Deliver organisational wide structured Quality Improvement continuous learning programme

We recognise the importance of investing in our staff and supporting their well-being to ensure high-quality care and better outcomes for our patients. We have developed the ENH Continuous Improvement model. 'Here to Improve' provides a simple, easy to understand model using familiar language and terminology for staff at every level of the organisation to adopt and use. It is a model that is underpinned by a common approach, identity and underlying toolkit that supports both local, small scale improvements, to large-scale, complex, transformational change projects and programmes. Here to Improve dovetails with our Quality Strategy and People Strategy and seeks to develop our people capability and drive ownership and continuous improvement through services.

Colleagues from education, organisational development, transformation and workforce are working collaboratively to deliver capability and capacity building in the 'Here to Improve' 7-step model for improvement launched in November 2020.

The approach will deliver training at different levels of the organisation to encourage all people to understand that in the organisation they have two requirements. These are to meet the requirements in the job description and to continuously improve in that role.

In addition the Trust is one of only 14 organisations in England chosen to be a part of the Clinical Excellence programme (part of the Pathway to Excellence programme). The Pathway to Excellence programme is recognised globally as enabling nursing excellence and offers proven strategies to help ensure that the care that we deliver to our patients is of the highest standard. The programme was paused in wave one of COVID and relaunched in July 2021. See section 1.4 for further details and priority 2 section for details of other Trust-wide improvement programmes.

1.4 Clinical Excellence Accreditation Framework

The Pathway to Excellence® programme is a nursing excellence framework aiming to create a positive practice environment for nursing and midwifery staff that improves nurse and midwife satisfaction and retention. Following a competitive nomination and selection process, ENHT was selected as one of 14 Trusts, and one of three in the East of England, to participate in the first national cohort.

The Pathway to Excellence® is made up of three components which come together to demonstrate different ways to support nurses and midwives to influence and effect change:

1. Nursing and midwifery excellence – six pathway standards
2. Local accreditation
3. Shared decision making

1. Nursing and midwifery excellence – six pathway standards

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

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

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

2. Local accreditation

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

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

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

The assessment process includes:

- **Baseline/self-assessment** of the standards in the metrics, a staff and volunteer survey, completing the self-assessment templates and preparing a portfolio of evidence.
- **Independent assessments** against the metrics supported by specialist teams e.g. Infection Prevention and Control, Tissue Viability, Pharmacy, Patient and Carer Experience etc.
- **Time to Shine discussion** which is an opportunity for the multi-disciplinary team to share all that they are proud of.
- Collating the **evidence and clinical assurance** that the fundamental standards are met.
- **Credentialing Award panel** where the final award level is agreed.

Since the CEAF was introduced, we have assessed 11 ward areas and have awarded 3 gold and 6 silver wards. The CEAF provides the senior nursing and midwifery team with assurance of the standards being met within each clinical area and enables the Trust to reward and recognise excellence in care.

Pirton, Barley, Bluebell and 5B ward receive their awards (October 2020)

3. Shared decision making

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

Within the Trust we have different types of councils:

- **Ward Councils –** Team members from one ward or department create their own local SDMC and develop improvement initiatives for their areas. They then have the opportunity to share their learning.
- **Themed Councils -** Team members from across the whole Trust create a SDMC focussing on a particular theme such as Staff Wellbeing and developing improvement initiatives to share with the Trust.
- **Specialist Councils -** Team members from across the whole Trust create a SDMC representing a specialist area such as Research and developing improvement initiatives to share with the Trust.

Currently within the Trust we have six shared decision making councils and the Trust's first Leadership shared decision making council. Each council member is given working time to attend the monthly council meetings.

Ward Councils	Themed Councils	Specialist Councils
▪ NICU	▪ Well Being ▪ Reward & Recognition ▪ Newly Qualified	▪ Research ▪ Pharmacy

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

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

- **Research Training:** Coaching sessions, Bite-size training and drop in sessions, 1:1 support, Critical appraisal course.
- **Quality Improvement Training:** Bite-size QI, Project Coaching.

Plans for 2021-22:

Nursing and midwifery excellence: Organisational culture survey with registered nurses and midwives Develop gap analysis Work with Pathway Standard Leads to embed culture of excellence Develop our Elements of Performance demonstrating the culture of excellence Document submission for Pathway to Excellence	May 2021 June 2021 Ongoing Ongoing January/February 2022
Clinical excellence accreditation: Cohort 4 – 9A, 9B Introduce our 'fundamental standards' within the metrics Cohort 5 – 6A, 10A, AMU2, Ashwell	 May 2021 June 2021 July 2021

Cohort 6 – AMU1, 5A, 11A/B, Critical Care Cohort 7 – ACU, SSU, MVCC 10/11 Cohort 8 – 7B, 8A, Gloucester, Dacre Reassessments: 6B, 7A, 10B, Swift, 5B, Neonatal, Pirton, Barley, Bluebell	August 2021 September 2021 October 2021 Ongoing
Shared decision making: Development of more Shared Decision Making Councils. Council representation at Executive committees: Nursing and Midwifery Executive Committee, Nursing and Midwifery Excellence Committee Introduce an additional platform for sharing the learning – Recognition of council work and celebration commencing with presentation to the Nursing and Midwifery Quality Huddle. Development of training- Bitesize training, Exploring the idea of E-Learning for shared decision making.	Ongoing Developments

Priority two: Keeping our patients safe

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

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

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

Reporting: Scheduled updates to the Quality and Safety Committee

Responsible Directors: Chief Nurse

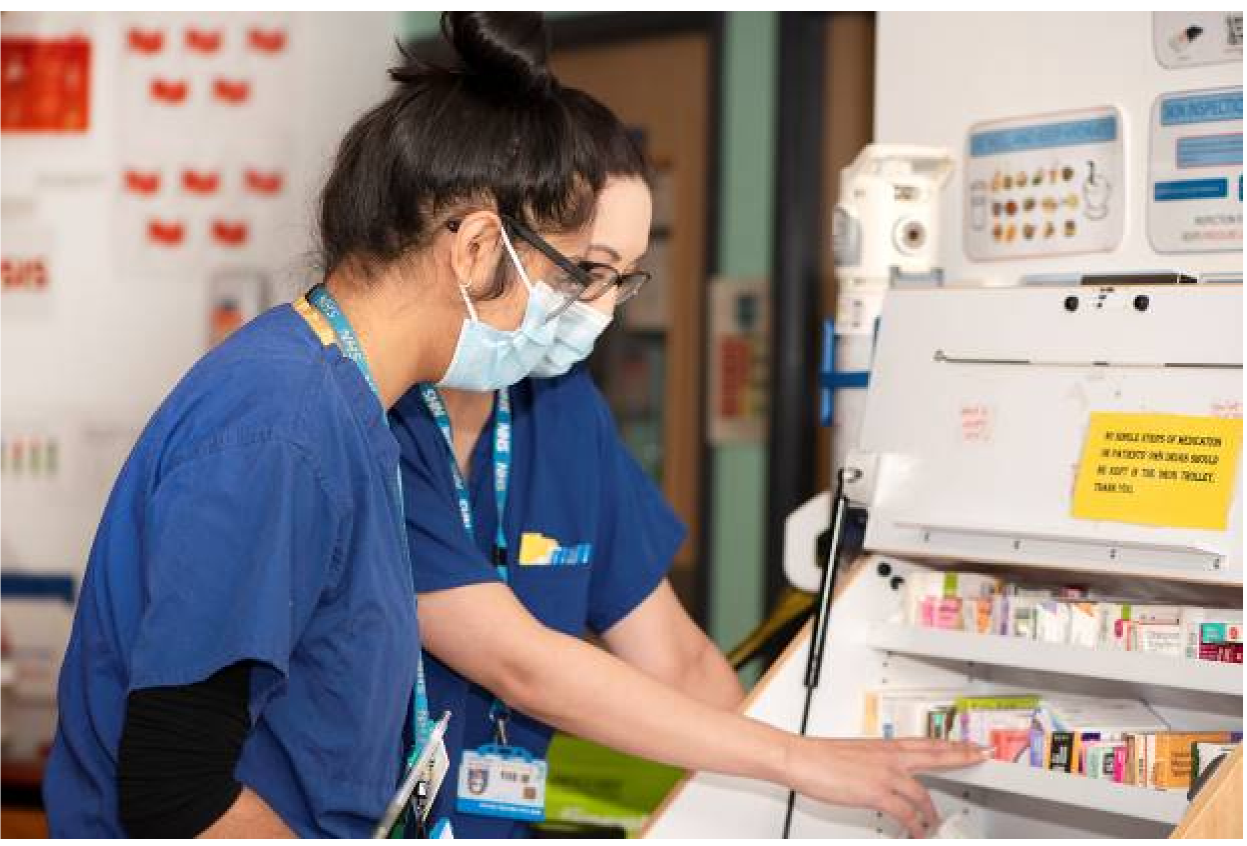
	Theme	Measure	19/20	20/21	21/22
2.1	Medication management	Omissions of critical medications	<5%	<4%	<4%
		Medicines optimisation framework score (max 168)	135	150	135
		Antimicrobial stewardship	>90%	>90%	>90%
		Electronic prescribing / administration	-	Launch	Launch
2.2	Sepsis pathway compliance	Screening for sepsis in ED	>97%	>95%	>95%
		Neutropenic sepsis door to needle time	>80%	>95%	>95%
		Antibiotics in ED within an hour	>90%	>95%	>95%
		Antibiotics on the ward within an hour	>90%	>95%	>95%
2.3	Safer Invasive Procedure Standards	Phased approach to developing and imbedding Local Standards for Invasive Procedures	>95%	LocSSIPS for 80% of invasive procedures	LocSSIPS for 80% of invasive procedures
2.4	Deteriorating patient	Reduce rate of cardiac arrests	<0.8%	<0.8%	<0.8%
		Audit of compliance with timely observations	> 95% reliability all observations	Variable	Variable
		Launch escalation module and develop a means of monitoring the escalations	Launch	Launch	Launch
2.5	Safeguarding adults and children	Ensuring reduction of harm of patients with known learning disability	Ascertain baseline data and set trajectory	Triangulate incidents, complaints & mortality data	Triangulate incidents, complaints & mortality data
2.6	VTE risk assessment	Improved compliance with VTE risk assessment part 1 and part 2	>95%	>95%	>95%

2.1 Medication management

Medicines and COVID-19 Pandemic

The COVID pandemic required rapid change and flexibility in how we managed medicines and provided care.

- Pharmacy staff upskilled to provide a specialist clinical pharmacy service and medicines support to critical care.
- A dashboard to manage the shortage of medicines was developed, and real time stock control systems were introduced to ensure critical care medicines were always available despite local and national surges in demand.
- Introduced an outpatient prescription delivery service to our vulnerable and shielding patients.
- The aseptic service prepared prefilled syringes of critical medicines for ease of administration by nursing staff to free up time.
- Pharmacy along with the nursing staff reviewed and developed a Trust-wide COVID medicines management policy to ensure all medicines were safely managed during the pandemic and electronic medicine ordering was introduced in some areas.
- New evidence was reviewed in a timely manner and guidance was developed to manage patients with COVID such as thromboprophylaxis and the safe introduction of specialist medicines for treating COVID such as tocilizumab and rituximab, and support of the Recovery Trial.

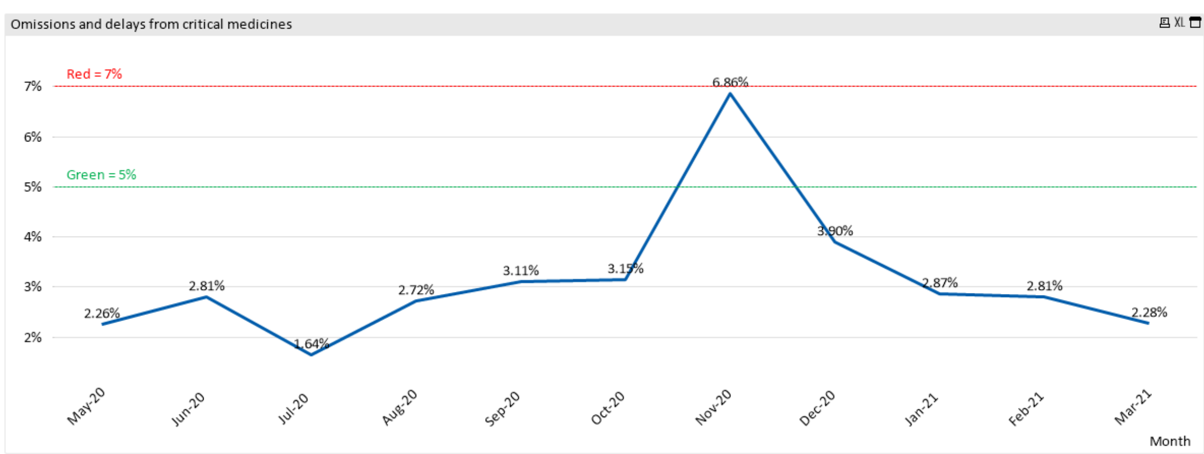


Medicines Management

	Target 2020/2021	Achieved 2020/2021
Omissions of critical medications	<4%	Average 3.1%
Medicines optimisation framework score (max 168)	150	130
Antimicrobial stewardship	>90%	Average: 92%
Electronic Prescribing	Launch	Launched (and paused due to COVID)

Omissions and delays in critical medicines

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



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

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

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

The Trust's Medicines Optimisation Strategy for 2019 – 2022 was developed using the NHS Improvement, Hospital Pharmacy and Medicines Optimisation Assessment Framework. The strategy was reviewed and updated in April 2021 post COVID pandemic.

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

The outcome of the baseline assessment, conducted in February 2019, showed an achievement score of 115 out of a maximum score of 168. We aim to improve our score over the next three years to be comparable with the highest achieving Trusts. The target for 2020/2021 was 150. This improved from 123 in November 2019 to 130 in April 2021, however, further plans for improvement have been impacted by COVID.

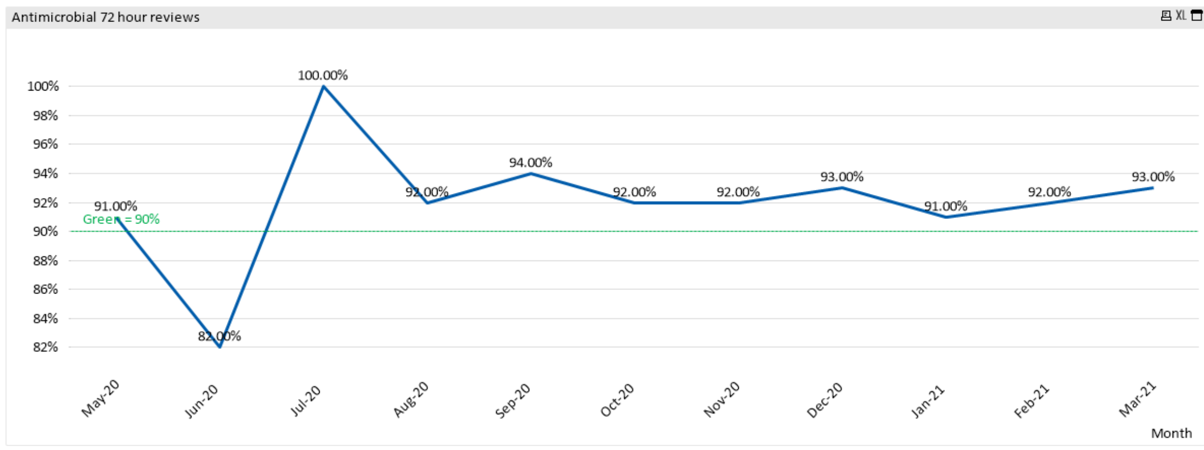
Despite the COVID pandemic progress has been made in the following areas:

- The Medicinal Products Policy is regularly audited across the Trust; quarterly controlled drugs audits are performed by pharmacy, unlicensed drugs audits, safe and secure medicines audits and drug chart completion audits are all performed on a bimonthly basis.
  The clinical areas and wards have demonstrated they have consistently achieved the target of 85% for ambient and fridge temperature recording.
- The Medicines Optimisation key performance indicators (KPIs) on Qlikview have been presented at Planned Divisional Board, the Nursing Quality Huddle, Medication Forum and Pharmacy Rolling Half Day.
- The Medical Director and the Director of Nursing receive a biweekly report and action plan on Medication Safety and Security from the Pharmacy and Senior Nurse Executive Walk Around.
- A Therapeutics Policy Committee biannual report was presented to the Clinical Effectiveness Committee in September 2019.
- An audit has also been completed to assess the level of adherence for non-formulary drug prescribing and supply against recommendations set by the Hertfordshire Medicines Management Committee (HMMC). A new Trust-wide formulary is being introduced in May 2021. This will bring benefits of improved compliance against HMMC recommendations as well as improved patient safety due to better access to up to date clinical information.
- The pharmacy department introduced the electronic staff rota system.
- Following the pilot phase Lorenzo Electronic Prescribing and Medicines Administration system (EPMA) is now embedded on two wards; Pirton and Barley. The EPMA project board resumed in April 2021 after a pause due to COVID-19 with a provisional Trust-wide roll out later this year.

Antimicrobial stewardship

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

The aim is to achieve >90% compliance with good governance of antibiotic stewardship. The graph below demonstrates the results of a monthly audit and shows the target have consistently been met since July 2020.



The pharmacy team will focus on the medicines management and the roll out of the Lorenzo EPMA system for 2021-2022. The Trust-wide roll out of EPMA will improve medicines optimisation and therefore patient safety.

2.2 Sepsis pathway compliance

Antibiotics administration within one hour for ED and wards was selected as thermometer for the Trust Integrated Performance Report.

While the target has not been met, when compared to 2019/20 the figures remained substantially stable in ED, noted a slight improvement in the inpatient settings.

	Aim	Achieved
Antibiotics in ED within an hour	> 95%	70%
Antibiotics on the ward within an hour	> 95%	38%
Neutropenic sepsis door to needle time	> 95%	83%
Sepsis six bundle	>95%	31%

Emergency department Sepsis Care

Throughout the pandemic the sepsis team have been redeployed to support direct patient care. While this has supported on going delivery of sepsis care, it has also impacted on reliability of data collection related to timely delivery of sepsis interventions.

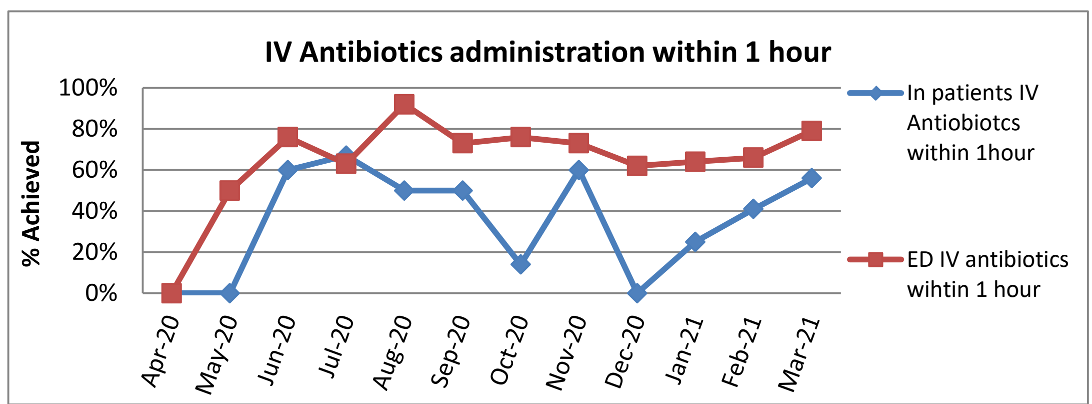
Compliance figures have been variable throughout the year; on average IV antibiotics have been given in the ED with 60min time frame 70% of the time. The variation overtime can be seen in figure 2.2.1 below, with a range of 45%-80%.

Inpatient Sepsis Care

Compliance figures within in patient setting timely IV antibiotics within 60min time frame on average 38% of the time. The variation overtime can be seen in figure 2.2.1 below, with a range of 14%-60%. Learning themes identified include:

- Time to escalation by ward team after first red flag (trigger for immediate action)
- Time to doctor review after trigger
- New antibiotics being written on the regular side of the drug chart rather than stat (single dose)

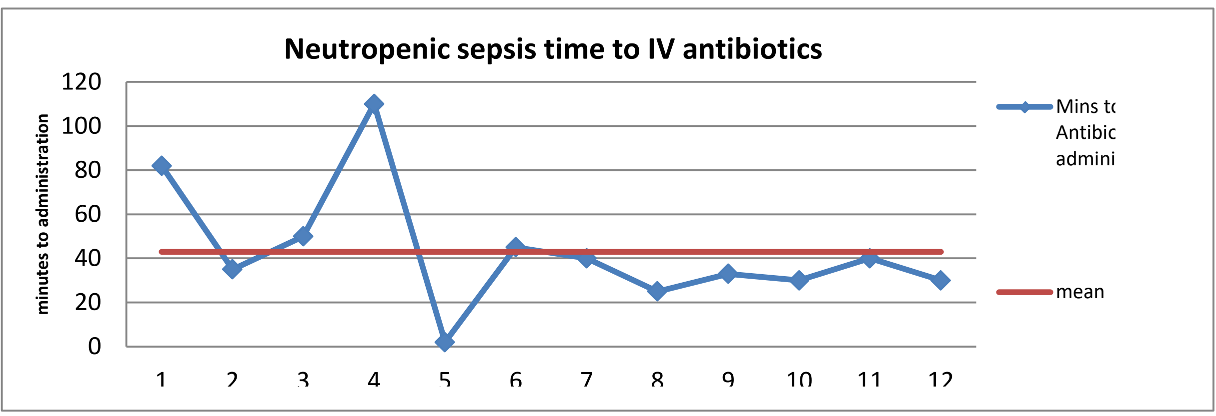
Fig 2.2.1



Neutropenic sepsis

A total of 12 patients were audited for neutropenic sepsis between the period of January 2021 and April 2021 across the Mount Vernon Cancer Centre (MVCC) and Lister Hospital. The average time of administration to antibiotics following sepsis red flag triggers was 43mins. 83% of patients had the antibiotic within 60 min recommended timeframe. The variation across 12 patients can be seen in fig 2.2.2

Fig 2.2.2



Sepsis 6 bundle

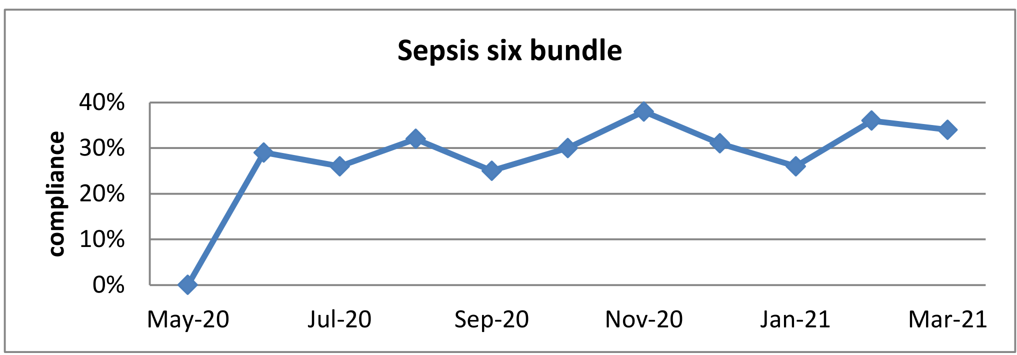
During 2020/21 the Trust had focused on reliability of delivering all aspects of the sepsis bundle:

- Administration of IV antibiotics
- Serum lactate measurement
- Accurate Fluid Balance chart

- Sample for blood culture
- Administration of IV fluid challenge
- Administration of 02 therapy

Compliance with all six elements of the bundles has varied throughout 2020/21, with an average compliance of 31% as seen in figure 2.2.3 below.

Fig 2.2.3



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

Changes made in 2020/21 include:

- Combined sepsis and critical care outreach clinical teams and clinical leadership
- Introduced out of hours emergency cannulation and phlebotomy team
- Improving practice and access to gas machine in patient areas
- Piloting new sepsis grab bags within in patient setting
- Improved awareness and early confirmation of optimum antibiotic, taking account of allergies.
- Ongoing root causes analysis of all per-arrest calls, identifying and feedback early sepsis care learning
- Pilot of ePMA to facilitate more accurate measurement of doses of antibiotics and intravenous fluid therapies administered

Priorities 2021/22 are:

- Improving competency and reliably of recording vital signs, including fluid balance chart
- Learning programme that includes Sepsis and deteriorating patient simulations and core essential training for all clinical staff embedded core learning modules in the Trust centralised learning system.
- Real-time patient level feedback sessions with clinical teams
- Scaling of ePMA to facilitate more accurate measurement of doses of antibiotics and intravenous fluid therapies administered

2.3 Safer Invasive Procedure Standards

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

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

National Safety Standards for Invasive Procedures (NatSSIPs) outline a range of standards that optimise safety during an invasive procedure. Trusts are required to develop their own Local Safety Standards for Invasive Procedures (LocSSIPs) for the invasive procedures they carry out.

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

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

The Trust Invasive Procedure Group has an aim that 80% of invasive procedures undertaken at the Trust will have published LocSSIPs by March 2022. This governance

shall oversee the delivery of the national standards across multiple specialities, while also focusing building capability and better understanding of human factors.

Through the pandemic many teams involved in invasive procedures, particularly the Trust theatre team, have ran multiple team high fidelity simulations to practise safely carrying out procedures whilst adopting enhanced PPE polices and changing national guidance.

During 2020 there has been successful launch of new re-designed theatre 'Natssip' paperwork – that will follow the patient pathway across pre, intra and post-operative Care. (See annex 1)

The adoption of the new NATSSIP audit tool has been challenging to fully implement during the pandemic; however this has now been re-launched with the new theatre paper work and being adopted for other clinical specialties.

Standardisation of the theatre white-boards across 19 theatres are now fully implemented and embedded with completion of a safer surgery demonstration video showing all steps involved in Nattsip steps, this shall be adopted as tool within the Trust essential training modules on the Trust learning management system.

A patient safety human factor curriculum in under design and will be used with teams to support learning together on implementation of Natssip guidance and learning from internal safety incidents.

2.4 Deteriorating patient

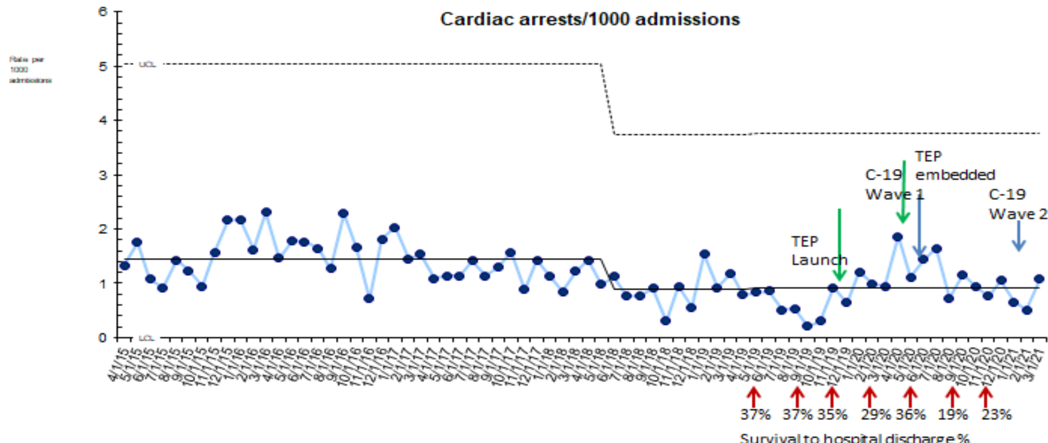
	Aim	Achieved
Reduce rate of cardiac arrests	<0.8%	Sustained reduction
Audit of compliance with timely observations	> 95% reliability all observations	Variable
Launch escalation module and develop a means of monitoring the escalations	Launch	Partial progress

Cardiac arrests

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

The chart below shows that Trust cardiac arrest data demonstrates a sustained reduction in in-hospital cardiac arrests, with an average rate of 0.9 per 1000 admissions. The Trust cardiac arrest rate can be see below in Fig 2.4.1

Fig 2.4.1



It also shows the Trust's survival to discharge following cardiac arrest during 2020-March 2021 has ranged from 19%- 23%, this has improved from 2019 and is now below the national average range of 23.9-25% survival to discharge home.

Timeliness of observations

The deteriorating patient improvement steering group, including team members from patient safety, critical care outreach and specialist services such as sepsis leads, acute kidney injury leads and the resuscitation teams, continue to review data and share learning on a monthly basis.

Following the challenges faced by the pandemic, large scale improvement work due to January 2020 had to be redesigned. A key priority for improving the recognition and management of the deteriorating patient is the reliability and competency across clinical teams to record and escalate vital signs, including Fluid balance assessment.

Clinical areas have been prioritised for targeted improvement work following occurrence of. serious incidents to work closely with subject matter experts including critical care outreach, resuscitation, sepsis, acute kidney injury and learning disabilities to re-establish training and competency standards for recording vital signs.

This is a Trust-wide training initiative that aims for 95% of all clinical staff to have passed the structured competency training by December 2021.This will be tracked and monitored through the Trust's central learning system as an essential core competency skill.

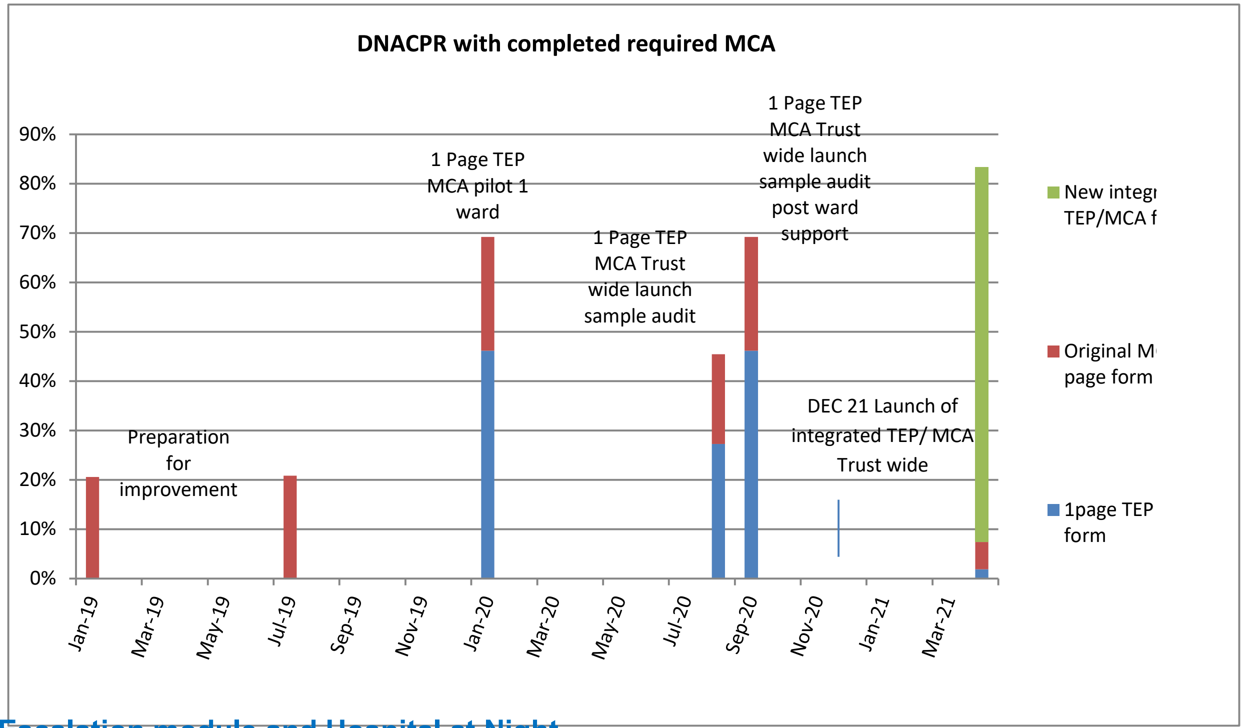
DNACPR and Treatment Escalation Plans (TEP)

In October 2020 the Department of Health and Social Care commissioned the CQC to conduct a review during November - January 2021 to review how DNACPR decisions are made in the context of advance care planning, across all types of health and care sectors. Nationally 750 people shared their experiences of the distress they faced when they did not feel involved in decisions about their care. The Trust has undertaken gap analysis against the 8 recommendations following this review.

Following the launch of the Trust Treatment escalation plan in 2019, further development in January 2020 included a pilot of a combined TEP and Mental Capacity Assessment documentation that showed an increased compliance to 69% of a high quality documented decision making process.

Ongoing development of the document was supported through staff education and training, with a final integrated document launch across the Trust in December 2020 of an integrated MCA and Treatment Escalation Plan (TEP) document (see annex 2). In March 2021 a Trust-wide audit of 'Do Not Attempt Resuscitation' and high quality document 'TEP and MCA' decision making saw improved compliance at 83%. This improvement journey can be seen in fig 2.4.2 below

Fig 2.4.2



Escalation module and Hospital at Night

In alignment with Harm Free Care approach to safer systems, the designing of a new hospital at night system and doctors escalation digital module are now under way. This has involved deployment of new hand held devices, and will be supported through training and escalation awareness to junior doctors. The new hospital at night team structure has been agreed and plans are under way to operationalise in early 2021. This shall be monitored and tracked through both our Harm Free Care and Deteriorating patient collaborative groups.

2.5 Safeguarding Adult and Children

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

Safeguarding remains an integral aspect of patient care within the Trust, and we continue to undertake our duties under the statutory frameworks of the Care Act 2014 and Children's Act 1989 and 2004.

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

All staff receive training and regular updates based on the guidelines within the Intercollegiate documents for adults and children's safeguarding, based on local and national safeguarding policy, research and learning from case reviews.

The Trust continues to be an active member of the Hertfordshire safeguarding boards and partnerships – with work this year looking at medication errors, complex case reviews, Female Genital Mutilation guidelines, Serious Crime and Violence strategy and Neglect Strategy. In addition, we participate in Partnership learning for serious case reviews, domestic homicide reviews and Rapid Reviews.

During 2020/2021, the 2 safeguarding teams (adults and children's) for ENHT merged and undertook a restructuring process to form one Trust safeguarding team in order to provide a safeguarding team spanning the whole life course and further embedding a 'think family' culture within the organisation. This has led to further improvements in identifying vulnerable families and earlier intervention and more timely responses to risk and vulnerabilities.

There is strong evidence how social isolation increases the risk of abuse significantly. Nationally there has been an increase in safeguarding concerns in what has been referred to as a safeguarding surge, in direct correlation to the impact of the restrictions imposed in response to COVID-19.

Children are not visible to external agencies by virtue of not attending school, or by the different methods employed by agencies to 'keep in touch' have changed, giving less opportunity for safe disclosure. Adults in care homes are not visited by relatives and the usual agencies that can potentially identify concerns. As the lock down measures continue to ease – children and adults will become more visible, meaning opportunities to identify /disclose safeguarding and abuse will only increase. Agencies working with people must make the most of every opportunity to identify concerns and respond in a timely fashion.

In line with the national picture we have seen a significant increase safeguarding referrals and issues. The following section identifies the activities and how we have worked together with our internal and external services:-

- Adapting to the COVID-19 pandemic and the implications for safeguarding – including response to a 'safeguarding surge' in complex cases.
- Launch of the Safeguarding Dashboard.
- Achieved 'Good' and elements of 'outstanding' in the section 11 external assessment.
- 60% increase in child protection medical examinations.
- 3% increase in referrals to children's social care – despite a significant reduction in attendance to the Trust as a result of the COVID 19 pandemic.
- An increase in children being seen for neglect child protection medicals.
- Parental mental health is the predominate reason for a referral to children's social. care, with children's mental health as the second reason for a referral being made.
- 39% increase in strategy meetings involving the Trust.
- 24% increase in maternity information sharing forms.
- 33% increase in maternity safeguarding initial child protection conferences.
- 29% reduction in request for information under section 17 and 47.
- 14% reduction in information sharing forms for pediatrics, with a 40% reduction in overall attendance to unscheduled care (based on Liaised activity).
- 19% increase in the number of adult safeguarding concerns raised in the organisation a total of 620 individuals reporting to be victims of abuse were supported by the team.
- 16% of concerns raised against a Trust service were substantiated and largely centred on omissions in the discharge process and tissue viability incidents – a further 12% re awaiting section 42 enquiries to establish if the concerns will be substantiated. A Trust-wide Discharge Improvement Plan has been informed by these incidents to improve the care and safety of the patients.
- Domestic abuse was the biggest cause for concern raised by Trust staff in relation to abuse perpetrated in the community – accounting for 27% of all the referrals made, with Neglect and acts of omission accounting for 26% of all referrals made.
- 43% increase in deprivation of liberty applications.
- 8 serious incidents six of these incidents related to omissions in discharge process
- 2 Hertfordshire Safeguarding Children's Partnership rapid reviews, 2 learning events and 1 learning discussion.
- 1 Hertfordshire Safeguarding Adult Board Safeguarding Adult Review.
- 2 Domestic Homicide Reviews.
- New Safeguarding Training passport and Safeguarding Learning and Development Strategy.
- Multi Agency Child Exploitation information sharing process established.
- Child in Need information sharing process introduced for unscheduled care settings.
- The safeguarding team continue to place a high priority on the care of individuals with a learning disability. We have a dedicated working group to ensure that LD standards for acute hospital Trusts set out by NHS England / NHS improvement are met. The key achievements of this group during 2020/21 included the provision of easy read appointments letters bespoke for individuals with LD, a revised radiology department policy including an outline for the provision of reasonable adjustments. Guidance in easy read format was developed and introduced so that patients and/or carers know how they can raise concerns about their care or the service. The Trusts LD champions programme was reinvigorated (60 LD champions recruited). Basic LD awareness added to the mandatory training requirements for all staff.

- Members of the safeguarding team continued to attend site safety huddles several times a week to advise ward matrons on the management of concerns and provide education on the management of the various categories of abuse.
- Prevent Level 3 training was extended to all staff and it is anticipated that we will reached 85% of staff completion in July 2021.
- All Clinical staff in the Trust continue to receive training and education on the clinical application of the mental capacity act. Work is currently being undertaken to ensure education is delivered to staff in preparation for the introduction of Liberty Protection Safeguards which is expected to come into statutory force from April 2022.
- Full business continuity was achieved by the safeguarding team throughout 2020/21 unaffected by the pandemic.

2.6 VTE Risk Assessment

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

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

VTE risk assessment historically has been measured in several ways within the Trust:

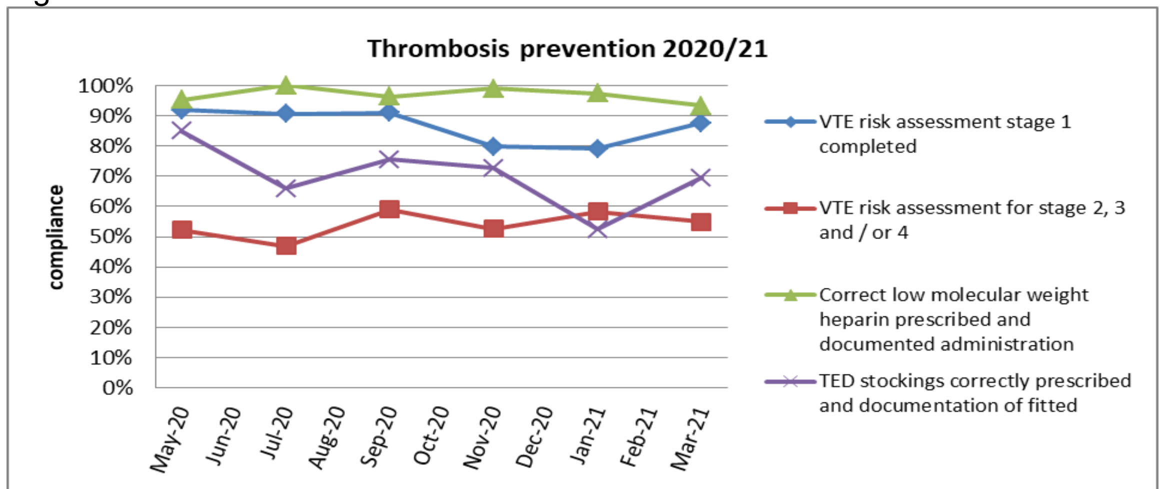
- National safety thermometer- a point prevalence audit on one day each month – currently suspended during pandemic.
- National NHS Quality Standards – currently suspended during pandemic.
- Internal Pharmacy audit- random sampling in real time in the patient setting, continued reporting. Results can be seen in fig 2.6.1 below.

	Aim	Achieved
Improved compliance with VTE risk assessment part 1 and part 2	>95% compliance with part 1 and parts 2-4	Pharmacy survey: 87% (part 1) 54% (part 2)

Pharmacy inpatient sampling

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

Fig 2.6.1.



While the Trust has seen good compliance with correct dose of VTE prevention heparin administration, we recognise the documentation of Stage 1 risk assessment data shows an average of 87% compliance; and stages 2-4 show less reliable completion of VTE risk re-assessments average of 54% compliance; both remain a priority for improvement.

Root cause analysis learning is undertaken when potential hospital associated thrombosis (HAT) cases are identified. Trends can be seen whereby the reassessments have been missed or not re-performed when clinical condition changes.

Learning captured from medical staff during the pandemic include the challenges around both continuity of medical staff on wards with the added challenge of practicalities of undertaking high quality ward rounds, for example due to isolation areas and limiting paperwork and computers taken to bedside. This has sometimes required an extra process to be in place to look back at charts after the round; sometimes this has left a gap in risk assessment completion.

Harm Free Care Priority

Oversight of VTE outcomes, strategy and action planning is undertaken by the Thrombosis Action Group and the Harm Fee Care Collaborative Group. The aim is to improve both stage 1 and stage 2 risk assessment to 95% by March 2022.

Changes made in 2020 include:

- Adjusting current drug charts to provide allocated space for ‘time’ of VTE review. This is currently missing and therefore not allowing accurate documentation of when risk assessments were completed.
- Progression towards the appointment of a VTE specialist nurse or pharmacist
- Testing of new electronic prescribing system, currently in pilot phase.

Improvement priorities:

- Whole system review to establish a more co-ordinated, sustainable HAT prevention cycle that support rapid RCA and learning
- Progression towards the appointment of a VTE specialist nurse or pharmacist
- Ongoing deployment of electronic prescribing across the Trust
- Work with other informatics and digital systems within clinical areas that can support the recognition and management of thrombosis prevention.

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

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

Links to Quality Strategy: Good Governance and Patient Experience

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

Reporting: Scheduled update to the Quality and Safety Committee

Responsible Directors: Chief Operating Officer

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

*shadow monitor against the proposed new clinical standards for ED

3.1 Improving discharge processes

	Aim	Achieved
Reduce number of discharge summaries not sent to GP within 24 hours of discharge	90% reduction	87.2%
Patients discharged by midday	>15%	11.6%
Reduce proportion of beds occupied with length of stay > 14 days	<19%	17.78%

Discharge summaries

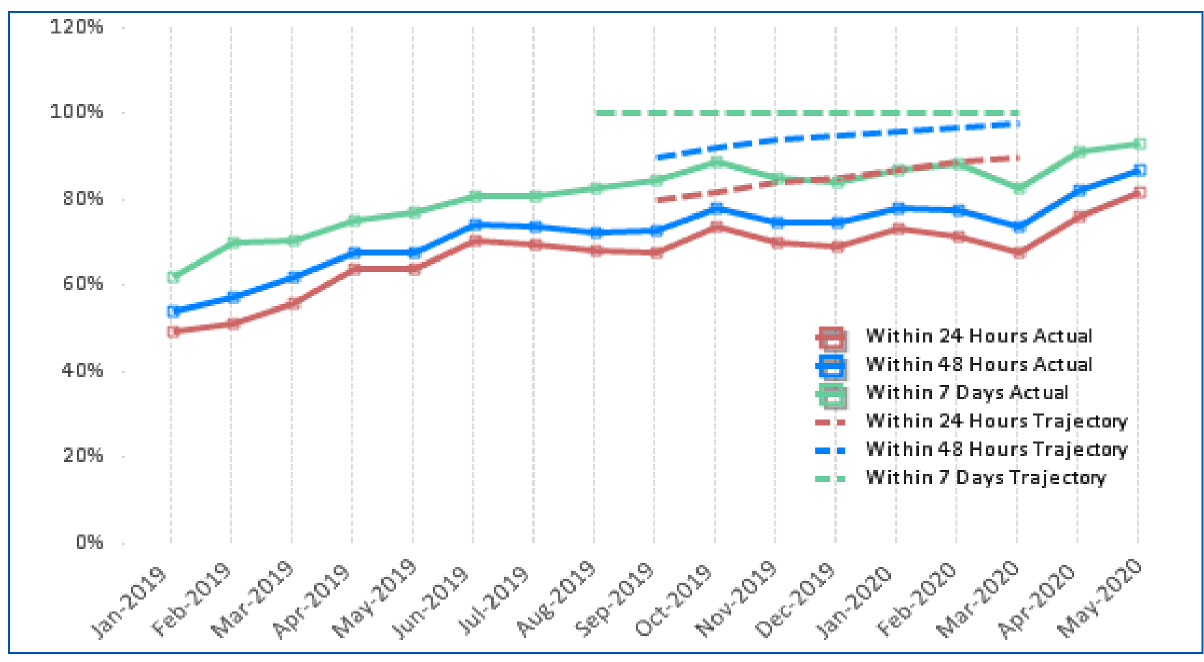
During 2018/19 it was identified that a significant number of discharge summaries had not been sent to the patient's GP within 24 hours of discharge. Any delay in sending the discharge summary poses a potential risk to a patient's future management if tests are not requested or medications not prescribed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

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

- Engagement with staff involved in the discharge process
- Training and education for the creation and distribution of the discharge summary
- Review of templates standardising format
- Daily monitoring through improved data
- Improvement to process, removing unnecessary steps in the discharge process.

The backlog had reduced to 1224 by the end of the financial year 19/20. The data showed an increase of reliability sending summaries within 24 hours and within 7 days. However, the Trust acknowledged that the required targets had not been met and so this would be a continued focus for 2020/21 (see below for 19/20).

Overall for the Trust 2019/20

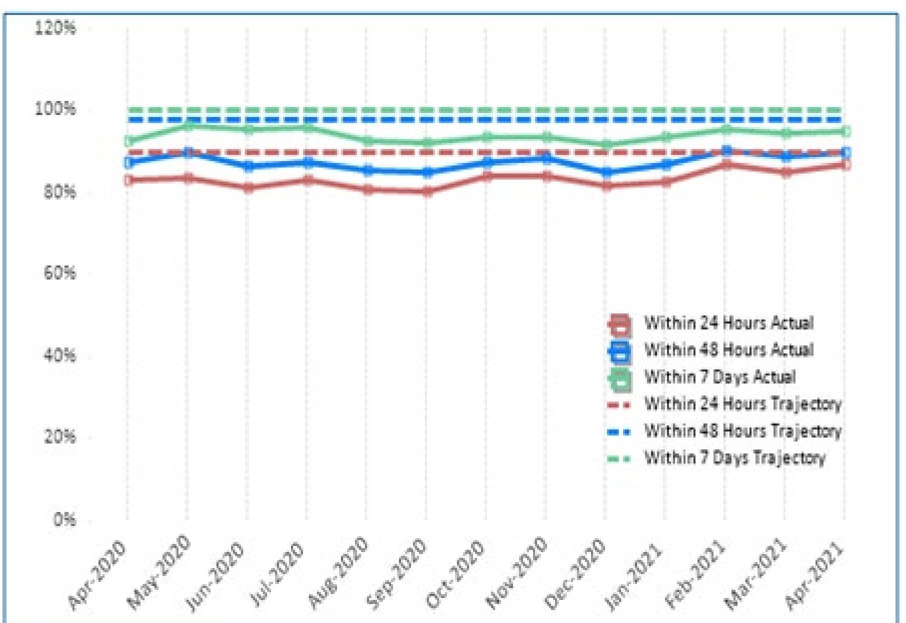


Focus has continued daily with a robust discharge summary team who validate, chase, train and advise all staff involved in outstanding discharge summaries.

An internal discharge summary audit was completed in January 2021 with actions for various teams improve not only the reduction in quantity of outstanding summaries but the quality of how they are written.

The backlog for 2020/21 is now at 148 unvalidated - 128 validated. Please see the breakdown below. This is a significant improvement from 1224 in 2019/20.

Overall for the Trust for 2020-2021 to date



Mid-day discharges

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

Good planning to ensure medication, transport, discharge summaries etc are ready in a timely way allows a patient to go home in the morning, thus freeing up a bed to accommodate demand from the ED and supporting a better patient experience. On average 11.6% of discharges occurred before midday.

Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Discharges before midday	11.7%	12.2%	13.7%	11.8%	11.7%	10.8%	9.6%	10.4%	10.2%	9.9%	11.3%	10.5%

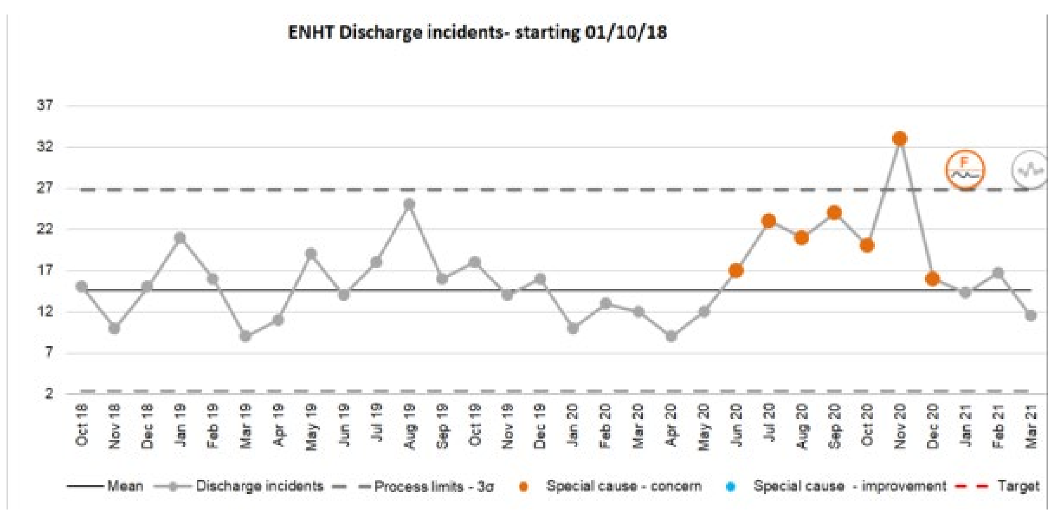
Reduce proportion of beds occupied with length of stay > 14 days

Length of stay reviews occur weekly within divisions, measurement throughout the year has shown normal variation. The Trust continues to work with community partners to safely expedite patient discharge in a timely way. On average 17.78% of beds were occupied by patients where the length of stay was more than 14 days; a slight reduction from the previous year.

Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Proportion of beds occupied by patients with length of stay over 14 days	13.6%	18.4%	17.7%	15.2%	15.9%	19.0%	18.4%	17.9%	19.3%	19.4%	20.4%	18.24%
Proportion of beds occupied by patients with length of stay over 21 days	6.8%	9.1%	9.6%	7.0%	7.4%	10.4%	9.8%	8.5%	9.5%	9.4%	10.8%	9.07%

Discharge improvement programme

A number of concerns were raised to the Trust through different sources, such as family complaints and safeguarding enquiries regarding unsafe discharge arrangements. Thematic review of several different discharge incidents was undertaken in October 2020.



Learning for the thematic review identified some key areas for improvement:

- Poor understanding of processes and policies.
- Lack of clarity of roles and responsibilities within key decision makers, seen at all stages of Multi-Disciplinary Team (MDT)/board rounds and between the Patient Flow Coordinators (PFC), leading to missed opportunity to clarify discharge needs.
- Poor clarity of assessment within the Discharge to Assess (D2A) process and the requirements of the Hospital Discharge Service Requirements.
- Poor communication across the safe discharge pathway and with families and carers.

The safe and timely discharge of patients has been a Trust priority and is overseen at executive board level.

A Discharge Improvement Programme Board with an executive sponsor has been established with newly formed discharge improvement clinical and operational leads, divisional leads, subject matters experts and improvement experts.

The aims of this program are to improve the flow, safety and experience of inpatient discharges by end of March 2022, by:

- Flow- Reducing LOS for patients who are in hospital for over 7 days by 1 day.
- Safety – Reducing incidents related to serious harm from discharges by 50%.
- Experience- Reducing concerns related to discharges by 50% (including formal complaints, PALS and GP concerns).

Clinical areas and teams have been identified to test and learn about variation in the use of discharge policies and processes e.g.:

- Baseline audits for TTO's undertaken by the pharmacy team.
- The design and implemented new standardised discharge passport for the patient and carers that is started on admission and given to the patient at discharge.

Our digital systems are critical to safely plan and deploy high quality discharges. Work has started to utilise our internal patient information system 'nerve centre' for standardising our information and raising situation awareness of critical information regarding patients who meet 'criteria for discharge'. A reliable nerve centre adoption will also support the monitoring and tracking of real time safe and timely discharges.

The Trust were also successful in gaining support with National ECIST (Emergency care improvement support team) programme 'Alliance 16' who will support the emergency admissions and ward systems adopt quality improvement methodology across key priority areas.

3.2 Improve access

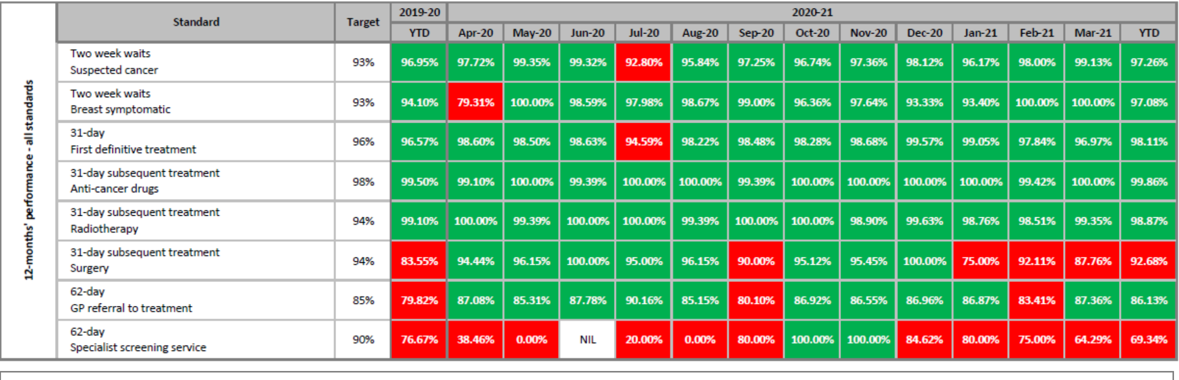
	AIM	Achieved
Improve cancer waits from 2018/19 position	National standard	Met 6 of 8 national standards
Improve delivery of 7 days services	Ascertain baseline and agree Trajectory	Partly met
Reduce delays in ED 4 hour waiting time	National standard (95%)	83.47%

Improve cancer performance

Cancer performance was sustained over the course of 2020/21. The 62 day cancer target was achieved for all months, except for September 2020 and February 2021 and our performance against this standard remains one of the best regionally and nationally.

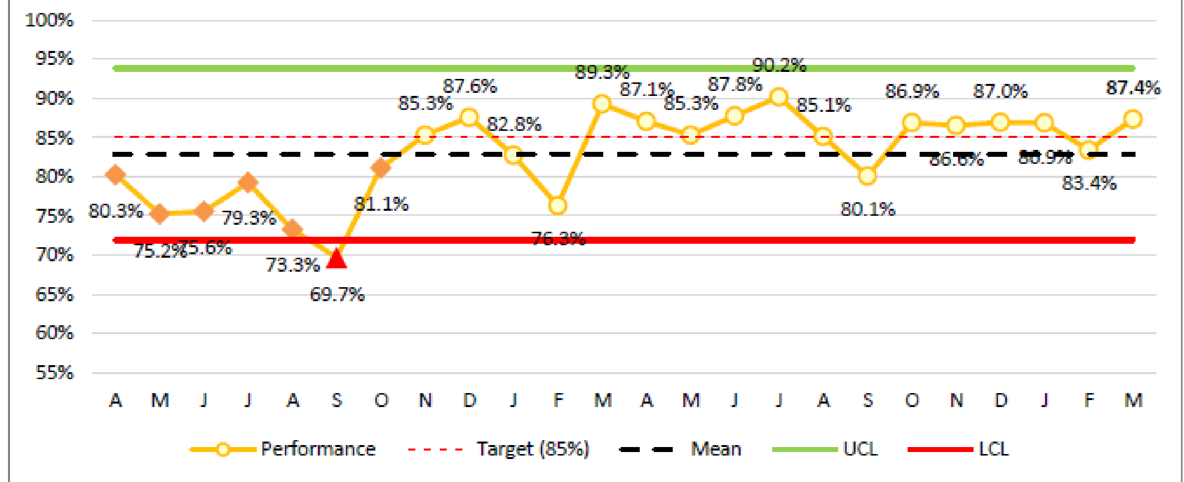
Across all of the cancer standards, the year-end position was compliant with 6 of the 8 standards. Of the 8 standards, the Trust has achieved the 31-day subsequent Anti-cancer drugs and 31-day subsequent treatment (radiotherapy) standards in every month of 2020/21. Also for the two week wait for suspected cancer, breast symptomatic and 31 day first treatment the Trust has achieved the standards 11 out of 12 months.

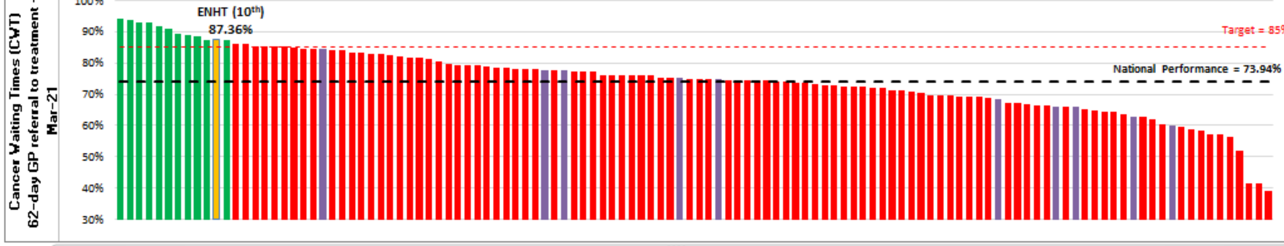
The Trust continues to comply with the new faster diagnosis standard for 2020/21 on confirming or ruling out diagnosis within 28 days.



12-months' performance - all standards

Standard	Target	2019-20	2020-21												
		YTD	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
Two week waits Suspected cancer	93%	96.95%	97.72%	99.35%	99.32%	92.80%	95.84%	97.25%	96.74%	97.36%	98.12%	96.17%	98.00%	99.13%	97.26%
Two week waits Breast symptomatic	93%	94.10%	79.31%	100.00%	98.59%	97.98%	98.67%	99.00%	96.36%	97.64%	93.33%	93.40%	100.00%	100.00%	97.08%
31-day First definitive treatment	96%	96.57%	98.60%	98.50%	98.63%	94.59%	98.22%	98.48%	98.28%	98.68%	99.57%	99.05%	97.84%	96.97%	98.11%
31-day subsequent treatment Anti-cancer drugs	98%	99.50%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	100.00%	100.00%	99.42%	100.00%	99.86%
31-day subsequent treatment Radiotherapy	94%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	98.90%	99.63%	98.76%	98.51%	99.35%	98.87%
31-day subsequent treatment Surgery	94%	83.55%	94.44%	96.15%	100.00%	95.00%	96.15%	90.00%	95.12%	95.45%	100.00%	75.00%	92.11%	87.76%	92.68%
62-day GP referral to treatment	85%	79.82%	87.08%	85.31%	87.78%	90.16%	85.15%	80.10%	86.92%	86.55%	86.96%	86.87%	83.41%	87.36%	86.13%
62-day Specialist screening service	90%	76.67%	38.46%	0.00%	NIL	20.00%	0.00%	80.00%	100.00%	100.00%	84.62%	80.00%	75.00%	64.29%	69.34%





Improve delivery of 7-day services

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

An assessment of provision towards meeting the 7-day objectives using the Seven Day Hospital Services Board Assurance Framework was undertaken in 2019/20. The results of the assessment against four standards are shown below alongside the 2020/21 position.

Standard	Requirement	Outcome (2019/20)	2019/20	2020/21
2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission	44% for weekday admissions; 33% for weekend admissions	Not met	Partly met

Standard	Requirement	Outcome (2019/20)	2019/20	2020/21
5	Inpatients must have scheduled 7-day access to diagnostic services	All diagnostic requirements have been met but with limited provision of MRI scanning which is restricted at the weekend to the diagnosis of spinal cord compression only	Met	Met
6	Inpatients must have timely 24 hour access to key consultant-directed interventions	Interventions available, although interventional radiology is available on an ad hoc basis	Met	Met
8	Patients with high dependency needs should be seen by a consultant twice daily; then daily once a clear plan of care is in place	100% compliance with twice daily review 89% compliance with daily consultant review (May 2019 data)	Not Met	Partly met

Following the development and submission of speciality level business cases last year, a clinical Seven Day Service Investment Review Panel was held at the beginning of March 2020 to prioritise the investment recommendations for the delivery of seven day services in 2020/21. Further progress was postponed due to the needs of the COVID-19 pandemic and there has been no further formal assessment of current provision against the 7-day standards. However, there were a number of service changes as a response to the pandemic which temporarily provided additional capacity to meet standards 2 and 8 such as a 24/7 general medicine consultant rota. There have been other improvements such as 7-dayconsultant ward rounds in general surgery, urology and orthopaedics.

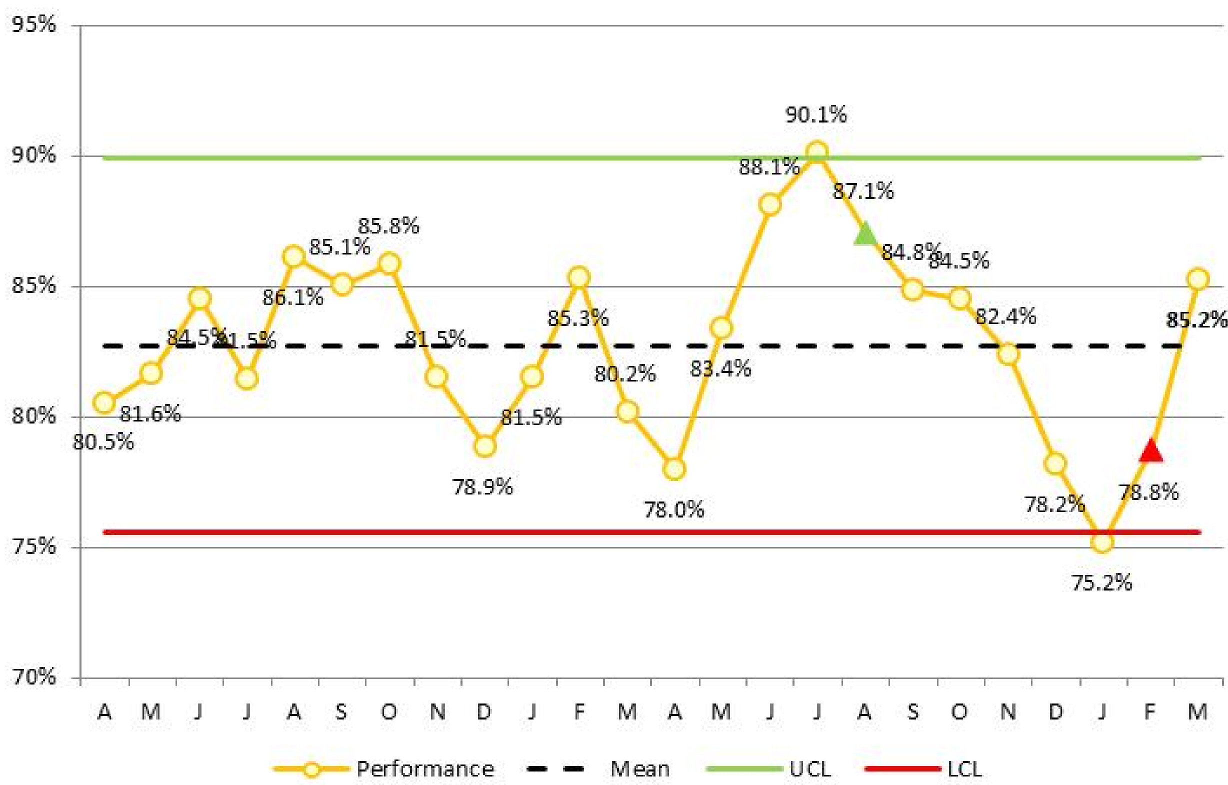
The plan for 2021-2022 is to commence the roll-out of a new job planning policy and process. Part of this includes meeting with specialty leads to discuss and agree

expectations and plan for the year ahead. It is intended that these discussions will include planning for a full 7-dayservice provision, in order to understand the financial implications of the resource levels required.

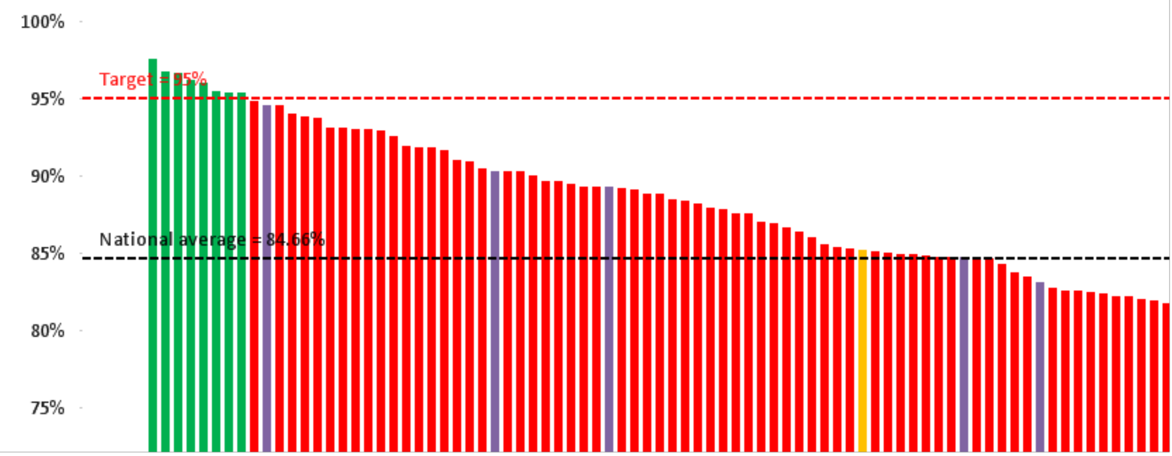
A major step towards improving 7-dayprovision in unplanned care is a staff consultation to be undertaken this summer for all those consultants on the acute medicine and general internal medicine rota. The aim is to improve continuity of consultant led post for patients admitted overnight and morning handover.

Reduce delays in ED 4 hour waiting time

The Emergency Department 4-hour standard requires 95% of patients being seen, treated and either admitted or discharged within four hours of arrival. The Trust's year-end performance was 83.47%, demonstrating improvement of over 3% on 19/20 year-end performance. There was some variation in the Trust's performance during the year, largely due to the impact of COVID-19.



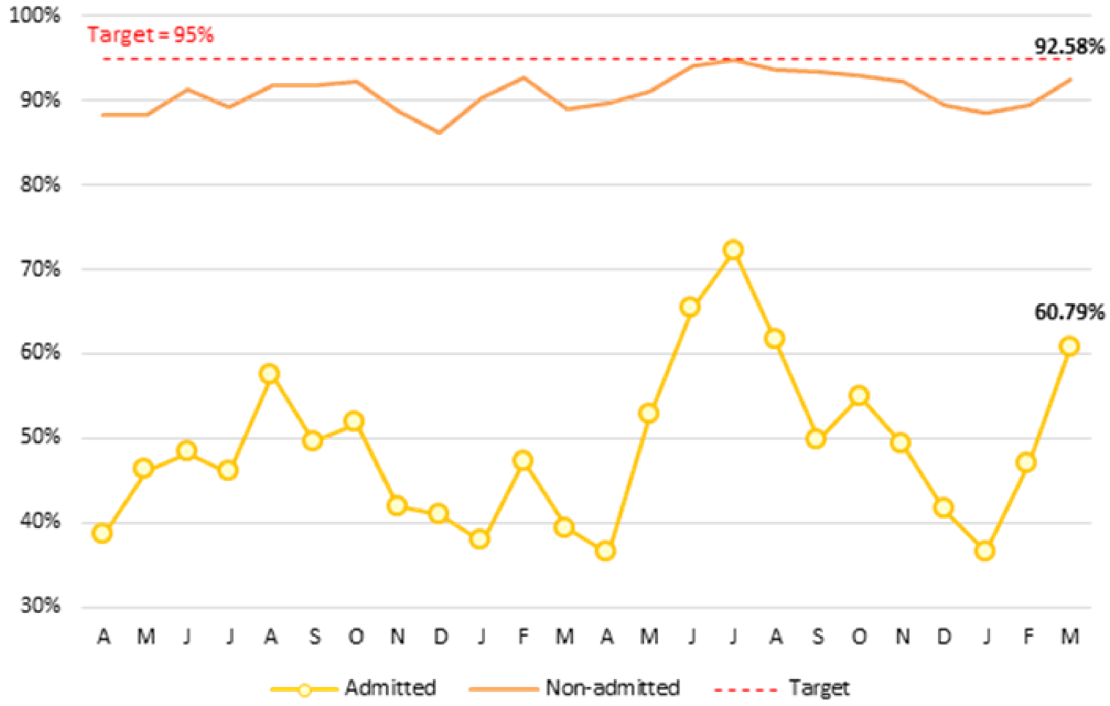
It is noteworthy that relatively few NHS Trusts achieve this target nationally and that ENHT are above the national average.



The Trust treated approximately 400 non-elective patients each day, of which 63% attend via A&E and 31% attend via the Urgent Treatment Centre. On average 36% of patients required admission. In addition the number of admissions very closely aligned with the number of discharges so delays to discharges have a detrimental effect upon the ability to move patients through the emergency department to a ward. COVID did impact significantly on ability to flow efficiently through ED due to the challenges around turnaround of COVID swab results and availability of side room capacity.

New processes were implemented in ED which included stratifying of patients' COVID status. Pathways were adopted that separated patients into COVID and non COVID areas. This was to ensure that we were compliant with infection prevention and control standards to support the reduction of microbial infections but did to some extent impact on the operational efficiency of the system.

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



Priority four: Patient & Carer Experience

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

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

Link to the Quality Strategy: Patient Experience

Monitoring: Patient Experience Committee

Reporting: Scheduled update to the Quality and Safety Committee

Responsible Director: Chief Nurse

	Theme	Measure	19/20	20/21	21/22
4.1	Patient feedback	Maintain Friends & Family Test scores (average) for inpatients, out-patients, maternity (birth) and emergency department	IP 96.7% OP 94.8% Mat 93% ED 89.6%	IP 95.84 OP 97.57 Mat 96.47 ED 94.58	IP >95% OP >95% Mat >93% ED >90%
4.2	PALS Responsiveness (new and replaces always events)	PALS response closed within 5 days	70.5%	79.2%	Aim 80%
4.3	Improve partnership working with patients and carers within key Quality Strategy goals	Design and support patient co-design within planning, design and testing phases of quality improvement initiatives.	Ascertain organisational readiness and agree Trajectory	Demonstrable involvement of patients and carers	Demonstrable involvement of patients and carers
4.4	What matters to you (WMTY) (new)	Measuring the themes of the WMTY conversations	N/A	Launch	Analysis in progress March 2021

4.1 Patient feedback

Indicator	Measure	Trust result	Time period	Trust previous result	National average

Indicator	Measure	Trust result	Time period	Trust previous result	National average
Maintain Friends & Family Test scores (average) for inpatients, out-patients, maternity (birth) and emergency department	Patients	IP 95.84% A/E 94.58% Mat 96.47% OP 97.57%	20/21	IP 96.7% A/E 94.58% Mat 96.47% OP 97.57%	Submission and publication ceased during Covid **

*Maternity indicator is a measure relating to birth experiences only

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

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

- The highest proportion of positive comments from inpatient / day case patients relate to staff being attentive, friendly and caring with good communication and care and treatment provided. Negative comments relate to the environment, noise at night, food standards and patients not able to identify their named nurse.
- Members of the public attending the outpatients department have complimented staff for being kind and helpful, and for the care, treatment and information provided. There are concerns about waiting times in clinics, appointment letters, and administration of appointments, direction to clinics and the cost of the car park.
- In maternity the majority of women have complimented the staff for the support, care and information provided to them during their birth experience. Women would like a quieter environment, provision of recliner chairs for partners and for partners to be able to stay and visit during their appointments and admission. The majority of feedback from patients in the ED is positive particularly in relation to staff being friendly, kind and caring, providing an excellent service and good communication. Negative feedback mainly relates to the length of waiting times.

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

Domain	FFT	Metric	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Friends and Family Test	Inpatients	Proportion of positive responses	95%	92.7%	90.7%	93.8%	96.8%	95.5%	97.3%	98.5%	98.4%	96.7%	98.9%	92.2%	96.3%
		Total number of responses	1,778	233	689	705	780	1,031	803	710	745	657	364	424	774
	A&E	Proportion of positive responses	90%	100.0%	92.9%	89.0%	96.6%	98.3%	96.1%	98.7%	95.1%	98.3%	96.4%	93.1%	95.6%
		Total number of responses	1,241	8	56	282	149	117	103	79	81	60	28	29	114
	Maternity	Antenatal care Proportion of positive responses	93%	n/a	100.0%	n/a	100.0%	0.0%	100.0%	50.0%	100.0%	85.7%	100.0%	100.0%	88.9%
		Birth Proportion of positive responses	93%	95.7%	n/a	100.0%	100.0%	100.0%	92.6%	94.4%	96.2%	97.8%	97.9%	97.1%	95.8%
		Birth Total number of responses	137	23	0	2	1	8	27	126	133	135	143	139	142
		Postnatal ward Proportion of positive responses	93%	95.7%	n/a	100.0%	100.0%	100.0%	95.7%	95.9%	92.6%	94.4%	95.0%	95.5%	93.4%
		Postnatal community Proportion of positive responses	93%	n/a	n/a	n/a	100.0%	n/a	66.7%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Outpatients	Proportion of positive responses	95%	97.6%	95.8%	99.0%	98.9%	96.2%	95.7%	98.5%	99.2%	96.6%	91.2%	99.2%	97.0%
		Total number of responses	-	83	271	204	369	392	419	471	389	233	195	244	337

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

	2018-19	2019-20	2020-21	Aim
Inpatient / Day Case FFT response rate	42.26%	43.73%	23.34%	40%
Maternity response rate (birth)	33.79%	25.14%	17.71%	30%
Emergency department response rate	3.85%	3.67%	5.75%	10%

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

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

Data from December 2020 onwards reflects feedback collected during the COVID-19 pandemic, while, also, implementing the new guidance after a long period of suspension of FFT data submission. The number of responses collected is, therefore, likely to have been affected. Some services may have collected fewer FFT responses, or been unable to collect responses at all, because of arrangements in place to care for COVID-19 patients.
Publication of new data is expected to restart by the end of May 2021.

4.2 PALS Responsiveness (new and replaces always events)

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

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

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

Throughout 2020/21 an increased numbers of patient and carer partners have been invited to work with staff to design and shape our improvement work in the PACE programme, this has resulted in some individuals joining our programme board.

During the pandemic re-deployed staff formed 'task teams' to support patient experience on the wards and used daily continuous learning cycles to adopt new changes and improvements such as delivering free newspapers to the wards.

During the pandemic a 'keeping in touch' call centre was set up in January 2021 to help families to request clinical updates and request virtual visits with their loved one. This service was supported by a team of clinicians and team support workers who facilitated fulfilling those calls. In January and February 429 calls were successfully completed and service users reported 99% satisfaction with the service.

The ENHT Charity has supported the 'keeping in touch' service by donating devices for patient and carers to connect via video calls and access games and social updates e.g. newspapers.

Volunteer’s services have continued to support patients across the hospital. A new role has been developed of ‘rapid response volunteers’ in response to COVID-19. This role supported clinical care givers through various kinds of team support functions in the ward environment.

There is also a menu of options that patients and carers can make requests from the volunteers to support people whilst inpatients for example they can request befriending or a reading service. The volunteers and the PACE team also delivered 1519 letters and 1661 photos to patients from families and friends and supported the delivery of ‘knitted hearts’ donated to the charity by the public, paired with patients in hospital and matching pairs sent to their loved ones to help them to feel connected.

In June 2020 the Trust held a ‘what matters to you?’ awareness day, to support the ongoing understanding of patient and carer’s wishes and to connect more empathically in every conversation. The question ‘what matters to you?’ has been embedded into our ‘here to improve’ methodology. We now regularly ask ‘what matters most to you’ and ask, listen and do what matters and we are starting to collect this data.

4.4 What Matters To You (WMTY)

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

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

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

2.2 Statements of assurance from the Board

Review of services

During 2020/21, the East and North Hertfordshire NHS Trust (ENHT) provided and/or subcontracted 24 relevant health services. The ENHT has reviewed all the data available to them on the quality of care in 24 of these relevant health services. The Trust operated under the revised financial framework in the NHS last year. For further details please refer to the Trust Annual Report.

Participation in clinical audits

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

Audit activity

During 2020/21 there were 63 national clinical audits and 6 national confidential enquiries covering relevant health services that ENHT provides.

As a result of the COVID-19 pandemic NHS England advised that whilst all mandated clinical audits would remain open, data submission would no longer be mandatory, to enable clinical teams to prioritise clinical care. The ENHT clinical teams were highly commended by the Trust for participating in 57 (90%) national clinical audits and 6 (100%) national confidential enquiries.

Quality Account audits 2020/21

The two tables below show:

- The National Clinical Audits and National Confidential Enquiries that ENHT was eligible to participate in during 2020/21.
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2020/21, and for which data collection was completed during 2020/21, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Project Name	Eligible	Participated	Numbers submitted (by % or total number)
Antenatal and newborn national audit protocol 2019 to 2022	Yes	Yes	TBC
BAUS Cytoreductive Radical Nephrectomy Audit.	Yes	Yes	Continuous data collection
BAUS Female Stress Urinary Incontinence Audit.	Yes	No	NA[1]
BAUS Renal Colic Audit	Yes	Yes	34 cases
British Spine Registry	Yes	Yes	18 cases
Case Mix Programme (CMP)	Yes	Yes	Continuous data collection
Cleft Registry and Audit Network (CRANE)	Yes	No	NA[1]
Elective Surgery (National PROMs Programme)	Yes	Yes	Continuous data collection
Emergency Medicine QIPs - Fractured Neck of Femur (care in emergency departments) Subscription-based programme	Yes	Yes	TBC

Emergency Medicine QIPs - Infection Control (care in emergency departments)	Yes	Yes	TBC
Emergency Medicine QIPs - Pain in Children (care in emergency departments)	Yes	No	NA[1]
FFFAP - National Audit of Inpatient Falls	Yes	Yes	Continuous data collection
FFFAP - National Hip Fracture Database	Yes	Yes	Continuous data collection
Inflammatory Bowel Disease (IBD) Audit - Biological Therapies	Yes	No	NA[2]
Inflammatory Bowel Disease (IBD) Audit - Organisational Element	Yes	Yes	1
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Yes	Continuous data collection
Mandatory Surveillance of HCAI	Yes	Yes	Continuous data collection
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care	Yes	Yes	137 cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Yes	279 cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care	Yes	Yes	150 cases
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	162 cases
National Audit of Cardiac Rehabilitation	Yes	Yes	Continuous data collection
National Audit of Dementia	Yes	Yes	41 cases
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	28 cases
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Continuous data collection
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	615 cases
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	446 cases
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	667 cases
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	Yes	Yes	477 cases
National Comparative Audit of Blood Transfusion programme - Audit of the perioperative management of anaemia in children undergoing elective surgery	Audit postponed until May 2021 due to COVID		
National Diabetes Core Audit - Adults	Yes	Yes	Continuous data collection
National Diabetes Foot Care Audit - Adults	Yes	Yes	34 cases
National Diabetes NaDIA Harms Audit - Adults reporting on diabetic inpatient harms in England	Yes	Yes	TBC
National Diabetes Pregnancy in Diabetes Audit - Adults	Yes	Yes	Continuous data collection
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	600 cases
National Emergency Laparotomy Audit (NELA	Yes	Yes	95 cases
National Gastro-intestinal Cancer Audit Programme NBOCA - National Bowel Cancer Audit	Yes	Yes	434 cases
National Gastro-intestinal Cancer Audit Programme NOGCA - National Oesophago-gastric Cancer Audit	Yes	Yes	120 cases
National Joint Registry (NJR) - Ankle Replacement	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Elbow Replacement	Yes	Yes	Continuous data collection

National Joint Registry (NJR) - Hip Replacement	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Hospital Performance	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Implant Performance	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Knee Replacement	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Shoulder Replacement	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Surgeon Performance	Yes	Yes	Continuous data collection
National Lung Cancer Audit (NLCA)	Yes	Yes	73 cases
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Project does not collect data directly from the Trust
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Continuous data collection
National Ophthalmology Audit (NOD)	Yes	No	NA[3]
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	306 cases
National Prostate Cancer Audit (NPCA)	Yes	Yes	1098 cases
National Vascular Registry (NVR) - Carotid endarterectomy or carotid stenting	Yes	Yes	15 cases
National Vascular Registry (NVR) - Lower-limb amputation	Yes	Yes	16 cases
National Vascular Registry (NVR) - Lower-limb angioplasty/stent	Yes	Yes	0 cases
National Vascular Registry (NVR) - Lower-limb bypass surgery	Yes	Yes	2 cases
National Vascular Registry (NVR) - Repair for abdominal aortic aneurysm (AAA), both open and endovascular (EVAR).	Yes	Yes	16 cases
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	Continuous data collection
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	792 Cases
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	Continuous data collection
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	Unit data submitted
Surgical Site Infection Surveillance Service	Yes	Yes	100%
Trauma Audit & Research Network (TARN)	Yes	Yes	Continuous data collection
UK Registry of Endocrine and Thyroid Surgery BAETS	Yes	Yes	Continuous data collection
UK Renal Registry	Yes	Yes	100%

[1] Not inputting data this year due to COVID
[2] Requires a planned business meeting to review resources.
[3] Lack of financial resources to purchase and install the necessary software to submit audit data

National Audits

The reports of some of the national clinical audits the provider participated in 2020/21 were reviewed and the Trust have evidenced the following to improve the quality of healthcare provided.

National Hip Fracture Database Audit

The Trauma & Orthopaedic Team have been recognised and congratulated by the Royal College of Physicians as being one of only 9 Trauma units to have demonstrated that the quality of care provided to their patients was significantly above average across all of the 6 key performance indicators (KPI's) within the National Hip Fracture Database Audit. This is great news for our patients and a wonderful achievement for the team.

Adults Asthma Clinical Audit

The Respiratory Clinical Nurse Specialist Team have had their excellent work highlighted by the Royal College of Physicians National Audit and COPD Audit Programme (NACAP) for their Adults Asthma Clinical Audit 2019/2020. NACAP have recognised the Team's achievements at providing timely reviews and treatments with systemic steroid within the hour for patients with an asthma attack. This is a really positive demonstration of the excellent work happening in our Trust.

COVID-19 Specific National Audits

Since the start of the COVID-19 pandemic, 5 specialties have participated in 11 COVID related National Audits as follows;

- Integrate COVID-19 Emergency Care Audit – ENT
- COVID HAREM Study – General Sugery
- Rectal Cancer Management during COVID-19 Pandemic (ReCaP) – General Surgery
- CovidSurg-Cancer Study – General Surgery, Urology
- CovidSurg-Cohort Study – General Surgery, T&O, Urology
- The CHOLECOVID Audit – General Surgery
- GlobalSurg-CovidSurg Week - Determining optimal timing for surgery following SARS-CoV-2 infection – General Surgery
- COVID-19 Impact on Pancreatic Cancer Care Pathway – Cancer Centre

3 Specialties have also participated in 4 local audits, concentrating on COVID-19;

- COVID-19 testing in children – CH Acute
- A&E management of patients presenting with epistaxis during COVID-19 Era – ENT
- MRSA and COVID 19 swabbing prior to admission to CAU and Bluebell – CH Acute
- Stroke in Covid-19 positive patients: Characteristics and Outcomes – Stroke

Besides the clinical pressures caused by the pandemic, it is praiseworthy that Clinicians are contributing towards national COVID-19 datasets, and demonstrates their excellent commitment to patient safety.

Annual Audit Heroes Awards 2020

This has been an exciting year for nominations in the annual HQIP audit hero awards with Trust staff/teams being shortlisted in 4 of the 6 award categories, more than any other organisation out of the 228 nominations submitted.

HQIP reported that the standard of entries received was very high and congratulated all the individuals and teams who were shortlisted and made it into their Hall of Fame.

Our nominations were in the following;

- **Student of the Year Category** – An FY2 was nominated, shortlisted and won this award which recognises the student who evidences high levels of engagement within their area of study, understanding the importance of clinical audit to drive improvement and leading or making a substantial contribution to the successful delivery of an improvement project or initiative.
- **Florence Nightingale Category (Outstanding contribution by a Nurse or Midwife)** – Our Infection Prevention & Control Lead Nurse was nominated and shortlisted in this award for her clinical audit work to achieve a significant impact in helping to drive quality improvements within infection prevention and control.
- **Volunteer of the Year Category** - a Dr was nominated and shortlisted in this award which recognises the enormous contribution made by volunteers to our

health and care sectors. For making a significant contribution to the improvement efforts of the audit team, department or organisation they support, for providing invaluable support to a clinical audit and/or quality improvement process, as well as using their own insight and experience, or supporting other patients and users of services to give feedback, to influence and guide decision making

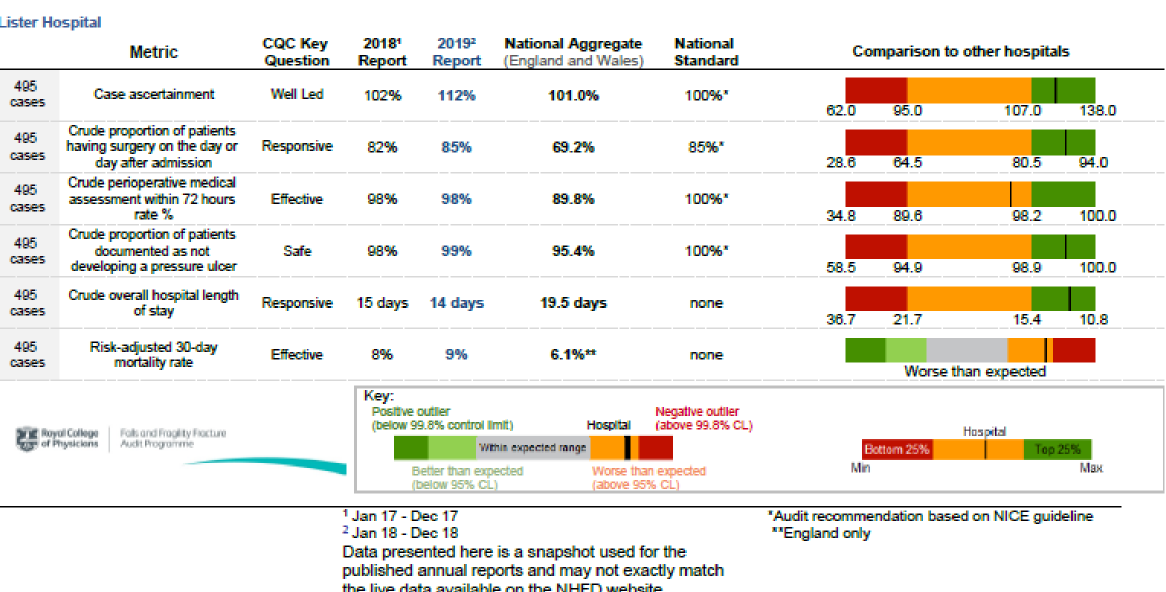
- **Team of the Year Category** - The Transitional Dialysis Unit were nominated and shortlisted in this award which is looking for teams that on or significantly contribute to systematic change in order to achieve a measurable improvement in the quality of operational processes, patient care or health outcomes, or who deliver or contribute to education and training that supports a culture of improvement, or who proactively work with patients and carers to co-design improvements/interventions that lead to better outcomes, care, or processes.

The Mount Vernon Cancer Centre Radiotherapy Department were also nominated in the Team of the Year category, for their excellent commitment to providing structured audit training for their staff, and converting this understanding in to many relevant audits that have created tangible changes to their working practise but unfortunately were not shortlisted.

National Clinical Audit Benchmarking Results (NCAB)

NCAB is an initiative originally created in collaboration between HQIP and CQC, with a vision to enhance the way medical directors, local clinical audit teams and others engage, interact with and share clinical audit data. NCAB provides a visual snapshot of individual Trust audit data set against individual national benchmarks.

The Trust participated and were published, in 12 reports. Some examples are shown below:



Lister Hospital

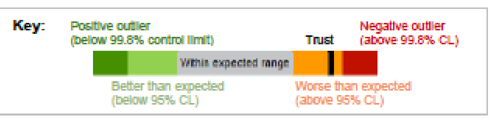
	Metric	CQC Key Question	2018[1] Report	2019[2] Report	National Aggregate (England and Wales)	National Standard	Comparison to other hospitals
495 cases	Case ascertainment	Well Led	102%	112%	101.0%	100%*	62.0 95.0 107.0 138.0
495 cases	Crude proportion of patients having surgery on the day or day after admission	Responsive	82%	85%	69.2%	85%*	28.6 64.5 80.5 94.0
495 cases	Crude perioperative medical assessment within 72 hours rate %	Effective	98%	98%	89.8%	100%*	34.8 89.6 98.2 100.0
495 cases	Crude proportion of patients documented as not developing a pressure ulcer	Safe	98%	99%	95.4%	100%*	58.5 94.9 98.9 100.0
495 cases	Crude overall hospital length of stay	Responsive	15 days	14 days	19.5 days	none	36.7 21.7 15.4 10.8
495 cases	Risk-adjusted 30-day mortality rate	Effective	8%	9%	6.1%**	none	Worse than expected

[1] Jan 17 - Dec 17
[2] Jan 18 - Dec 18
Data presented here is a snapshot used for the published annual reports and may not exactly match the live data available on the NHFD website.

*Audit recommendation based on NICE guideline
**England only

East And North Hertfordshire NHS Trust

	Metric	CQC Key Question	2018 Report	2020 Report	National Aggregate (England and Wales)	National Standard	Comparison to other hospitals
264 operations	Case ascertainment	Well Led	108.7%[1]	107.3%[4]	95.0%	none	Good (over 80%)
Incomplete data submission	Risk-adjusted post-operative length of stay >5 days after major resection*	Responsive	Not Reported[1]	Incomplete data submission[4]	62.0%	none	
Incomplete data submission	Risk-adjusted 90-day post-operative mortality rate	Effective	Not Reported[1]	Incomplete data submission[4]	3.0%	none	Not reported 0 Within expected range 20
Incomplete data submission	Risk-adjusted 2-year post-operative mortality rate	Effective	21.0%[2]	Incomplete data submission[5]	18.9%	none	Not reported 0 Within expected range 50
Incomplete data submission	Risk-adjusted 30-day unplanned readmission rate	Effective	Not Reported[1]	Incomplete data submission[4]	10.8% *	none	Not reported 0 Within expected range 30
Incomplete data submission	Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection	Effective	57.2%[3]	Incomplete data submission[6]	53.0% *	none	Not reported 0 Within expected range 90



[1] Apr 16 - Mar 17 [2] Apr 14 - Mar 15 [3] Apr 13 - Mar 16 *England only
[4] Apr 17 - Mar 18 [5] Apr 15 - Mar 16 [6] Apr 14 - Mar 17

Lister Hospital, Respiratory High Dependency Unit

	Metric	CQC Key Question	2017/18[1] Report	2018/19[2] Report	National Aggregate (England, Wales & N. Ireland)	National Standard	Comparison to other Units
	Case Ascertainment	Well Led	Not reported for this audit			none	n/a
626 admissions	Crude non-clinical transfers	Responsive	0.2%	0.0%	0.3%	0%*	0.0 Within expected range 6.0
425 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	Responsive	0.8%	0.2%	1.9%	0%*	0.0 Within expected range 25.0
3660 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	Responsive	12.2%	11.1%	4.4%	0%*	Not in the worst 5% of units
604 admissions	Risk-adjusted hospital mortality ratio (all patients)	Effective	1.1[3]	1.0[4]	1.0	none	0.2 Within expected range 2.8
422 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	0.9[3]	1.0[4]	1.0	none	0.2 Within expected range 2.8

icnarc intensive care national audit & research centre

KEY: Positive outlier (below 99.8% control limit) Unit Negative outlier (above 99.8% CL) Within expected range Better than expected (below 95% CL) Worse than expected (above 95% CL)

[1] Apr 17 - Mar 18
[2] Apr 18 - Mar 19
[3] $ICNARC_{H2015}$ risk adjustment model
[4] $ICNARC_{H2018}$ risk adjustment model
* FICM/ICS guideline

Key messages

• The table below summarises East and North Hertfordshire NHS Trust performance in the 2019 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2017. Mortality rates are presented both with and without deaths due to congenital anomalies.
• When compared against trusts with a similar service provision, East and North Hertfordshire NHS Trust was up to 5% higher or up to 5% lower than the average for the comparator group in both measures.

	Metric	CQC Key Question	2018[1] Report	2019[2] Report	Comparator group[4] average (UK)	National Standard	Comparison to other trusts with similar service provision
5,640 births	Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)	Effective	4.66 (4.03 to 5.73)[3]	4.69 (4.04 to 5.80)[3]	4.79	n/a	Up to 5% higher or up to 5% lower than the average for the comparator group[4]
5,639 births	Stabilised and risk-adjusted extended perinatal mortality rate, **excluding congenital anomalies** (per 1,000 births)	Effective	Not reported	4.13 (3.53 to 5.23)[3]	4.16	n/a	Up to 5% higher or up to 5% lower than the average for the comparator group[4]

1 Jan 16 - Dec 16
2 Jan 17 - Dec 17
3 Upper and lower 95% confidence intervals
4 (4,000 or more births per annum at 24 weeks or later)

East of England Cancer Alliance

		Metric	CQC Key Question	2017[1] Report	2018[2] Report	National Aggregate (England & Wales)	National Aspirational Standard	Comparative performance
Trust-level metrics	135 cases	Case ascertainment	Well Led	>90%	81 to 90%	79%*	none	Better than national aggregate
Trust-level metrics	135 cases	Age and sex adjusted proportion of patients diagnosed after an emergency admission	Effective	11.4%	12.4%	13.3%	none	Less than 15%
Trust-level metrics	Not eligible	Risk-adjusted 90-day post-operative mortality rate	Effective	Not eligible	Not eligible	3.2%	none	Not eligible
Cancer Alliance-level metrics	2224 cases	Crude proportion of patients treated with curative intent in the Cancer Alliance	Effective	37.5%	37.7%	38.6%	none	Similar to the national aggregate

National Oesophago-Gastric Cancer Audit

Key: Positive outlier (below 99.8% control limit); Within expected range; Trust; Negative outlier (above 99.8% CL)

[1] Apr 14 - Mar 16
[2] Apr 15 - Mar 17
*England only

Lister Hospital

		Metric	CQC Key Question	Year 4[1]	Year 5[2]	National Aggregate (England & Wales)	National Standard	Hospital performance
	136 cases	Case Ascertainment	Well Led	100%	89%	84.0%*	85%	85% and over
Proportion of patients for which each process of care was met	136 cases	Crude proportion of cases with pre-operative documentation of risk of death	Effective	34%	49%	77.3%	85%	Less than 55%
Proportion of patients for which each process of care was met	54 cases	Crude proportion of cases with access to theatres within clinically appropriate time frames	Responsive	96%	94%	82.4%	85%	85% and over
Proportion of patients for which each process of care was met	64 cases	Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre	Effective	73%	66%	83.1%	85%	From 55% to less than 85%
Proportion of patients for which each process of care was met	69 cases	Crude proportion of highest-risk cases (greater than or equal to 5% predicted mortality) admitted to critical care post-operatively	Safe	n/a	87%	77.5%	85%	85% and over
	136 cases	Risk adjusted 30-day mortality	Effective	13%	13%	9.6%	None	Within expected range

NELA National Emergency Laparotomy Audit

Key: ≥85%; ≥ 55% and <85%; <55%. Positive outlier (below 99.8% control limit); Better than expected (below 95% CL); Within expected range; Trust; Worse than expected (above 95% CL); Negative outlier (above 99.8% CL)

[1] Dec 16 - Nov 17
[2] Dec 17 - Nov 18
*England only

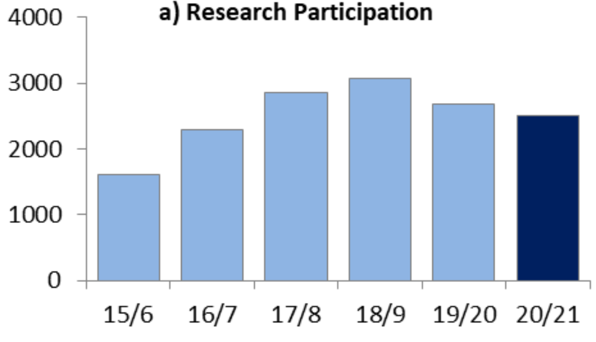
Research and development

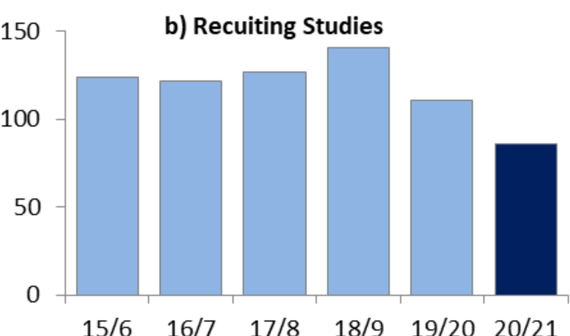
The number of patients receiving relevant health services, provided or sub-contracted by the ENHT in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 2,566.

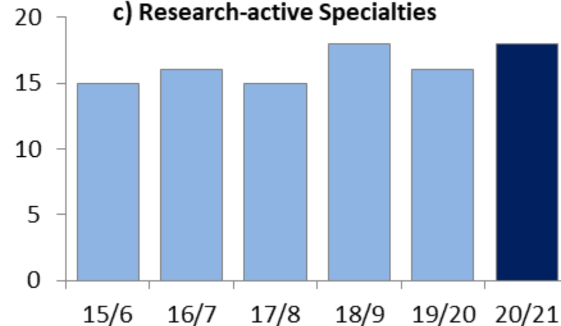
Research supports the Trust vision in the following ways:

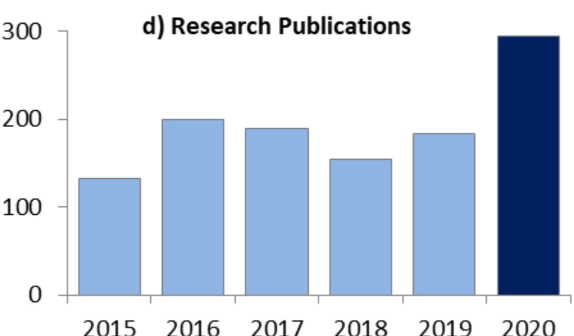
- Trust Vision: Proud to deliver high-quality, compassionate care to our community.
- Research Vision: To support high-quality, compassionate care to our community through research and innovation.
- Public & Patients: To ensure that the public and patients have the opportunity to contribute to a) the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

The Trust is proud to be part of the National Institute for Health Research which has a national vision "***to improve the health and wealth of the nation through research***". Research activity over recent years is summarised below. Our Trust website has a dedicated section for Research where you can access further details.









Providing the research and evidence base for meeting the COVID-19 challenge

During 2020/1 the Trust's Research teams reviewed their research commitments so as to identify how best they could support the response of the Trust and of the nation to COVID-19. Initially all research projects were reviewed to identify which could be paused to enable staff to focus on the nationally prioritised COVID-19 studies or be redeployment to frontline care. A significant contribution was made to Urgent Public Health COVID-19 Studies as summarised below and with further details in Annex 3.

The Trust recruited 991 participants to 11 different COVID-19 studies (83 to RECOVERY) and has supported the development of new treatments–many thanks to all patients, staff and others who made this possible. In addition a large proportion of the staff were redeployed at various times to support the frontline service.

The Trust supported the national research priorities and is proud to be part of part of the Clinical Research Network in the East of England which performed very well in 2020/1 as illustrated by the highlights below:

- Overall participation in NHS research 122,000 (~3% of the East of England population).
- Overall participation in Urgent Public Health Studies 75,000.
- Overall participation in RECOVERY trial 12.9% of the eligible patients.
- Overall participation in non- Urgent Public Health Studies 47,000 (top nationally).

Continuation of cancer research

The Trust supports the delivery of cancer research at both the Mount Vernon Cancer Centre and the Lister hospital. Much of the cancer research could continue in 2020/21 and the Trust recorded the second highest recruitment to cancer studies (518 participants) in the East of England after Cambridge University hospitals NHS Foundation Trust (1603 participants).

Being ready to support all research to enhance patient experience and outcome

With the pressures of the pandemic beginning to ease and COVID-19 caseloads falling, work is underway to support the recovery of research into other conditions, and to increase the strength of the UK's research base and life sciences sector. This supports the vision set out by the Department of Health and Social Care in the document Saving and Improving Lives: the future of UK clinical research delivery.

Listening to and acting on the Patient and Research Participant voice

The Trust's Patient and Public Involvement in Research Group ensures that the patient voices is heard and acted on. During 2020/21 the Trust completed a research participant survey to find out what it is like to take part in research and a summary of the findings is given below.

Statement	Agreed or strongly agreed
• The information that I received before taking part prepared me for my experience on the study	96% (48 of 50 responses)
• I feel I have been kept updated about the research	70% (33 of 47 responses)
• I know how to contact someone from the research team if I have any questions or concerns	98% (51 of 52 responses)
• The researchers have valued my taking part in the research	92% (48 of 52 responses)
• Research staff have always treated me with courtesy and respect	98% (51 of 52 responses)
• I would consider taking part in research again	85% (44 of 52 responses)

Example qualitative feedback from research participants

I was a research scientist for 10years so very happy to be involved. I have benefited from research by others to improve treatment, so happy to be involved and help those who follow in future years. It is something positive to come from having prostate cancer.

I received extra care, attention and results. I was informed all throughout the process
Nurses on the research programme have been very supportive throughout.

I am very happy with my research experience and can't think of anything that could have improved it.

Examples of research activity are given in Annex 3.

Commissioner's contractual requirements (CQUIN)

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

There have been no CQUINs in place during 2020/21 as they were nationally suspended due to the pandemic.

Care Quality Commission

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

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

The Care Quality Commission has not taken enforcement action against the ENHT during 2020/21. The ENHT has not participated in any special reviews or investigations by the CQC during 2020/21.

Since the last inspection undertaken by the Care Quality Commission in 2019, the Trust has not received an on-site inspection. Due to COVID-19 the Care Quality Commission had to evolve their approach to regulating and develop a remote inspection programme. They adapted and develop new methods by using transitional approach to monitoring services. This focuses on safety, how effectively a service is led and how easily people can access the service. It includes:

- a strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOEs), so they can continually monitor risk in a service
- using technology and their local relationships to have better direct contact with people who are using services, their families and staff in services
- targeting inspection activity where they have concerns

With this new approach CQC need to review which information they need to consider and use a risk based approach to their new remote inspection programme. CQC used information on the Trust such as previous inspection reports and ratings, monitoring information they collect through data sources and inspector knowledge on our services. After CQC have reviewed information about the services, they hold virtual conversations with core services. This is not an inspection and CQC do not rate services following a call. In 2020/2021 CQC held the below reviews under the Transition Monitoring Approach:

- Following the first surge of the pandemic
  - Medicines Management
  - Infection Prevention and Control

- Under the Transition Monitoring Approach:
  - Urgent & Emergency Core service – Patient FIRST Review – 29 October 2020
  - Surgery Core Service – 23 March 2020
  - Medicine Core Service (Lister) – 25 March 2020
  - Well Led Review – 30 March 2020
  - Medicine Core Service (MVCC) – 22 April 2020

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

Further reviews for 2021/2022 are scheduled and listed below:

- Outpatients Core Service (MVCC) – 10 June 2021
- Maternity Core Service – 27 July 2021
- Outpatients Core Service (QE11) – 4 August 2021
- End of Life Core Service – 12 August 2021

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

At the end of May 2021 the Care Quality Commission are due to publish their new strategy outlining their new methodology for inspections going forward.

<u>Current CQC ratings</u>

In 2019 the Care Quality Commission inspected eight of the core services provided by the Trust across Lister Hospital, the New QEII Hospital and Mount Vernon Cancer Centre in July 2019. The Well Led Inspection took place in September 2019 and the Use of Resources inspection in August 2019. The inspectors focused on Safety, Effectiveness, Responsiveness, Care and how well led services are in eight core service lines:

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

Summary of the Trust's Ratings

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

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

We were rated as requires improvement for use of resources.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Dec 2019	Good ↑ Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019

Rating for acute services/acute trust

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

Ratings for a combined trust

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

Examples of outstanding practice were found in children and young people's services at Lister Hospital and in radiotherapy services at Mount Vernon Cancer Centre.
The New QEII and Lister Hospitals both showed improvements, with surgery at the Lister Hospital and Urgent Care Centre at the New QEII both moving from an inadequate to requires improvement rating.

The inspectors found that:

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

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

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

The Trust adapted the Compliance Framework during the COVID-19 pandemic across the five compliance pillars which are: Intelligence Monitoring, Communication & Engagement, Departmental Visit Programme, Proactive and Not Reactive. The Trust-wide inspection programme has mainly been paused however, weekly audits and other internal audit programmes are held in collaboration with IPC, Pharmacy and estates. The Quality Assurance visits with the CCG have recommenced and will be taking place monthly with a new team or theme identified.

Data quality

East and North Herts Trust submitted records during 2020/21 to the Secondary User Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

Reporting Period - April 2020 to March 2021, extracted 21/04/2021. The information is intended to support data quality improvements for organisations delivering NHS services

Activity	Valid NHS Number	Valid General
Admitted patient care	99.90%	99.60%
Out-patient care	99.90%	100%

Ethnic Category	Provider % Valid	Region % Valid	National % Valid
Admitted patient care	94.80%	94.10%	95.70%
Outpatient care	91.40%	92.80%	93.60%

Accident and Emergency	Trust % Valid	STP % Valid	Regional % Valid	National % Valid
NHS Number	99.4%	99.30%	99.00%	98.10%
Registered GP	100.00%	99.90%	99.50%	98.80%

During the year 2020/21

The corporate data quality team tried to use this time as efficiently and to the betterment of the Trust and its patients as possible. They were involved in a number of programmes that improved the patient experience and assisted in the delivery of services during the pandemic.

- Implemented a Trust-wide PTL review and cleansing programme of legacy data:
  - New PTL, total number of open new referrals was just under 50,000. At the end of the programme, it had reduced to around 36,000.
  - Follow Up PTL – the team started working on breaking down the PTL into more manageable validation cohorts, this work in continuing into 2021/22.
- Data Quality Training Surgeries – during the validation and cleansing of both the New and FUP PTL, the project identified both recording errors and training needs. During the autumn of 2020, a series of training sessions were organised for staff across both divisions.
- The team were involved in populating Lorenzo with the national clinical risk stratification codes on the inpatient waiting list
- During the second wave of the pandemic, the Trust converted as many face to face appointments to telephone and the team were involved in contacting patients and updating the PAS system.
- The team were part of the Keeping in Touch project, manning the dedicated phone line for friends and family of our patients, maintaining an open line of communication
- The team were working on the development of a Data Quality Compendium (DQC), a documented record of all activity taking place and how this activity is captured across the Trust.

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

Plans for 21/22;

- To reinstate Data Quality Steering Group Meetings, moving from bi-monthly to monthly with both the Planned and Unplanned Divisions.
- Identify divisional champions who will promote the importance of DQ and provide first line support in the divisions.
- An output from the steering group will be a DQ improvement plan, framework for assessing data across all services, define areas for improvement, indicating short term and long term issues.
- Monthly DQ Audits – focussing on specialities, outcomes reported into the steering group.
- Educating staff on the importance of collecting data, i.e. ethnicity status, recording and the impact on population health management.
- Raising staff's awareness of their roles and responsibilities in maintaining high quality data.
- Development of the DQ Dashboard, KPI reports on DQ issues, identify areas of concern.
- Provide exception reports for staff to manage their data concerns and monitor improvements.
- Set up Trust-wide governance framework structure.
- Development of data quality training modules on the Trusts ENHT Learning Academy.

Information Governance / Data security

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

In response to the COVID-19 pandemic, the Trust opted to extend the deadline for the submission of the Data Security and Protection Toolkit 2019/20 to September 2020. The Trust declared a fully compliant position.

Progress with completion of the DSPT for 2020/21 is underway to meet the June 2021 submission and is monitored at the Trust's Information Governance Steering Group meetings which are held quarterly.

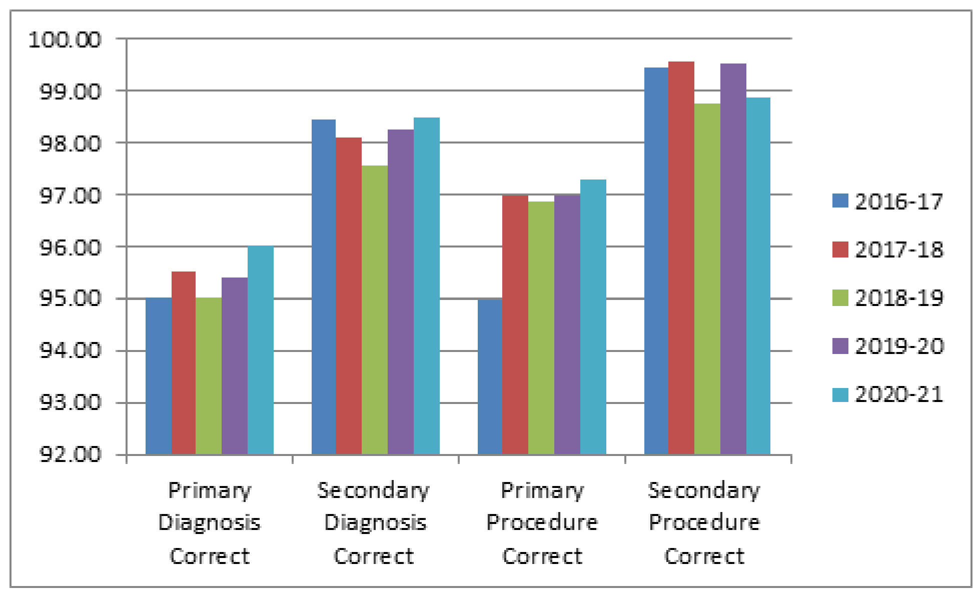
During 2020/21 we have not declared any incidents classified as Level 2 or that meet the requirements to report to the Information Commissioner's Office (ICO). All information governance incidents are reviewed by the Information Governance team and potential and actual serious incidents are reviewed in line with the national guidance through the Trust's incident review process to support learning.

Clinical coding

The ENHT was not subject to the Payment by Results clinical coding audit during 2020/21. However the Trust undertook a General Data Protection Regulation Standard 1 audit with results at Level 3 (highest level) as follows:

Year	Primary Diagnosis Correct	Secondary Diagnosis Correct	Primary Procedure Correct	Secondary Procedure Correct	Level
2016-17	95.00	98.43	94.96	99.46	3
2017-18	95.50	98.10	96.98	99.58	3
2018-19	95.00	97.55	96.86	98.77	3
2019-20	95.41	98.25	96.97	99.51	3
2020-21	96.00	98.50	97.30	98.89	3

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



Learning from deaths

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

Mortality review process

I. Stage 1 is undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It is a structured, evidence based review format comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections.
II. Potential areas of concern (ACON's) found by reviewers trigger a Stage 2 review by the relevant Specialty with discussion and identification of learning/actions points at their Clinical Governance Forum.
III. Outputs feed into Stage 3 where the case is considered by the Mortality Surveillance Group, a subset of the Trust's Quality and Safety Committee. Here the adequacy/appropriateness of actions/learning points suggested by Specialties is considered and an avoidability of death score is agreed (using the scoring criteria adopted from the RCP methodology). Scores of ≤3 (more than 50% likelihood that the death was avoidable) have been used to answer this question. Quality of Care rating is now also agreed using the scale adopted from the PRISM methodology.

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

Learning themes are shared with wider Quality Improvement initiatives such as Deteriorating Patient Collaborative and End of Life Board; where they are captured as key drivers for change ideas.

Key Themes from Mortality Review Areas of Concern: 2020-21

Communication

Poor communication between:

- CCOT and medical team
- Wards on transfer of patients
- ED , CCU and third team
- Wider health care community & Trust regarding vulnerable patient with LD
- Specialty and nutrition team regarding LD patient
- Specialties where there is a need for shared care
- Weekend and out of hours handovers
- Requested cardiology input not provided
- Requested surgical input not provided to Jnr Drs

Clinical management

Poor management of:

- Diabetes in complex LD patient with #NOF and COVID
- Diabetes over a weekend
- Stroke patient over a weekend
- BP not managed in line with Trust guidelines
- Delay between ward round clinical decision and action based on ward round blood results
- Failure to treat sepsis in line with policy
- Transfer of acutely unwell patient from ED to
- Failure to identify status epilepticus
- End of Life care not being considered early enough in elderly/frail patients

Review & Escalation

- Two hourly observations not completed as requested
- Failure to repeat observations in line with guidelines
- Lack of observations/escalation despite high NEWS score
- Failure to request planned repeat CT in PE case
- Delay in referral to plastics/delay in diagnosing necrotising fasciitis
- Incomplete assessment of sepsis with delay to ABX
- Delay to securing dietetics input for patient with nutrition issues
- Failure to review ECG taken on admission preventing recognition of MI
- Failure to recognise deteriorating patient
- Delay to consultant review for patient on outlying ward
- Ward nurses failure to complete BM charts regularly
- Junior doctor failed to book CT colongram
- Lack of referral to renal team on prior admission resulted in suboptimal care on readmission

Process & Policy

Poor adherence to policy/guidelines:

- Inter-ward patient transfer
- VTE guidelines not followed
- Ensuring DNACPR/TEPs in place
- FFP given OOH against guideline

Process issues included:

- ED care bundles not completed, including Patient Safety checklist
- Sepsis screening tool not fully completed – delay to treatment
- Mental Capacity Act form not fully completed
- Repeat falls assessment not completed following ward move
- Need for improved pathway relating to the swallowing of foreign bodies

Documentation

Poor documentation regarding:

- Aspects of review/decision-making
- Decision to withdraw care/EoL care
- Reason to delay surgery
- Falls prevention
- Cardiac arrest
- Reason for/authorisation for ward move
- Conduct of senior/PTWR review
- Patient with high risk of malnutrition
- Poor/inaccurate discharge summary
- Disorganised filing of paperwork in notes
- Chest examination
- Challenge of currently not being able to refer back to advice given verbally to the patient's GP

Operational/competency

- Lack of continuity of care of vulnerable patient over multiple admissions
- Concern regarding multiple ward moves over a short period
- Concern regarding an elderly patient with #NOF not being transferred to an orthopaedic ward (service compromised by early pandemic environment)
- Lack of communication between bed managers and specialty regarding patient ward move
- Concerns regarding appropriateness of transfer of acutely unwell Stroke patient from PAH
- Patient with coeliac disease deteriorated while awaiting an OPA
- Lack of competency regarding use of CPAP by nurses resulted in failure to realise machine was switched off during ward transfer
- Need to ensure that all staff caring for patients with nasogastric tubes are competent and can recognise complications and issues

Medication

- Change of meds from labetalol not considered following sustained BP elevation
- Error leading to double dose of Dalteparin
- Delay to administration of Octaplex in ED
- Flowtrons requested by consultant not prescribed by junior doctor
- Poor fluid resuscitation in septic patient

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**	**2020-21 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 2020-21, 1555 of ENHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 370 in the first quarter; 289 in the second quarter; 362 in the third quarter; 534 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 2021, 785 case record reviews and 91 investigations have been carried out in relation to 1555 of the deaths included in item 27.1. In 87 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: 311 in the first quarter; 207 in the second quarter; 177 in the third quarter; 63 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting	1 representing 0.06% of the patient deaths during the reporting period are judged to be more likely than not to

	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.	have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 1 representing 0.27% for the first quarter; 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter. [Note: this does not mean that no 2020-21 deaths will be identified within the item 27.3 definition, but that by 31 March 2021 only 1 concluded ACON investigation had fallen within this definition. As detailed in 27.8 below, investigations concluded after the end of the current reporting period will be reported in next year's Quality Account]. These numbers have been estimated using the Trust's Mortality Review process. Stage 1 is undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It is a structured, evidence based review format comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections. Potential areas of concern found by reviewers trigger a Stage 2 review by the relevant Specialty with discussion and identification of learning/actions points at their Clinical Governance Forum. Outputs feed into Stage 3 where the case is considered by the Mortality Surveillance Group, a subset of the Trust's Quality and Safety Committee. Here the adequacy/appropriateness of actions/learning points suggested by Specialties is considered an avoidability of death score is agreed (using the scoring criteria adopted from the RCP methodology). Scores of ≤3 have been used to answer this question (Death probably avoidable, more than 50-50). Quality of Care rating is now also agreed using the scale adopted from the PRISM methodology.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	1 2020-21 death has so far been identified within the item 27.3 definition. This information is based on concluded ACON investigations considered by the Mortality Surveillance Committee by 31 March 2021. [Refer to note in 27.3] This death was declared a formal SI with ensuing investigation and report provided to and approved by our Commissioners. The Mortality Surveillance Committee considered the case in September 2020. The Committee concluded that there was strong evidence of avoidability of the death.
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	The following were the key actions/learning as a result of the SI investigation of the death: 1. All AMU ward staff to read and understand the Trust Falls Prevention and Management Policy; ward manager to email staff and maintain a record of completion. 2. All AMU staff to have basic introduction to falls prevention and management at Trust mandatory

	27.4).	training. 3. All staff to attend bite-size training focussing on the management and prevention of falls. 4. Twice weekly audit of falls documentation to take place with any issues fed-back at time of audit and to those staff where sub-optimal practice is observed; audit to ensure that assessment reflects patient need. 5. Training to support staff practice around management of the patient post fall i.e. neurological observations and when they are required, moving the patient from the floor to be arranged for all staff. 6. High risk patients and their specific requirements to be included at site safety huddle. 7. Learning from this incident was fedback to ward team and shared Trust-wide.
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.	This extremely sad case had a significant impact on all acute areas. It highlighted the vital importance of certain aspects of care, which were reinforced with renewed rigour, in particular: 1. Accurate and timely handover – clear handover of relevant patient history 2. Ensuring that risk assessment is not just a paper exercise but is translated into a 'real' patient's needs i.e. what does it really mean for this patient 3. Importance of performing neuro observations correctly and appropriately – when neuro observations must be used and when AVCPU is sufficient 4. Acknowledging the increased risk to patient's when they are in a side room and are unobserved for periods of time – this is an increased risk even when the patient does not require a special or Baywatch, and taking appropriate extra precautions.
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.	20 case record reviews and 30 ACON investigations completed after 1 April 2020 which related to 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.	5 *[of the 30 investigations reported in 27.7 above]* representing 0.35% of the patient deaths before the reporting period *[ie 2019-20]* 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	6 representing 0.4% of the patient deaths during 2019-20 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]*.

	previous reporting period, taking account of the deaths referred to in item 27.8.	

2.3 Performance against national core indicators

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

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

Mortality

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

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

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

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

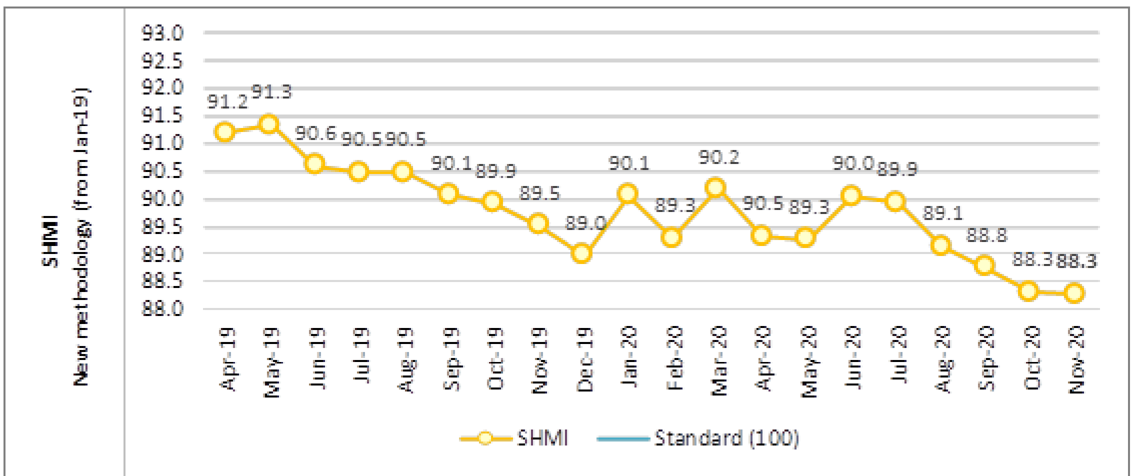
Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
SHMI	Value	0.8791	Jan-Dec 20	0.889	0.703	1.1845	1
	Banding	3 – Lower than expected		2 - As expected	-	-	N/A
% deaths with palliative care code	N/A	33		34	7	61	N/A

*NHS Digital, Published May 2021

SHMI is expressed as a ratio of observed to expected deaths so that a number smaller than ‘1’ represents a better than expected outcome. The Trust’s SHMI for the twelve months to November 2020 is **0.88**, positioned within the ‘lower than expected’ Band 3 category. SHMI is generally available 6/12 in arrears.

Following significant improvements in SHMI, there has now been a sustained period of stability. Our position relative to our national peers currently stands at 13th out of all acute non-specialist trusts (124).

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, provides some assurance that our response to COVID has not generally resulted in a disproportionate increase in deaths within 30 days of discharge.

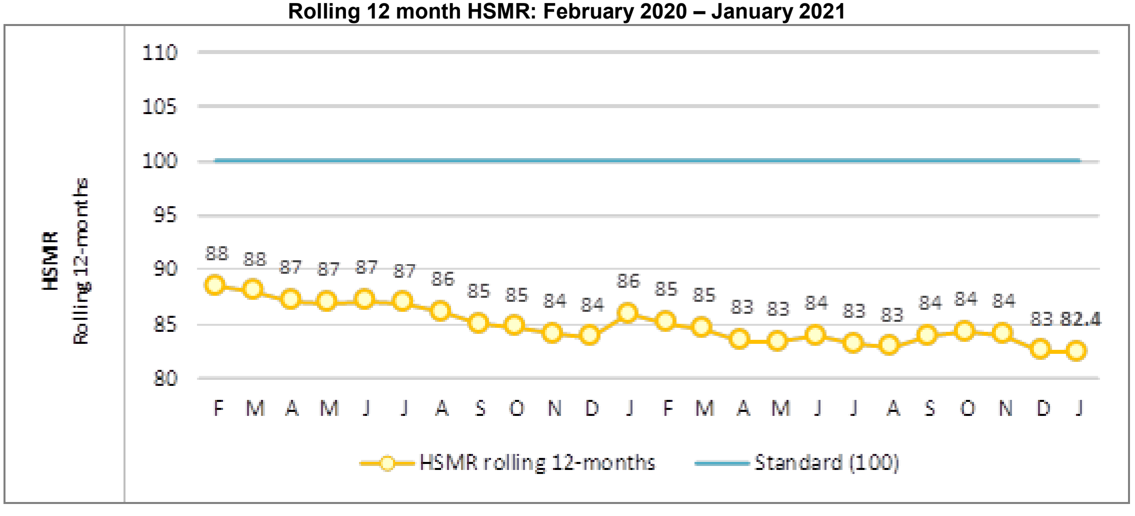


Note: In the chart above the observed to expected deaths have been multiplied by 100 (comparable to HSMR methodology) so that '100' and is comparable to the '1' as described above, where the number of observed deaths exactly matches the number of expected deaths

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 e.g. demographics.

In this metric the observed to expected deaths ratio is multiplied by 100 so that when observed deaths match expected deaths the rate stands at 100 (blue line in the graph below). Again this means that a figure below 100 indicates a lower than expected number of deaths. Performance has remained consistency in the first quartile of Acute Trusts. HSMR is generally available 3 months in arrears and the latest HSMR for the rolling 12 months to January 2021 is **82.4**. It should be noted that mortality data is now taken from CHKS rather than Dr Foster. This resulted in an apparent reduction in HSMR of approximately 10 points which was due to the fact that the CHKS data rebases once every 12 months, whereas Dr Foster rebases monthly. We are currently awaiting the latest CHKS re-base. This does not affect our ability to compare our performance with peers.

Rolling 12 month HSMR: February 2020 – January 2021

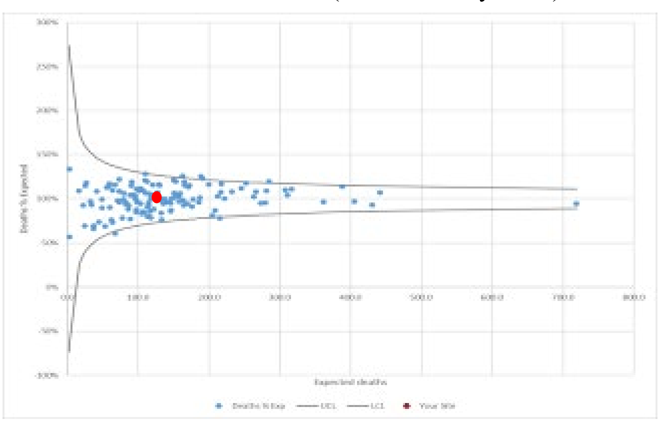


COVID-19

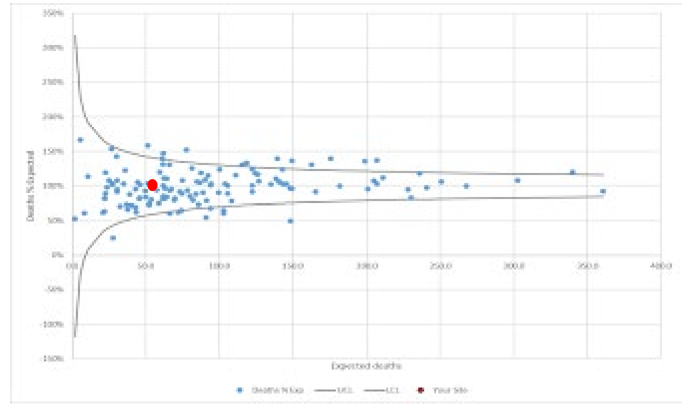
The multi-layered effects of the COVID-19 pandemic make meaningful analysis and comparisons regarding mortality data challenging. For example, there were nearly 200 more inpatient deaths in 2017-18 (the last year with a significant Winter spike in deaths) than in 2020-21, however, during 2020-21 our inpatient numbers and casemix were at times very different. Such facts underline the dangers of comparison.

CHKS, our specialist healthcare intelligence provider, is currently working on a model which will enable us to better understand our COVID mortality and the underlying reasons for mortality variances between hospitals across the country during the pandemic. They produced an interim report which showed that few trusts lie outside the expected range, indicating relative consistency in performance across English, Welsh and NI trusts. The following charts provided by CHKS show the Trust's central position relative to national peers in both the first and second COVID waves.

Covid-19 First Wave (March to May 2020)



Covid-19 Second Wave (October to December 2020)



At this point in time the following observations can be made:

COVID Deaths Pandemic start - 31 Mar-21	Definition
535	Patients who had a positive test or were clinically coded as COVID. These deaths are reported to NHS Digital so underpin our publically reported mortality rates.
493	Patients who had a laboratory-confirmed positive COVID-19 test and died within 28 days of the first positive specimen date. This is the Public Health England national reporting definition.

Additionally:

- Latest death trend has been in line with the local region and generally COVID data has shown clear alignment with the regional and national picture.
- HSMR and SHMI have remained stable & largely unaffected – providing some indication that non-COVID death rates have not significantly increased.
- CHKS latest interim COVID report indicated our performance is in line with our national peers.
- Significant increase in crude mortality April 2020 and January 2021.
- Significant increase in deaths in the January 2021 peak.
- Some changes seen to COVID deaths in the second wave regarding age and gender split, potentially due to new variants of the virus.
- Work remains ongoing to assess the impact of hospital onset nosocomial COVID infections with mortality reviews being prioritised for those patients who sadly went on to die from COVID.

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

Patient Reported Outcome Measures (PROMs)

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

Submissions were low for the 2020/21 as they have been impacted by COVID as a result of cessation of Elective orthopaedic surgery during this period. However, 190 submissions were received. Recovery plans are in place for the elective surgery and the Trust continues to exceed the 70% required against the 2019/20 activity levels. Sitting alongside this is a programme to support patients waiting well.

The Trust considers that this data is as described, as it is based on data submitted by users of the service to the national data collection team. The number of submissions of forms is insufficient to generate outcomes measures within the provisional data.

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

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

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

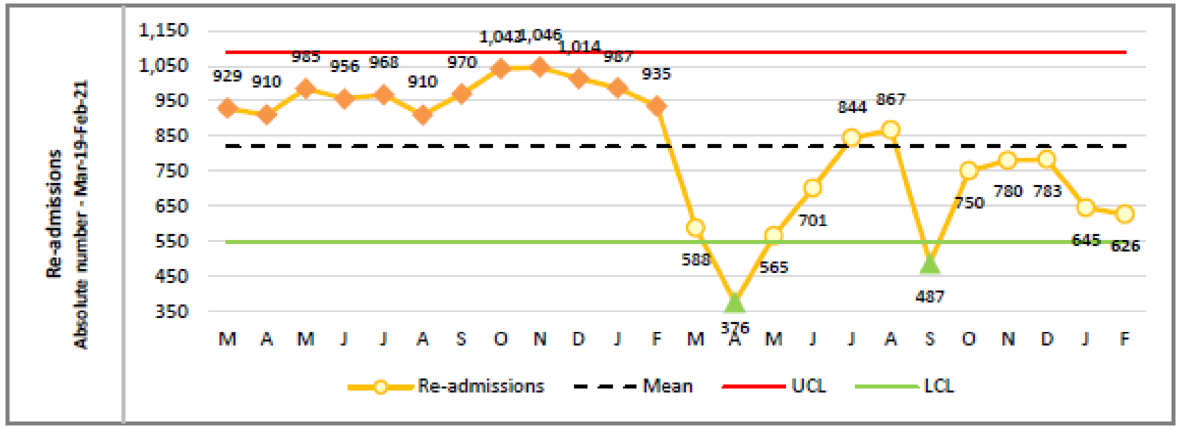
Oxford Score: The score records the views of patients on 12 aspects of their daily living with the total score ranging from 0 (worst) to 48 (best).

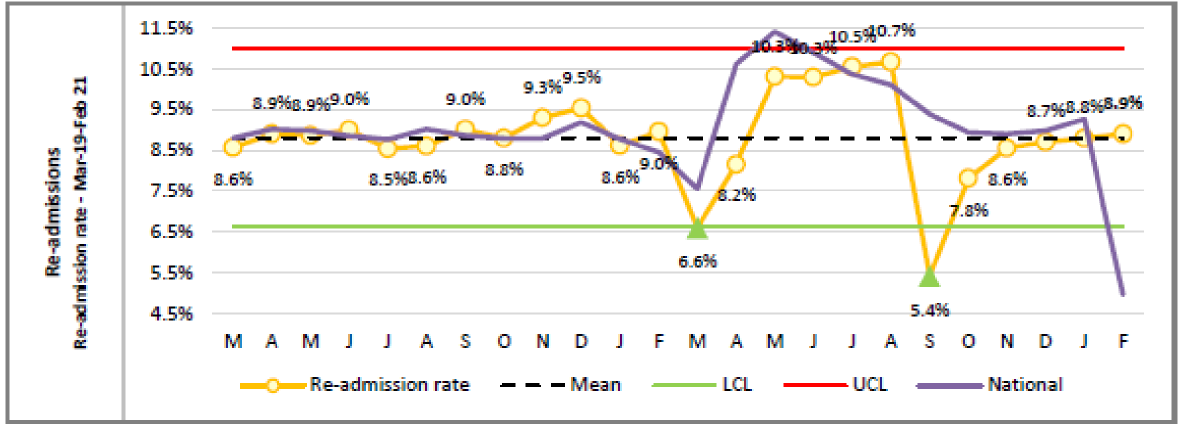
In October 2017 the collection of groin hernia and varicose vein patient reported outcome measures ceased, hence data is not provided.

Emergency readmissions

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

The Trust's re-admission rate has generally been consistent with the national performance. Significant dips in readmissions were seen in March and October 2020, while July and August saw the Trust’s rate rise slightly above the national picture. Recent months have seen performance return to those seen pre-COVID-19, with the Trust tracking just below the national average. The significant changes in overall admissions and the change in case mix during this period make interpretation of this data challenging but the Trust's position will continue to be monitored.

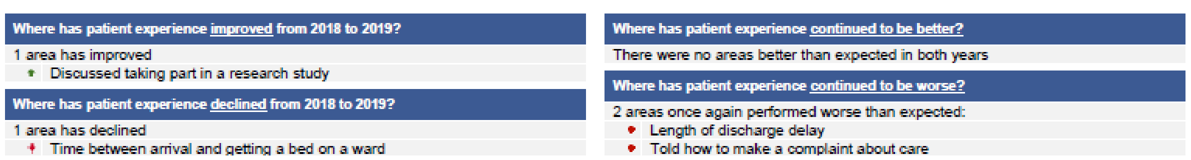




Responsiveness to patient needs

The CQC Adult Inpatient survey asked the views of adults who had stayed overnight as an inpatient in July 2019. 488 patients responded to the ENHT survey, a response rate of 41.4% (compared to 42.4% in the 2018 survey). The results from the 2020 Inpatient Survey have not yet been published.

Inpatients were asked what they thought about different aspects of the care and treatment they received. The survey is divided into 11 sections and a score out of ten allocated for each question and section. Each Trust is assigned a category showing whether their score is 'better', 'about the same' or 'worse' than most other Trusts for each section and question.



*CQC Insight, May 2021

Question	Trust Score	Compared with other Trusts
Were you involved as much as you wanted to be in decisions about your care and treatment?	7.0	Same
Did you find someone on the hospital staff to talk to about your worries and fears?	4.9	Same
Were you given enough privacy when discussing your condition or treatment?	9.4	Same
Did a member of staff tell you about medication side effects to watch for when you went home?	3.7	Same
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital	7.1	Same

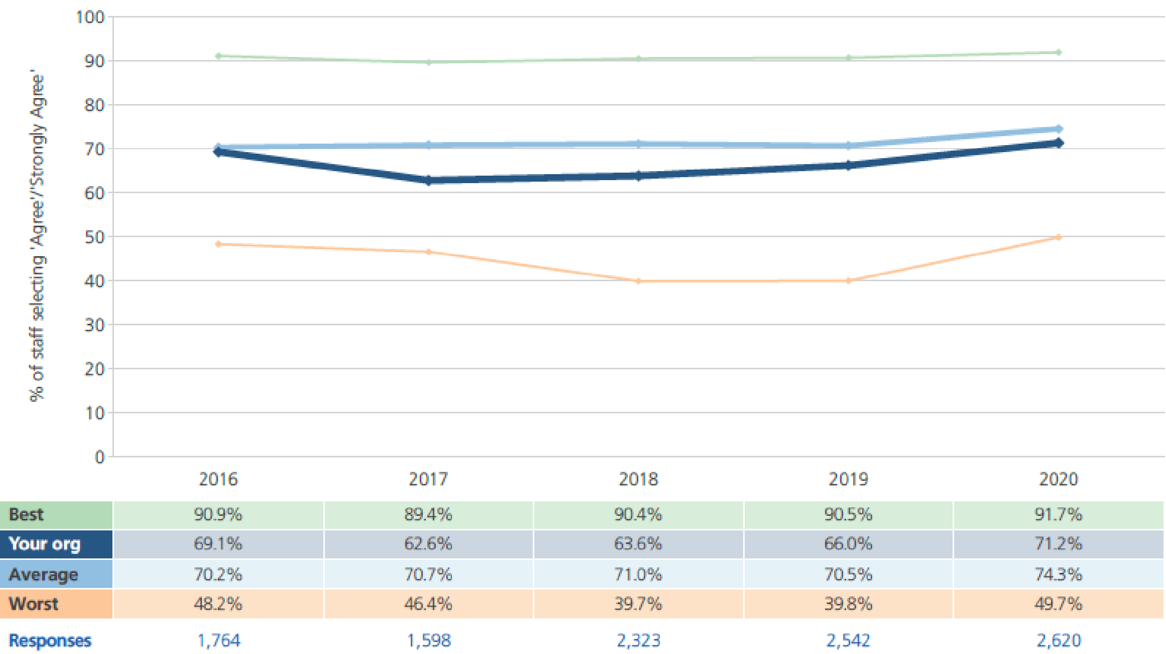
The Trust considers that this data is as described, and it is based on data submitted directly by patients to the national survey. The Trust continues to take action to improve patient and carer experience and this is detailed within the divisional patient experience action plans submitted to, and monitored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

Staff recommending the Trust

Indicator	Measure	Trust Result	Time Period	Trust previous result	Best performing Trust	Worst performing Trust	National average
Recommend the Trust	Staff	71.2%	2020/21 Q2	66%	91.7%	49.7%	74.3%

2646 staff completed the NHS national staff survey in 2020 representing a 44% response rate. Of those surveyed, 71.2% of staff state they would recommend the organisation as a place to receive treatment. This represents an improving picture over the last three years however remains below the national average.

2020 NHS Staff Survey Results > Question results > Your organisation > Q18d > If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2016	2017	2018	2019	2020
Best	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	69.1%	62.6%	63.6%	66.0%	71.2%
Average	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	48.2%	46.4%	39.7%	39.8%	49.7%
Responses	1,764	1,598	2,323	2,542	2,620

Throughout the survey there are again mixed scores although the year on year trends remains wholly positive and most scores are improving. When benchmarked by sector, we are however more than 0.1% below average for, 3 themes, namely; equality, diversity and inclusion; safe environment - bullying and harassment and safety culture.

Going forward it is now our priority to increase our focus on the culture of the organisation to improve staff experience in the areas listed above.

Patients recommending the Trust

Detailed information on this indicator is given in section 4.1.

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

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

*Maternity indicator is a measure relating to birth experiences only

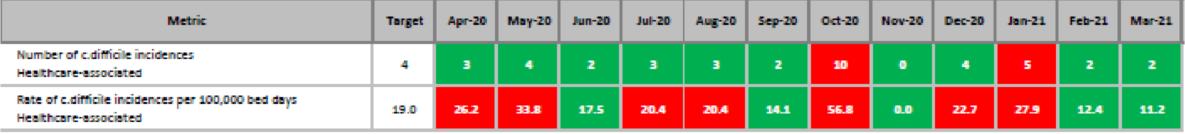
The Trust considers that this data is as described, as it is based on data submitted directly by patients to the national surveys programme. The Trust has taken the following actions to improve this score, and so the quality of its services, by reviewing the survey responses and producing initiatives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

Venous Thromboembolism (VTE)

The national bench making data collection has been paused and therefore is not currently available.

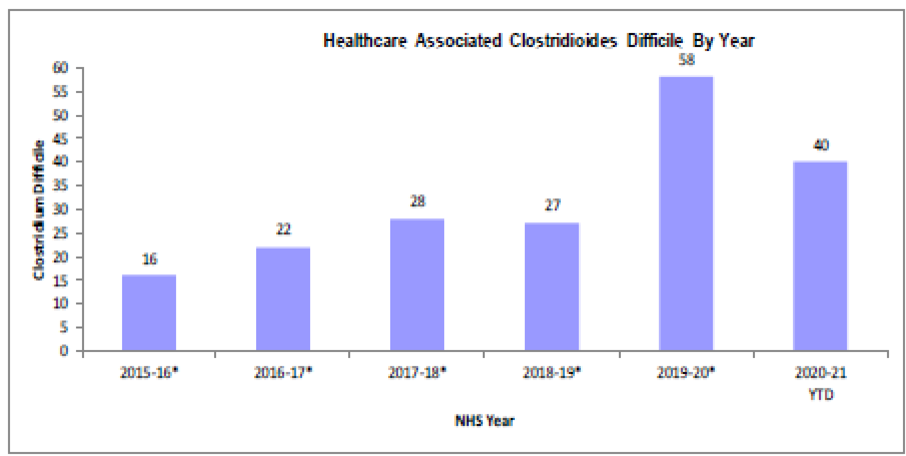
Clostridium difficile

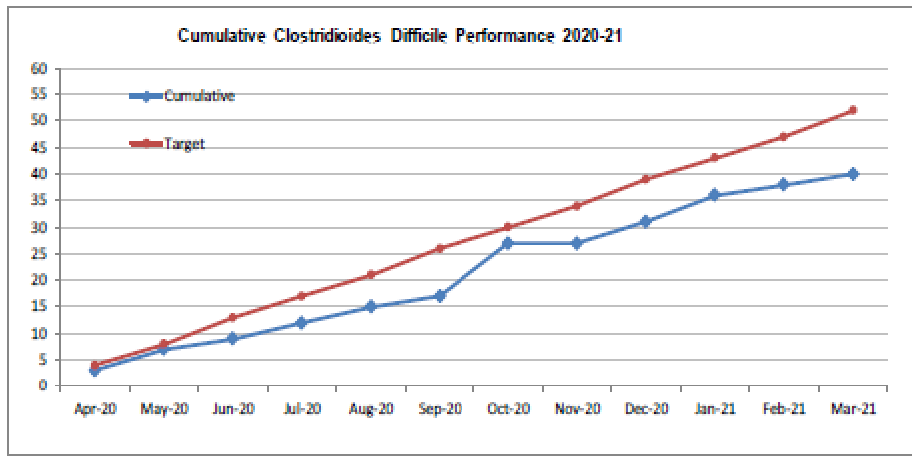
This indicator measures the number of hospital acquired Clostridium difficile infections per 100,000 bed days.



Metric	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of c.difficile incidences Healthcare-associated	4	3	4	2	3	3	2	10	0	4	5	2	2
Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	26.2	33.8	17.5	20.4	20.4	14.1	56.8	0.0	22.7	27.9	12.4	11.2

In 2020/21 the trust reported 40 cases of *c.difficile* against a planned ceiling of 52 cases.





All cases are usually reviewed by a joint Trust & CCG panel to ensure any learning is identified and appropriate actions are put in place, and to agree cases that should be exempt from financial sanctions. However, presentation of the remaining cases has been postponed due to the COVID pandemic. The Trust has a continued focus on Infection Prevention and Control; please refer to MRSA section for further details.

Patient safety incidents

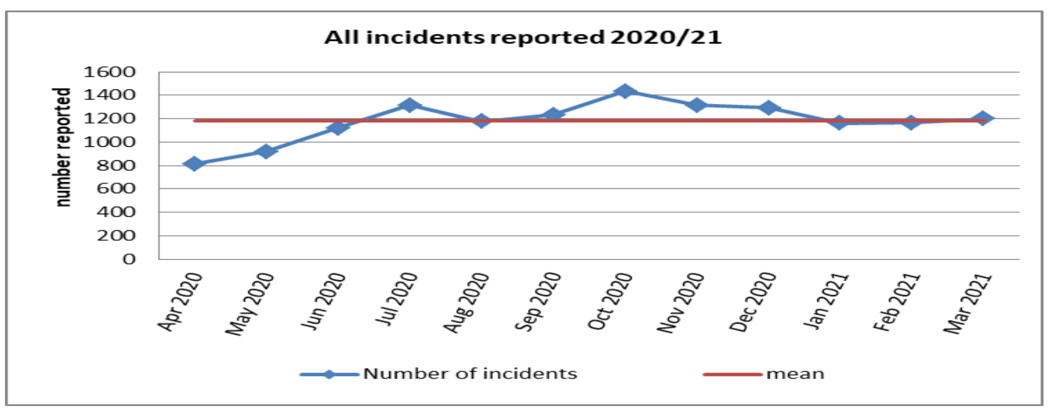
Incidents are reported on the electronic reporting system, Datix. The patient safety incident data is uploaded into a national system where incident reporting patterns, types of incidents can be analysed. The rate of incidents is the number reported per 1,000 bed days.

Between 1 April 2020 – 31 March 2021 the Trust reported a total of 11,876 patient safety incidents. This can be seen in the table.

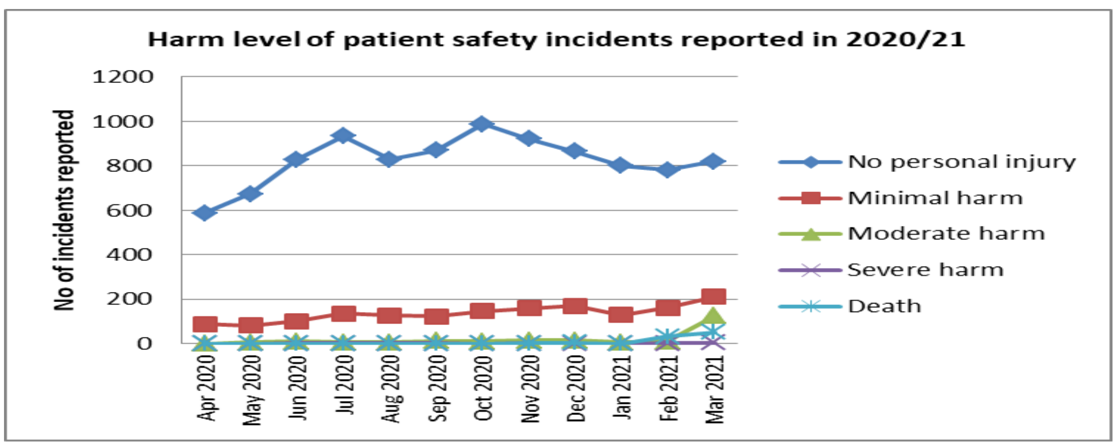
The National Patient Safety Reporting and Learning System (NRLS) noted a decrease in the numbers of incidents reported to the NRLS compared to the same period in the previous two years.

This period of April 2020 – June 2020 has been recognised as a key stage of the NHS responding to the COVID-19 pandemic which may have had an impact on reporting to the NRLS. There was an accompanying major shift in service provision during this time which could have led to limited staff capacity and lower patient demand for non-COVID-19 services. This was reflected locally as our incident reporting at the beginning of the pandemic in March 2020 noted a statistically significant decrease in reporting of all incidents, with April 2020 showing the lowest with 677 patient safety incidents reported for the month.

Through the second wave we have seen less of a decline in incident reporting, with a slight decrease to 937 reported in January 2021, with the Trust average stable at 989 patient safety incidents per month. However there remains local variation in reporting trends within some categories e.g. medication reporting, moderate harms and some clinical areas e.g. critical care.



Between 1 April 2020 and 31 March 2021, 97% of patient safety incidents (11,531) reported resulted in no or minimum harm. During February and March 2021 all of the definite and probable nosocomial COVID-19 infections were inputted onto Datix therefore during those 2 months there was an unusually high number of incidents recorded as resulting in moderate harm or above. Those incidents are currently being reviewed through the Trust nosocomial COVID-19 investigation process with harm levels being reviewed and amended as necessary.



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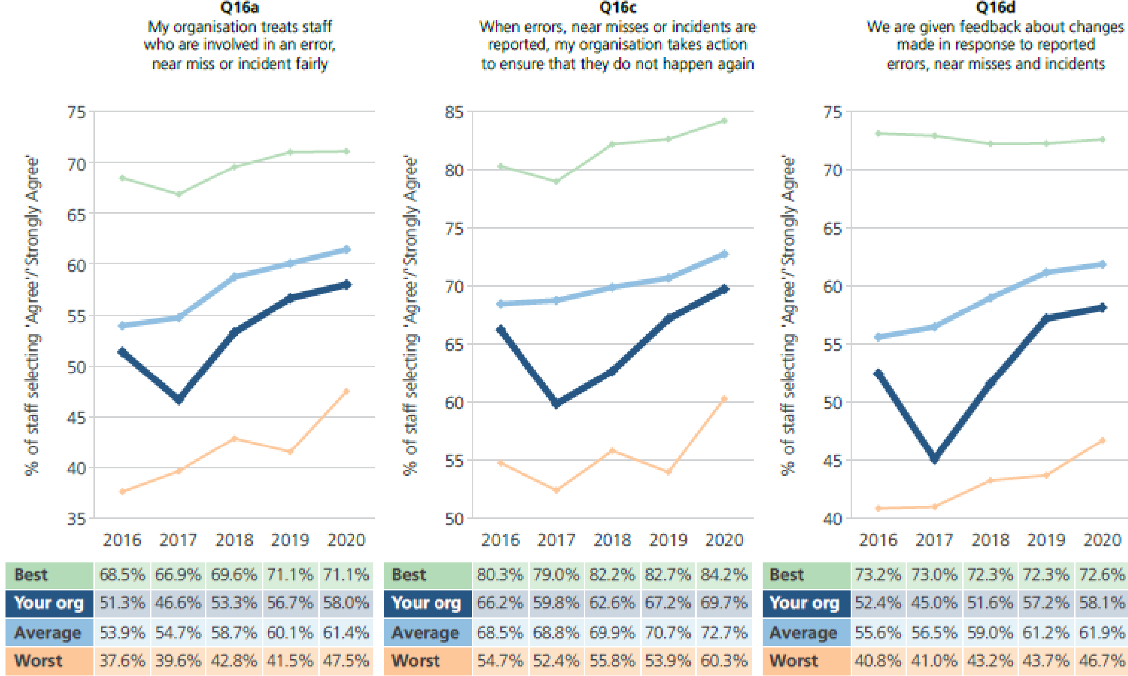
The next national incident reporting publication is now due September 2021.

The staff survey 2020 results demonstrate continuous improvement in key cultural areas relating to incident management as shown in the series of graphs below. This remains a priority for the Trust through continued, combined efforts of strengthen the Trust's speaking up framework, developing more analytical and user friendly Datix system.



Q16a

	2016	2017	2018	2019	2020
Best	68.5%	66.9%	69.6%	71.1%	71.1%
Your org	51.3%	46.6%	53.3%	56.7%	58.0%
Average	53.9%	54.7%	58.7%	60.1%	61.4%
Worst	37.6%	39.6%	42.8%	41.5%	47.5%

Q16c

	2016	2017	2018	2019	2020
Best	80.3%	79.0%	82.2%	82.7%	84.2%
Your org	66.2%	59.8%	62.6%	67.2%	69.7%
Average	68.5%	68.8%	69.9%	70.7%	72.7%
Worst	54.7%	52.4%	55.8%	53.9%	60.3%

Q16d

	2016	2017	2018	2019	2020
Best	73.2%	73.0%	72.3%	72.3%	72.6%
Your org	52.4%	45.0%	51.6%	57.2%	58.1%
Average	55.6%	56.5%	59.0%	61.2%	61.9%
Worst	40.8%	41.0%	43.2%	43.7%	46.7%

Part 3

3.1 Review against selected metrics

Patient safety

Indicator	18/19	19/20	20/21	Aim (20/21)
Never events	6	3	**3**	0
MRSA Bacteraemia (post 48 hours)	2	6	**0**	0
Number of inpatient falls	845	816	**652**	600
Number of inpatient falls resulting in serious harm	12	2	**11**	2
Number of preventable hospital acquired pressure ulcers	101	151 (0.62 PU per 1000 bed days) 2 cat 4	**235** **1 cat 4**	0.49 PU per 1000 bed days Zero Cat 4

Never events

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

	2017/18	2018/19	2019/20	2020/21
Wrong site surgery	1	4	1	2
Retained object	3	0	1	0
NG Feeding	1	1	0	0
Blood transfusion	1	0	0	0
Oxygen tubing to air	N/A	1	1	1
Trust	**6**	**6**	**3**	**3**

Previous to September it had been 340 days since the last reported never event.

29/09/2020 Unintentional connection to Wrong Medical gas (minimum harm)
29/10/2020 Wrong site surgery (minimum harm)
22/12/2020 Wrong site Surgery (minimum harm)

Nationally 298 never events were reported from 01/04/2021 – 31/01/2021, with the highest reporting month being October 2020.

Learning identified changes in staffing led to poor compliance with medical gas safety checks to reliably remove air outlet equipment form bed spaces. This has led to pharmacy led improvements to improve safety checks and communicate learning from this incident.

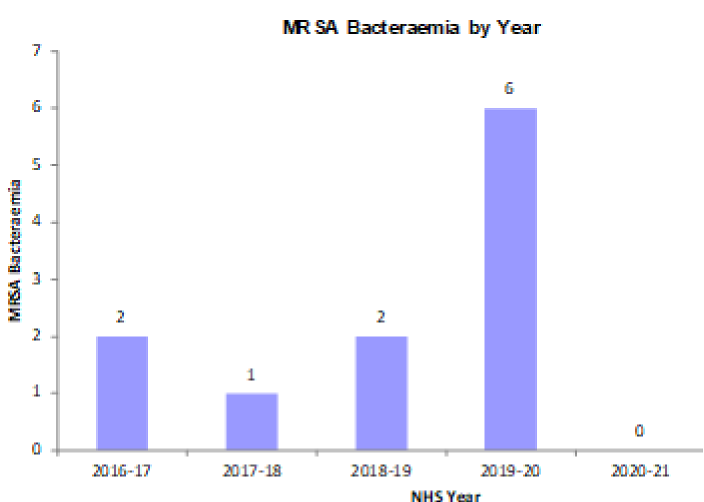
The Trust has established a 'Safer Surgery Collaborative' where clinical teams are supported to safely adopt local plans National Safety Standard for Invasive Procedures.

Ongoing multidisciplinary quality improvement efforts include:

- The Trust policy now reflects the National Safety Standard Invasive Procedure Policy (NatSSIP)
- There are ongoing plans to develop a 12 month rolling programme for teams undertaking invasive procedures to access, where they can consider and map 'Human Factors Contributory Factors' across their local invasive procedures. Plans for team videoing and learning materials are underway.

MRSA Bacteraemia (post 48 hours)

MRSA bacteraemias are classified as Hospital Onset if the sample is taken later than the day following admission. The Trust achieved the target of zero MRSA bacteraemias in 2020/21 for the first time since 2015/16. Perhaps as a result of ongoing enhanced IPC measures in place across the Trust during the pandemic.



The 2020/21 pandemic has influenced a fast changing, extreme national incident response to all Infection and Prevention Control (IPC) services.

From the 27 January 2020 the Trust started managing COVID-19 as a high level priority with daily incident response meetings. This was adopted through a strong clinical and executive leadership approach in conjunction with a structured daily national emergency planning response. The IPC service responded and developed an onsite seven day service to support the Trust at this time.

Key priorities have included:

- An infection and prevention control communication and training programme to support staff understanding and awareness of COVID risks and management.
- Supporting training and staff within local care homes to adopt new IPC standards.
- Introducing and embedding new national PPE requirements.
- Supporting staff undertake individual and local risk assessment across clinical and non-clinical workforce.
- Supporting the introduction of COVID swabbing pod sites for the community and new COVID swabbing regimes for patients while they stayed in hospital.
- Introducing a new IPC standard screening tool to enable staff to assess risk of patients presenting to services.
- Supporting the development and embedding of family and carer risk assessments when required to visit loved ones during the pandemic management.

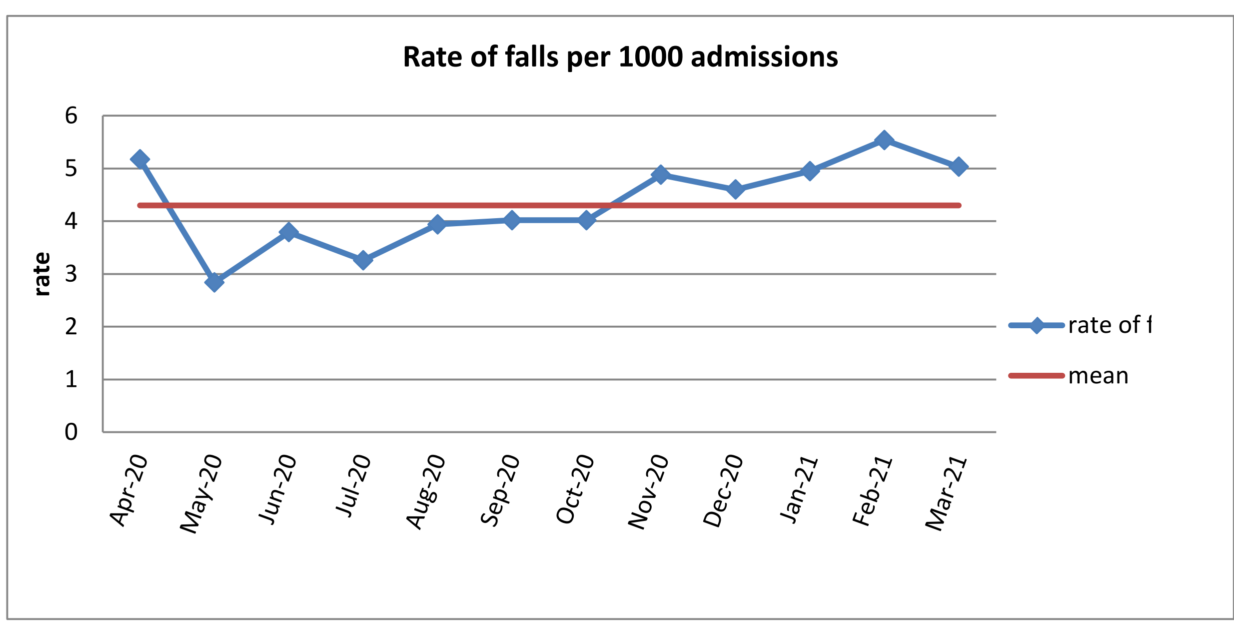
Inpatient falls

During 2020/21 there were 652 inpatient falls. This represents a 12.72% reduction when compared to 2019/20. This also meets the reduction target of fewer than 832 set for the year 2019/20. Last year has been an extra ordinary year as we have experienced a global crisis due to the pandemic. Despite of this, we have continuously meets the reduction target that was set same in the previous year.

Financial Year	Number of Inpatient Falls	Reduction year on	% of Reduction	Number of Falls with Harms	Reduction in harm
2018-2019	806	-	-	21	
2019-2020	747	59	7.32% ⇩	14	66% ⇩
2020-2021	652	95	12.72 ⇩	11	21.4% ⇩

The Trust has sustained an average falls rate of 4.3 per 1000 bed days which is lower than the national average of 6.6 (NHSI).

Rate of Falls per 1000 bed day



Number of inpatient falls resulting in serious harm
Learning from incidents.

Patients admitted to the hospital are assessed for their risk of falling within 4 hours of admission. Any identified risk should have an action plan in place to minimise these risks. The Trust has a number of measures in place aimed at minimising the risk of falling. These include use of bed rails, low rise beds, enhanced care team support and Baywatch.

Despite these measures, patient falls resulting in serious harm have occurred and remain a priority for the Trust. The level of harm associated with falls has progressively reduced from previous years 2019/2018 and learning identified from recent serious incidents are shared with the wider clinical teams. During the pandemic we have experienced new environmental challenges associated with risk of isolation required to deliver infection, prevention and control quality care, combined with challenges with reduction in safer staffing numbers at times. We continue to drive quality improvement initiatives relating to improving compliance with the Trust falls assessment and timely escalation and referral to the wider multi-disciplinary team.

Harm Free Care Priority AIM:

Quality Improvement work for falls this year is focused on the aim of further reducing Trust-wide falls by 2 % by March 2022. The overarching goal will be to improve communication and involve service users in co-designing the falls improvement work described below:

- **8A ward QIP project**
- **Priority Theme 1:** 8A has high incidences of fall for their alcohol withdrawal patients. One of the issues highlighted is that patients are not getting the right dosage of medication at the right time.
  Work Underway: Project will focus on developing an alcohol withdrawal proforma so patient gets the medication with the right dosage at the right time. Ideas will be tested and the prediction is that a new proforma will ensure that patients will have quicker turn arounds of symptoms, falls risk will be lowered, and length of stay will be shorter.
- **Assessment Areas (AMU 1, AMU 2, SSU):**
- **Priority Theme 2:** Assessment areas have a quick turnaround of patients, though risk assessments are mostly completed, actions and mitigations are often overlooked.
- **Work Underway**: Quality Improvement work in these areas will be focused on timely escalation and mitigation following the risks identified on the falls risk assessment, testing of new risk of falling – Falls Prevention Plan.
- **Baywatch**
- **Priority Theme 4**: Compliance with Baywatch has been poor since the pandemic which gives negative impact in managing high risk falls patients.
- **Work Underway:** To re-launch Baywatch High falls incidence areas, then Trust-wide, focusing on new staff and ensuring that guidelines are adhered to by offering real time/bespoke falls education training.

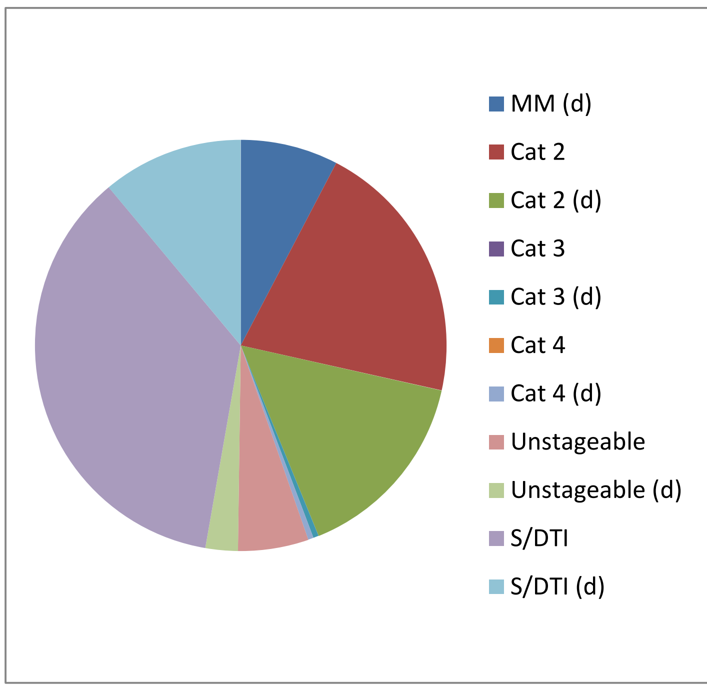
Inpatient pressure ulcers

The Trust is committed to minimising harm caused to patients whilst in hospital, particularly through the prevention of Hospital-Acquired Pressure Ulcers (HAPU) of all Categories.

In compliance with the new NHSI PU recommendations the terms Unavoidable and Avoidable are no longer used in reporting categories of pressure ulcers however, all pressures ulcers undergo a 'root cause analysis' review to capture learning. The Trust is fully compliant with the 2018 NHS Improvement measuring and reporting of PU framework including the recording and reporting of Moisture Associated Skin Damage (MASD) of all types.

	2018/19	2019/20	2020/21
Number of patients with reportable PU	101	151	235

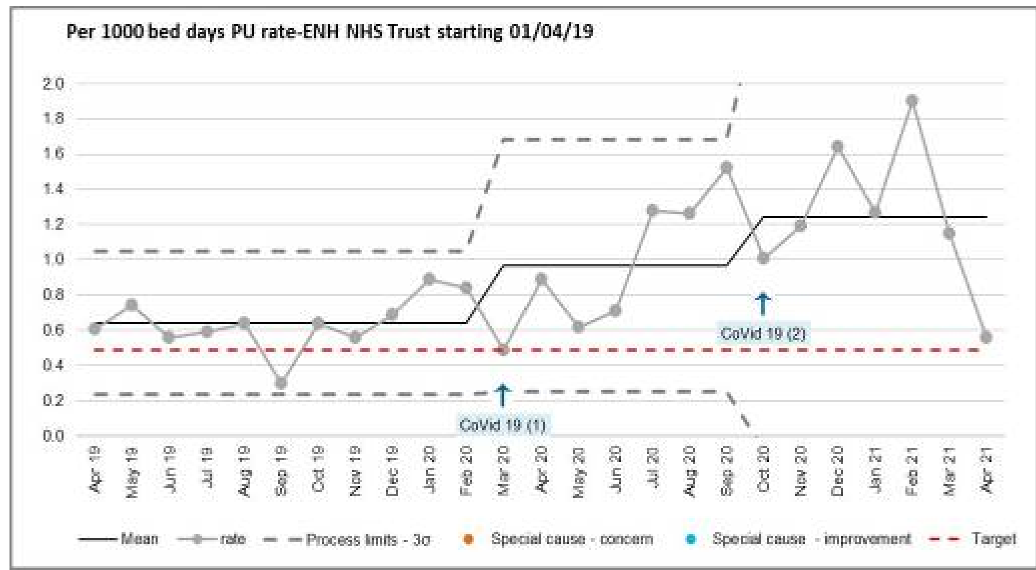
The Trust has report 235 new pressure ulcers since April 2020, the most prevalent category has been 'Category 2' tissue damage accounting for 36% (85) of total ulcers, 42% of these were associated with use of medical devise (36). Categories and prevalence can be seen in diagram below.



Category	Total PU
MM (d)	18
Cat 2	49
Cat 2 (d)	36
Cat 3	0
Cat 3 (d)	1
Cat 4	0
Cat 4 (d)	1
Unstageable	13
Unstageable (d)	6
S/DTI	85
S/DTI (d)	26
Total:	235

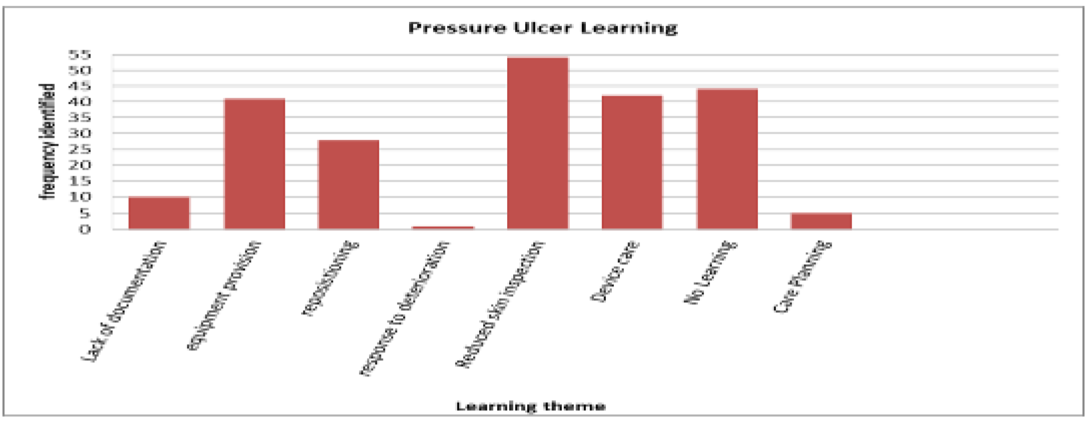
**MM = moisture membrane; DTI = deep tissue injury; (d)= medical device related*

This year we have reported 235 HAPU for 2020-2021 this is an increase of 55% from 2019 data it is likely this is partly related to the COVID 19 pandemic with 30% of PU reported (n:71/235) directly affecting patients diagnosed as COVID positive. This can be seen in the diagram below, where time series data demonstrates rate of ulcer per 1000 bed days.



Every hospital acquired Pressure Ulcer is investigated by a Tissue Viability Nurse. This is to enable identification of gaps in care so that learning can be identified and improvements delivered. These can be seen in the diagram below.

Every HAPU identified is reported via Datix by the ward staff and validated by a Tissue Viability Clinical Nurse Specialist (TV CNS) to ensure accurate reporting and the delivery of evidenced based wound care. A Root Cause Analysis (RCA) is conducted at time of validation and themes identified are fed back to ward staff. Overall themes are reported to the Trust executive team and CCG via the monthly HAPU report. Category 4 HAPU are discussed at serious incident review panel to determine if a serious incident investigation is required. Themes this year include issues around Skin Inspection (23%), Medical Device care (18%) and equipment provision (17%). Good care could be demonstrated by nursing documentation in a further 18% and therefore no learning could be determined for these patients.



Harm Free care priority AIM

A priority is to continue to provide an infrastructure that supports recognition of clinical accurate risk assessment and early escalation to prevent the harm from Hospital Acquired skin damage occurring. Waterlow Risk assessments are audited monthly by our Clinical Nurse Advisor as part of our beds and mattress contract these audits have shown that on average 95% of patients are assessed for their risk of pressure ulceration and of this over 65% are either at High risk or Very high risk.

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

1. To reduce medical device related pressure within critical care.
2. To improved repositioning care on general wards in collaboration with the clinical practice team.
3. To improve quality of SSKIN care documentation to facilitate delivery of care across the Trust.

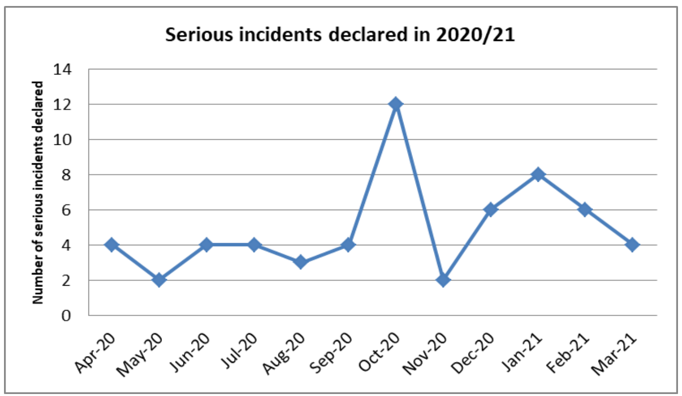
Serious incidents

When an incident occurs that might fulfil the criteria for a serious incident an initial investigation is undertaken and any immediate safety actions are identified and put into place. A short rapid incident review is completed by the relevant clinical team and discussed at the Serious Incident Review Panel that meets twice weekly, chaired by either the Chief Nurse or Medical Director. The panel consider whether any further investigation is required and, if so, what level of investigation. If the incident meets the definition as set out in the national Serious Incident Framework then a serious incident is declared and the investigation undertaken by the Patient Safety team with input from subject matter experts and relevant clinicians.

The Trust reported 59 serious incidents during the year across a wide range of categories as shown in the table below.

Category	Number	Category	Number
Care related incidents	14	Treatment incidents	3
Capacity incidents	5	Cancellations related incidents	2
Safeguarding incidents	5	Falls	2
VTE incidents	5	Infection control incidents	2
Diagnosis incidents	4	Anaesthesia related incidents	1
Resuscitation related incidents	4	Operation/theatre related incidents	1
Admissions related incidents	3	Pathology incidents	1
Discharge related incidents	3	Violence and aggression incidents	1
Obstetric incidents	3		

The graph below shows the number of serious incidents declared by month from 1 April 2020 – 31 March 2021.



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

- Review and update policies and guidance in accordance with any new evidence base guidance publications.
- Introduction of new additional mobile tablet devices with appropriate programme to ensure photographs can be taken of skin integrity and stored centrally as part of patient's medical records.
- Patient booking process under review to drive changes from a paper-based service to electronic with failsafe in place.
- PPCI pathway amended to include clear actions to be taken by nursing and medical staff if any concerns are highlighted pre-discharge.
- Review and design of discharge passport through adoption of QI testing tools.
- Data Quality report established for patients with no access plan.
- The focus for 2021/22 is around implementing immediate safety actions and review of SI processes to ensure a prompt investigation with appropriate learning implemented in a timely manner. We are introducing round table discussions into the SI investigation process to ensure a collaborative approach with appropriate subject matter experts from the outset and regular points along the investigation.

Clinical effectiveness

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

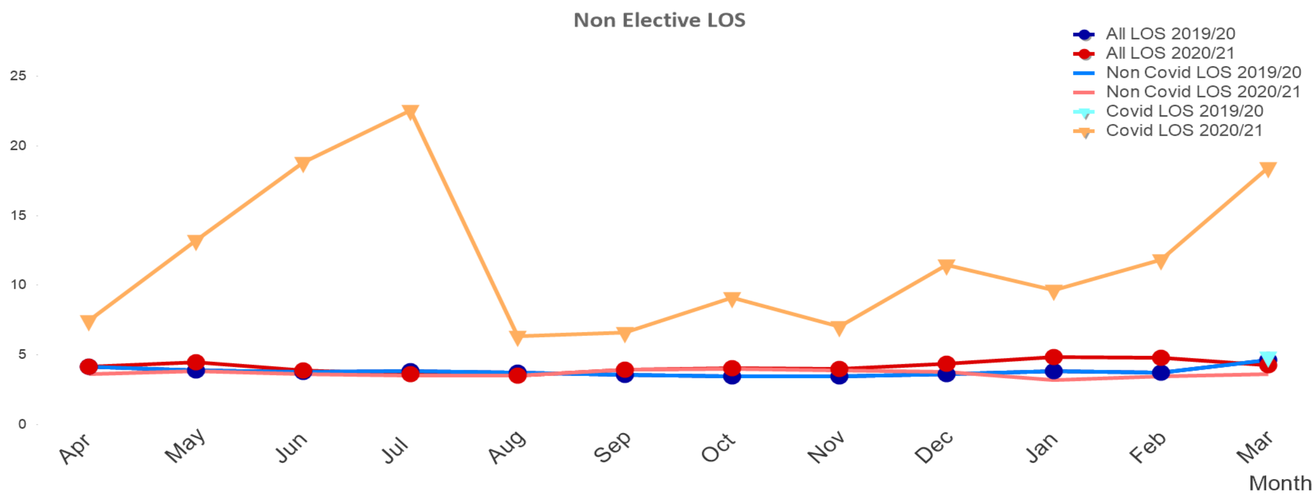
Length of stay (LOS)

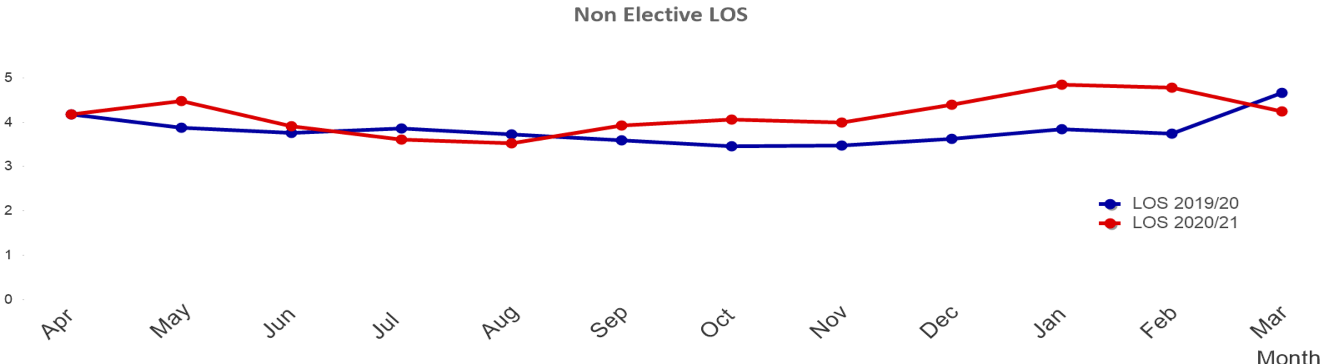
Minimising the time that a person spends in hospital is better for the patient, for the next patient currently waiting in the Emergency Department or Assessment unit and is an indicator of the efficiency and effectiveness of the organisation.

The length of the stay for both COVID and non-COVID patients is shown below demonstrating an improvement in non- COVID patients compared to the previous year with the exception of quarter 3 when the Trust experienced the impact of wave 2. The acuity of patients during this period would have been higher as other pathways and admission avoidance were in place to keep patients away from the acute Trust as well as patients not presenting either to primary care or to the Emergency Department due to the national response and lockdown. Additional support for discharge was in place including COVID virtual ward, additional community provision and system wide support during COVID. All of which have enabled improved patient flow.

The charts below show:

- All LOS and non COVID LOS
- All LOS with Covid/Non Covid LOS Splits
- Non-elective LOS





Stroke – thrombolysis rate

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

Metric	2020-21 Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
% of all stroke patients who receive thrombolysis	11%	14.5%	18.8%	11.4%	15.5%	9.6%	5.3%	5.7%	23.2%	11.0%	11.3%	10.6%	5.7%

A task and finish group was established in September 2020 for the thrombolysis pathway to review improvement plans for recovery of performance. This has supported an improved performance with the exception of March 2021 when the thrombolysed rate dropped to 5.7%. A review identified that this related to 4 patients of which 3 were clinical need – the patients required other treatment before thrombolysis could be safely administrated.

In light of the changes to all services due to COVID-19 both ambulance and ED triage and scanning protocols added some delays. Internal analysis of each case is to be carried out for future learning to be carried forward and to achieve the standard going forward.

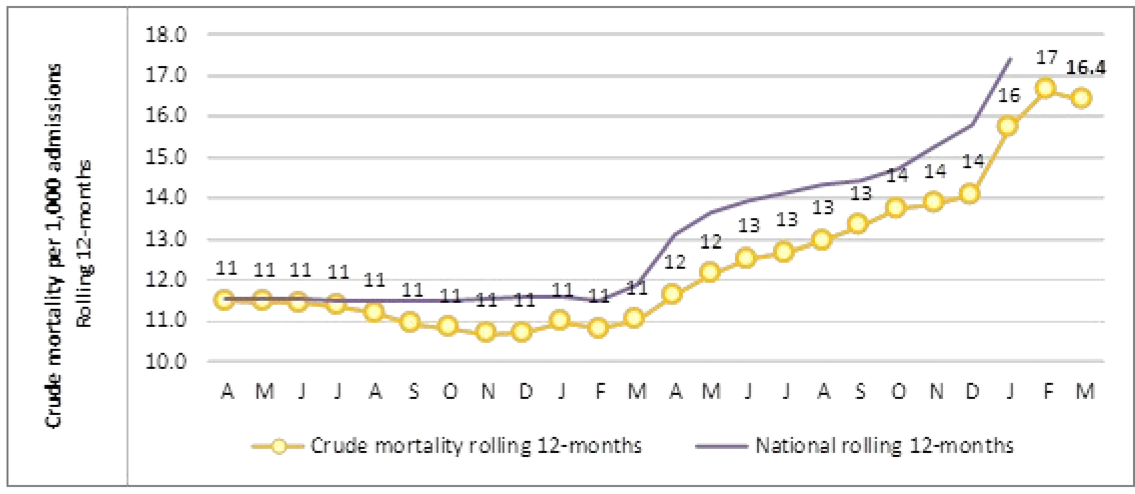
Crude mortality

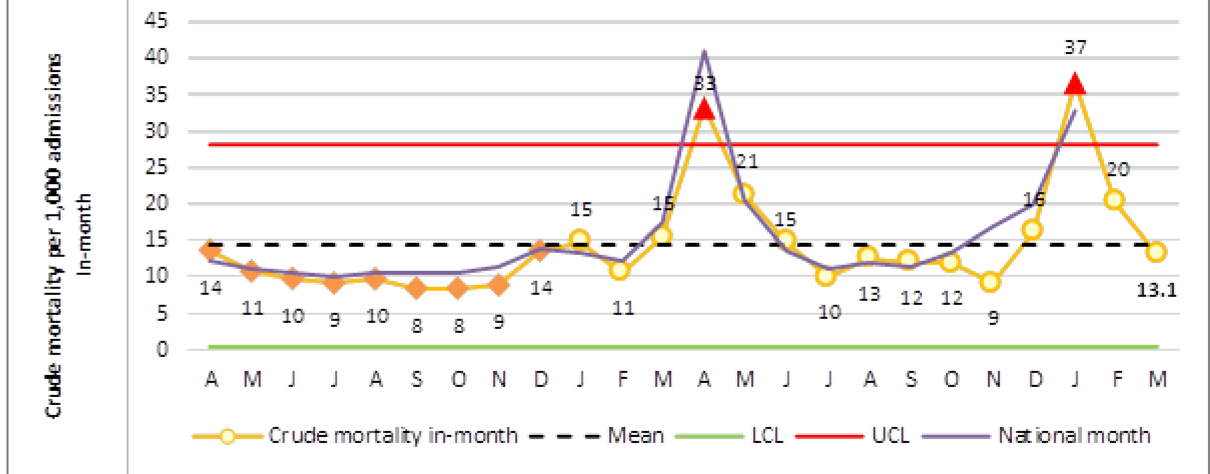
Crude mortality is based upon the number of patients who die in the Trust whilst an inpatient. It is measured per 1,000 admissions.

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

The general improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc. together with our continued drive to improve the quality of our coding.

The crude mortality has steadily improved over recent years. In the second half of 2019 our rolling 12 month crude mortality rate was consistently better than the national average. While our in-month rate increased significantly in April 2020 at the start of the peak COVID period, this steadily decreased returning to levels similar to pre-COVID period, until January 2021, when it peaked again. While recent months have seen a steady increase in our rolling 12 month rate, it has remained below the national rate for the corresponding month.





Patient experiences

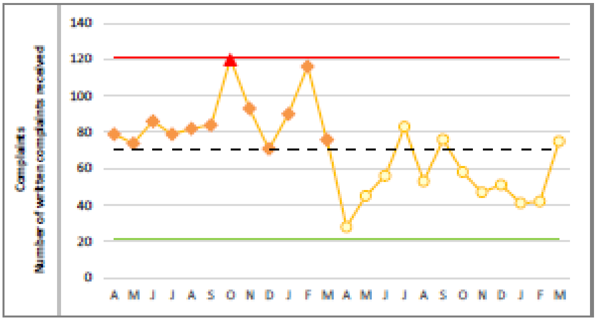
Indicator	18/19	19/20	20/21	Aim (20/21)
Number of written complaints	1036	1058	656	<previous year
Number of PALS concerns	4502	3693	2935	N/A
Number of PALS concerns closed within 5 days / %	3419 78%	2607 70.5%	2931 79.2%	80%
Complaints per level of activity - per 100 bed days	1.2-2.2	1.8	0.4	<1.9
Complaints – response within agreed timeframe	54%~	82%	89%	≥80%*

Source: Datix internal system & information held by local teams

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

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

In 2020/21, 656 formal complaints were received across all services (from 1058 in 2019/20) within the Trust, and 2930 informal PALS (from 3693 PALS 2019/20) concerns were received. The reduction is reflective of the pandemic.



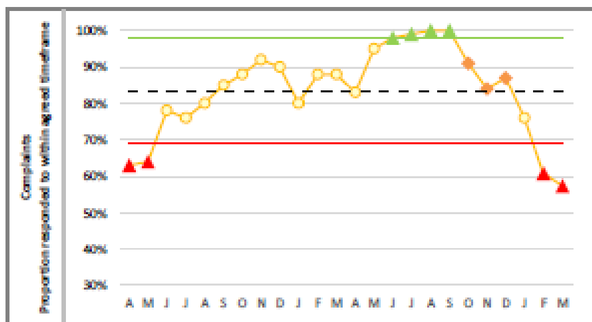
The monthly reporting pattern of the written complaints received is shown below. With the exception of July, September and March, approximately 40-50 complaints were received each month over the last year.

	Metric	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Complaints	Number of written complaints received	92	28	45	56	83	53	76	58	47	51	41	42	75
	Rate of written complaints received	1.9	0.5	0.7	0.9	1.3	0.8	1.2	0.9	0.7	0.8	0.6	0.6	1.1
	Proportion of complaints acknowledged within 3 working days	75%	100%	100%	82%	100%	100%	100%	100%	100%	100%	96%	86%	95%
	Proportion of complaints responded to within agreed timeframe	80%	83%	95%	98%	99%	100%	100%	91%	84%	87%	76%	61%	57%

The Trust aims to respond to at least 80% of formal complaints within an agreed timeframe. Current performance of responding to the patients and families is not within the expectations of the service and steps are being taken to improve this.

The Trust recognises that there were challenges in ensuring that comprehensive investigations are conducted and responded to in a timely manner and the availability of the clinical teams to support this whilst supporting the operational challenges. To address this, the complaints team are developing stronger relationships with staff across the trust to

support and review the processes. During 2021/22 we will be reviewing the complaints service in line with the new good practice standards recently published by the PHSO.



The Patient Advice Liaison Service (PALS) and the Complaint Teams received several contacts in relation to the management of appointments during the COVID Pandemic and have linked with the operations teams to be able to respond to patients.

PALS have supported relatives who are not allowed to visit patients during the pandemic by contacting the wards during busy periods and relaying messages.

Formal complaints were raised by patients in relation to the way staff communicated with them during their admission as inpatients and several patients or their relatives raised concerns regarding the quality of care provided and access to treatment. Actions have been taken locally to address these concerns including establishing a Discharge Improvement Programme.

The Trust has received complaints throughout the COVID Pandemic raised by women, their partners or MP's on maternity restrictions. During the first lockdown the Government guidance was followed that recommended women attend the maternity scans on their own. However, exceptions were made for women with a known mental health condition or if they had a carer. This was reviewed and provision was made when it was safe to do so to allow women the support of a partner during their scans. Throughout the pandemic birthing partners were still able to support women in active labour. All information in relation to the restrictions was made available on the Trust website and updated regularly. The Trust has continued to closely monitor and update the guidelines to ensure the safety of the women and their babies remains the priority. This also related to visitors in other areas where in exceptional circumstances (e.g. a vulnerable patient, end of life and dementia) and following a risk assessment a visit was facilitated.

National Cancer Survey

The Trust opted to participate in the national cancer survey, but this has not been published yet.

Staff

The following table represents some indicators relating to staff.

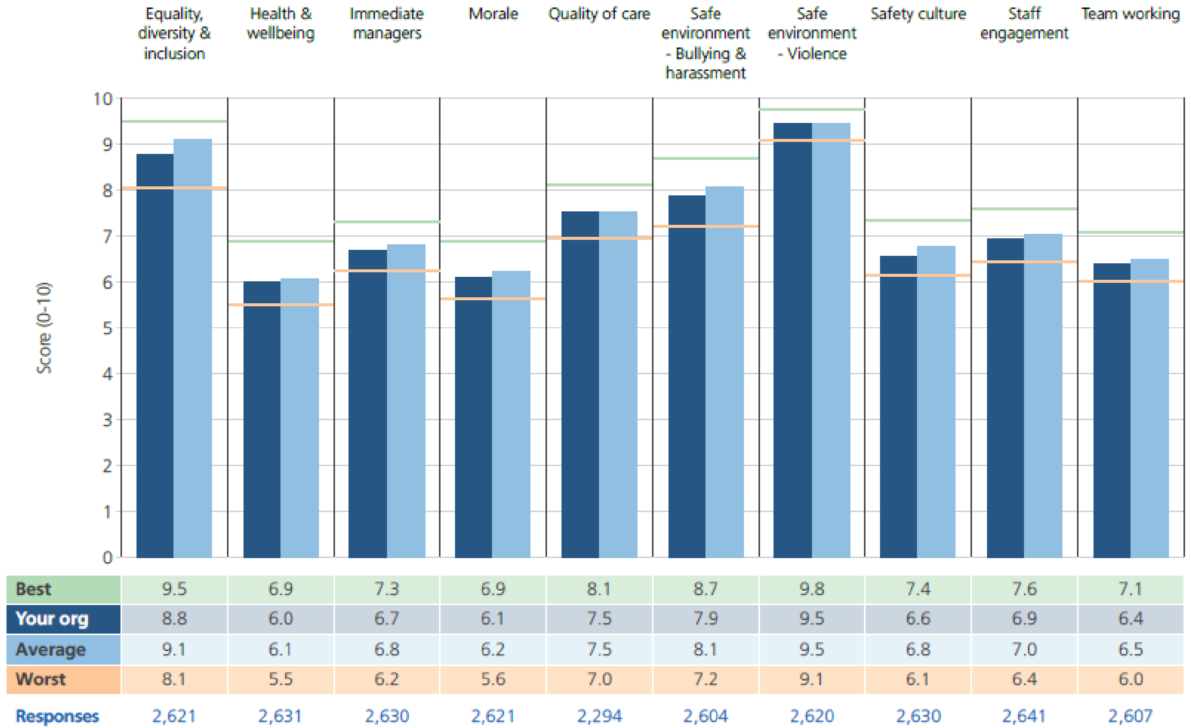
	Plan	Actual*
Permanent staff wte	6039	5656
Vacancy rate		2.63%
Turnover rate	10%	11%
Appraisal	90%	58%
Statutory / Mandatory training 100% complaint	90%	46%

*March 2021

Appraisal and statutory/mandatory training are key indicators to leadership and the support our staff are receiving from their managers. Throughout the pandemic it was recognised nationally that face to face training even for statutory/mandatory purposes could not take place. These training sessions were therefore placed on hold with incremental progression unaffected. Over the course of the year our subject matter experts supported by our capability team have converted most face to face training to on line learning events. With the development and implementation of our on line learning platform which went live in May 2021 we expect all our staff to have easier access and therefore compliance with essential learning. Recovery plans have been discussed and established within the divisions to ensure that staff are given the time to complete and update their learning following the extension to compliance last year.

National staff survey

The national staff survey was published in September 2020. 2646 staff completed the survey representing a response rate of 44%. The overall findings are shown in the chart below.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	8.8	6.0	6.7	6.1	7.5	7.9	9.5	6.6	6.9	6.4
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	2,621	2,631	2,630	2,621	2,294	2,604	2,620	2,630	2,641	2,607

For 2021/22, we will focus on making improvements on

- Safety Culture
- Equality, Diversity and Inclusion (EDI)
- Bullying and Harassment

The survey results show a significant improvement in all areas of staff safety over the last 5 years which has led to the trust returning the same position in 2016. However, there are two key areas for improvement where we are significantly lower than the national best. These being safety in reporting concerns and confidence that action will be taken. The Freedom to Speak up process is being reviewed to support these areas being addressed.

The trends for EDI has seen our position worsen by 0.2 over the last 5 years. Unfair promotion opportunities, and discrimination from patients, carers or staff is unacceptable. While the EDI lead has made some significant changes in engaging the staff networks, additional intervention is needed to support organisation wide change. The new Equality and Inclusion Committee (subcommittee of the Board) has been introduced to provide oversight and assurance on this area.

The theme of bullying and harassment has seen very little variation over the last 5 years. As a Trust we consistently score worse in this area than the average for our sector. National toolkits for civility and respect and just culture are being considered by the Trust for implementation and will be discussed in detail at the newly formed culture group in June 2021. Similar to EDI, it is expected that initial complaints and reporting will increase. However, combined with the national toolkits to reduce tolerance and change behaviour we believe the staff survey will improve.

3.2 Performance against national requirements

National standards

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

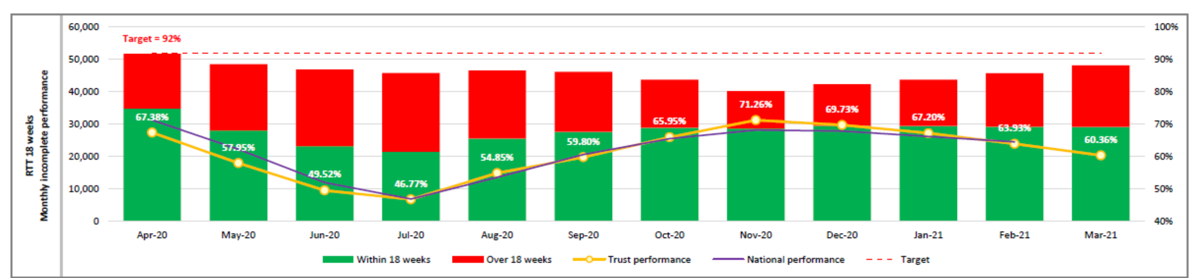
	18/19	19/20	20/21	Aim
Max 18 weeks from referral in aggregate – patients on incomplete pathways	90.3% (To Feb)	**77.4%**	60.36%	≥92%
Four hour maximum wait in A&E	81% (To Mar)	**80.2%**	Not Met 83.47%	≥95%
62-day urgent referral to treatment of all cancers	66.8% (To Jan)	**79.82% (full year)**	Met 86.13% (full) year)	≥85%
Maximum 6 week wait for diagnostic procedures	98.79% (Feb)	**99.48% (to Feb)****	Not met 33.07% (Full year)	>99%

In response to the COVID-19 pandemic, the Trust reconfigured services and wards to provide COVID-19 and Non-COVID-19 areas for patients, within the emergency department, assessment areas and across the wards. All minor injuries and illnesses were redirected to the Urgent Care Centre at the New QEII Hospital to support these reconfigurations. The Trust also increased capacity in the Critical Care Unit and worked in partnership with the independent sector to continue to treat urgent and cancer patients.

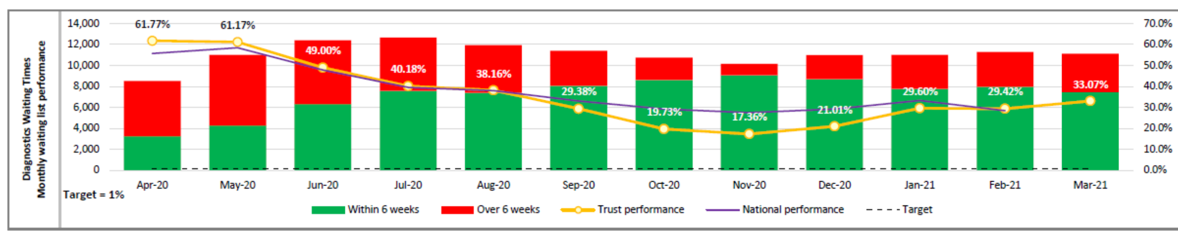
All surge capacity has been filed away or ‘flatpacked’ to ensure that the detailed response to COVID-19 demand and the resultant service capacity can re – emerge in response to triggers, so that the organisation remains responsive to any potential and subsequent surges.

Performance against the key operational standards should be considered in the context of the unique challenges posed by the pandemic.

18 week referral to treatment (RTT) performance was in line with the national average, though it is recognised that waiting times increased substantially as a result of the COVID-19 pandemic.



DM01 – The diagnostics performance was in line with national performance however there was a significant deterioration due to the impact of the COVID-19 pandemic.



Details of emergency department waiting standards and cancer standards have been given in earlier sections.

The focus in 2020/21 will be to recover the standards whilst maintaining access for COVID-19 patients.

Freedom to Speak Up / Raise Concerns

The Trust is committed to achieving the highest possible standards of quality, openness and accountability in all its practices. To achieve these, the Trust is committed to supporting any members of staff who are worried about any areas of poor practice, attitudes or inappropriate behaviour within our organisation. We believe in promoting a departmental culture which encourages open communication between staff and managers to ensure that questions and concerns can be raised and, resolved quickly.

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

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

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

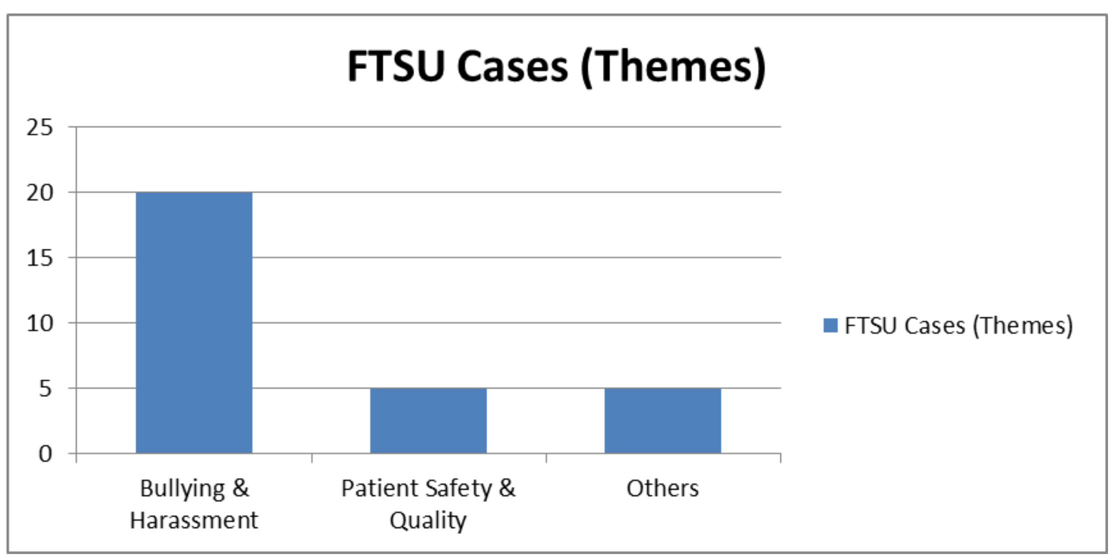
Our Commitment to our staff is:

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

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

With reference to the FTSU cases raised across 2020/21, while overall numbers remain consistent, bullying and harassment has been the most frequent theme as illustrated by the chart below. This data is supported by recent staff survey results (2020) which showed

marginal improvement but still demonstrate bullying & harassment as an issue. Whilst it is encouraging that our colleagues are speaking up we are still a long way off seeing speaking up becoming business as usual. To improve this position the FTSU agenda will now be shared between the nursing and people directorates with identified support available within each to promote the need and change culture to support reporting.



Rota gaps

Gaps to rotas of doctors and dentists in training are monitored on a monthly basis. The table below shows the total average number of rota gaps per quarter in the financial year April 2020 to end March 2021 year. This shows a much improved position to the previous year

April-June	July-Sept	Oct-Dec	Jan-March
Data not available Junior Doctors on Emergency rotas due to COVID-19	16.67 (33.33 in 2019/20)	8.0 (30.67 in 2019/20	8.33

Actions continue to be taken to improve vacancies:

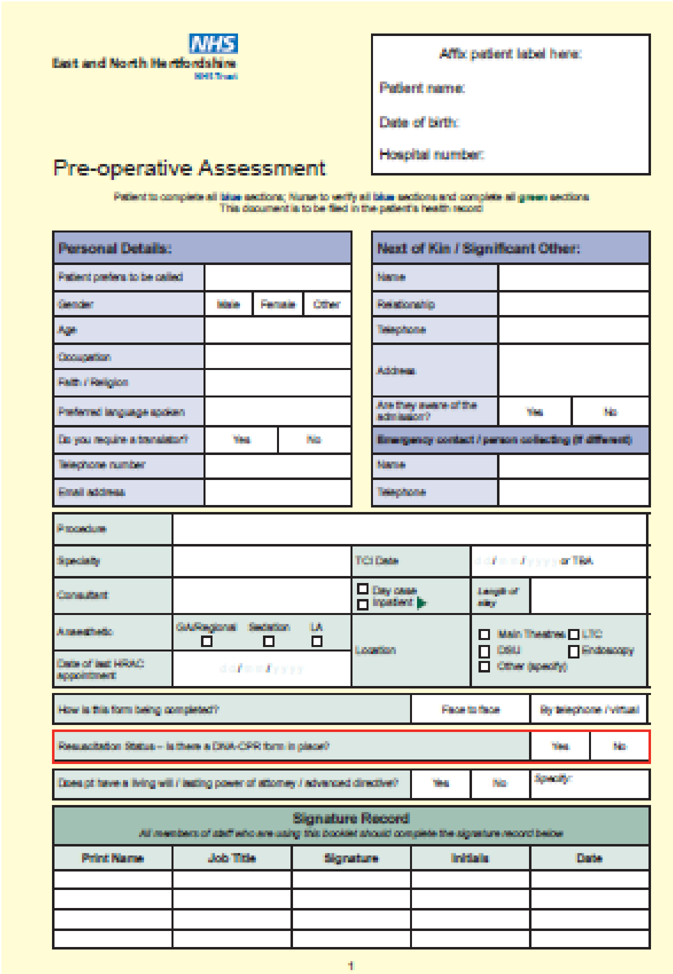
Direct

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

Indirect

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

Annex 1 NATSSIP documentation



NHS
East and North Hertfordshire NHS Trust

Affix patient label here:
Patient name:
Date of birth:
Hospital number:

Pre-operative Assessment

Patient to complete all blue sections; Nurse to verify all blue sections and complete all green sections
This document is to be filed in the patient's health record

Personal Details:			
Patient prefers to be called			
Gender	Male	Female	Other
Age			
Occupation			
Faith / Religion			
Preferred language spoken			
Do you require a translator?	Yes	No	
Telephone number			
Email address			

Next of Kin / Significant Other:		
Name		
Relationship		
Telephone		
Address		
Are they aware of the admission?	Yes	No
Emergency contact / person collecting (if different)		
Name		
Telephone		

Procedure			
Specialty		TCI Date	dd / mm / yyyy or TBA
Consultant		☐ Day case ☐ Inpatient	Length of stay
Anaesthetic	GA/Regional ☐ Sedation ☐ LA ☐	Location	☐ Main Theatres ☐ LTC ☐ DSU ☐ Endoscopy ☐ Other (specify)
Date of last HRAC appointment	dd / mm / yyyy		

How is this form being completed?	Face to face	By telephone / virtual

Resuscitation Status – is there a DNA-CPR form in place?	Yes	No

Does pt have a living will / lasting power of attorney / advanced directive?	Yes	No	Specify:

Signature Record
All members of staff who are using this booklet should complete the signature record below

Print Name	Job Title	Signature	Initials	Date

1

Date of completion	dd / mm / yyyy

Have you ever had, or are you being treated for any of the following symptoms or conditions?	Please circle No or Yes		If yes, please give details
Shortness of breath, or difficulty breathing	No	Yes	
Do you snore	No	Yes	S T O P B A N G .... / 8 If ≥ 5, perform ESS Epworth Sleepiness Score: .... / 24
Sleep apnoea	No	Yes	Do you use CPAP or NIPPV?
Asthma / COPD / emphysema	No	Yes	
Recurrent chest infections / TB (pulmonary tuberculosis)	No	Yes	
Angina or chest pain at rest, walking or climbing stairs	No	Yes	
A heart attack	No	Yes	
Heart failure	No	Yes	
Swollen ankles	No	Yes	
Previous vascular or heart surgery	No	Yes	
High blood pressure	No	Yes	
Palpitations, blackouts or faints	No	Yes	
Any implanted cardiac device e.g. pacemaker / ICD / loop recorder / reveal device	No	Yes	Specify type:
Any other heart problems e.g. AF (irregular heartbeat) or valve disease (including rheumatic fever) or metallic valve	No	Yes	
A blood disorder e.g. anaemia / sickle cell	No	Yes	
A blood cancer e.g. lymphoma / myeloma	No	Yes	
Excessive bleeding or bruising	No	Yes	
Blood clots in the lungs or legs: Deep Venous Thrombosis (DVT) or Pulmonary Embolism (PE)	No	Yes	
Have you had a reaction to a blood transfusion or blood products?	No	Yes	
Would you refuse a blood transfusion or blood products?	No	Yes	Specify reason:
Diabetes	No	Yes	☐ Diet ☐ Tablet ☐ Insulin
Thyroid problems	No	Yes	
Kidney problems	No	Yes	
Do you have a catheter or use intermittent self-catheterisation?	No	Yes	
Prostate problems	No	Yes	

Staff member to initial to confirm answers have been verified	

Have you ever had, or are you being treated for any of the following symptoms or conditions?	Please circle No or Yes		If yes, please give details
Bowel problems including constipation	No	Yes	
Stomach ulcers, heartburn, reflux, or hiatus hernia	No	Yes	
Jaundice, hepatitis or other liver problems	No	Yes	
Special diets or food intolerance	No	Yes	
Arthritis or joint problems	No	Yes	
Major back problems	No	Yes	
Are you restricted in your neck movements so that are unable to look up to the ceiling?	No	Yes	
Do you have any skin conditions? e.g. dermatitis, friable skin, eczema	No	Yes	
Do you have any pressure sores, leg ulcers or any broken skin?	No	Yes	Specify:
A stroke / TIA	No	Yes	
Convulsions or fits (seizures)	No	Yes	Date of last fit (seizure):
Do you have a neurological condition? e.g. muscle weakness / spasms / numbness / pins and needles	No	Yes	
Have you suffered a previous head injury that required hospitalisation?	No	Yes	
Have you ever attended a memory clinic or have concerns about your memory?	No	Yes	Mini – Cog Score: .... / 10 If < 4 / 10, discuss with HRAC consultant
Do you have a diagnosis of dementia / cognitive impairment?	No	Yes	
Do you have a history of / currently suffering with depression or anxiety?	No	Yes	
Do you have any learning difficulties / disabilities? (include physical or sensory impairments)	No	Yes	If yes, do you have a purple folder? Yes No
Do you have dentures / implants / caps / crowns / loose teeth?	No	Yes	
Do you wear glasses or contact lenses?	No	Yes	Specify:
Do you wear a hearing aid or cochlear implant?	No	Yes	Specify:
Do you have any implants? eg metalwork or brain / spinal stimulators	No	Yes	Specify:
Do you take combined contraceptive pills or hormone treatment?	No	Yes	N/A
Is there a possibility that you could be pregnant? (Questions only for pts aged 12-55 years who are able to bear children)	No	Yes	N/A
Have you had any significant unintentional weight loss in the last 6 months?	No	Yes	
Do you visit your GP for any other health concerns or are you being investigated for anything else that is not mentioned above?	No	Yes	
Do you have cause to visit your community pharmacist on a regular basis?	No	Yes	Specify:
Miscellaneous			

Staff member to initial to confirm answers have been verified	

Annex 2

New revised Personalised treatment plan 2020/21

4. Assessment of patient's mental capacity to be involved in TEP decisions		
The Mental Capacity Act (2005) requires you to assume that individuals have capacity, unless you suspect the person has an impairment or disturbance of the mind or brain, which affects their ability to make the decision. It requires any assessment to be decision specific. If you think someone may lack capacity you are required to complete the 2 stage Mental Capacity Assessment.		
Stage 1: Document below the reason why you believe the individual has an impairment or disturbance of the functioning of their mind or brain (record symptoms, behaviour and any relevant information below).		
Reason:		
Stage 2: Can the individual:	**Yes**	**No**
1. Understand information about the decision made?		
2. Retain that information in their mind, long enough to make the decision?		
3. Use or weigh that information as part of the decision making process?		
4. Communicate their decision (by talking, using sign language or any other means)?		

Is the response 'Yes' to all four Stage 2 questions?

- **Yes** → You must involve the patient in discussions relating to their TEP. Document discussion in patient records
- **No** → Is this loss of capacity likely to be temporary?
  - **Yes** → Improvement in capacity MUST trigger review of the TEP involving the patient. A new TEP will be required where treatment decisions change
  - **No** → Is there a valid Advanced Decision to Refuse Treatment (ADRT) that is valid to this decision?
    - **Yes** → Indicate this on the TEP form and record this in the patient records → Ensure LPA or ADRT document has been seen and that a copy is obtained in the current patient records
    - **No** → Is there a Lasting Power of Attorney (LPA) for personal health and welfare decisions?
      - **Yes** → Ensure LPA is consulted and understands decisions relating to TEP. Document discussions in patient records → Ensure LPA or ADRT document has been seen and that a copy is obtained in the current patient records
      - **No** → Proceed with completing TEP in line with **Best Interests Principles** (please note that if the person has no friends, relatives or unpaid carers then you must include Independent Mental Capacity Advocates (IMCA services). Please document the rationale/ Best Interest Principles for treatment and discussions in patient records.

5. Signature	Grade	Signature / name (print)	Date/time
Clinical staff (<ST3 / nurse) involved in the discussion and subsequent completion of this TEP:		Sign Print	
ST3 or above responsible for this plan: **Plan is not valid unless signed by an ST3 or above**		Sign Print	
Consultant decision or endorsement: (within 24 hours or next working day) Applies for duration of stay: Yes ☐ No ☐ Review date:		Sign Print	

This plan must be reviewed following every transfer of care and every 7 days unless stated otherwise

6. Consultant review	Signature / name (print)	Date/time
I have reviewed the above plan and agree with decisions: TEP applies for duration of stay: Yes ☐ No ☐ Review date:	Sign Print	
I have reviewed the above plan and agree with decisions: TEP applies for duration of stay: Yes ☐ No ☐ Review date:	Sign Print	
I have reviewed the above plan and agree with decisions: TEP applies for duration of stay: Yes ☐ No ☐ Review date:	Sign Print	

ENH00920-S Health Record File: front of patient records Page 2 of 2

Annex 3 Research and development

Some of the 2020/21 research highlights:

ISARIC Clinical Characterisation Protocol (UKCCP) for Severe Emerging Infection - tier 0 (RD2020-15) Local lead Prof Natalie Pattison. Rapid, coordinated clinical investigation of patients with confirmed novel coronavirus infection - involving data only. Opened 12th March 2020, recruited 632 patients.
RECOVERY trial - Randomised Evaluation of COVID-19 Therapy (R&D2020-18)
Local lead Dr Pietro Ferranti. Randomised controlled trial to assess suggested treatments. Opened 7th April 2020, recruited 83 patients.

RECOVERY-RS Respiratory Support (R&D2020-23) Local lead Dr Alison McMillan. Comparison of ventilation methods: Continuous positive airway pressure, High flow nasal oxygen or Standard care. Opened 11th May 2020, recruited 4 patients.

GenOMICC (R&D2020-22) Local lead Prof Natalie Pattison. Study to identify the specific genes that cause some people to be susceptible to specific infections / severe injury. Opened 30th April 2020, recruited 63 patients.

MERMAIDS (R&D2020-26) Local lead is Carina Cru.z EuRopean study of MAjor Infectious Disease Syndromes (MERMAIDS): Acute Respiratory Infections in Adults? Opened 24th July 2020, recruited 8 patients.

RIC in COVID-19 (R&D2020-24) Local lead is Prof Diana Gorog. Can remote ischaemic conditioning reduce inflammatory markers in COVID-19 patients? Opened 14th July 2020, recruited 2 patients

CLARITY (R&D2020-48) Dr Johanne Brooks. ImpaCt of bioLogic therApy on saRs-cov-2 Infection and immuniTY. Opened 26th Oct 2020, recruited 81 patients.

Pregnancy and Neonatal Outcomes in COVID-19 (R&D2020-51) Local lead is Dr Rabia Zilll-e-Huma.
To better understand how COVID-19 affects early pregnancy, fetal growth, prematurity and virus transmission to the baby. Opened 01/12/2020 Recruited 31 patients

HICC (R&D2021-08) Local Lead Dr Alex Wilkinson. Investigating and characterising primary and secondary immunodeficiency. Opened 23/02/2021 Recruited 5 patients.

CoV-2 antibody (RD2021-15) Local Lead is Dr Enric Vilar. SARS CoV-2 antibody responses in immunocompromised patients. Opened 4th March 2021, recruited 51 patients.

UKOSS Pandemic Influenza in Pregnancy (adapted for COVID19) Local lead is Dr Rabia Zilll-e-Huma.
Study about all pregnant women admitted to hospital who are COVID-19 confirmed. Opened 1st May 2020 recruited 31 patients.

Annex 3 Statements from stakeholders

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

East and North Hertfordshire Clinical Commissioning Group (ENHCCG) welcomes the opportunity to provide this statement for East and North Hertfordshire Hospitals NHS Trust (ENHT).

2020/21 was significantly affected by the Covid-19 pandemic, and all organisations across our healthcare system have pulled together to redesign services and deliver safe care to our patients. Additionally, processes have been adapted and developed to ensure that families can communicate with their loved ones and remain updated in relation to their care. The CCG recognises the work of the Trust and thank all of their staff and volunteers for their efforts during this incredibly challenging time.

The information provided within this account presents a balanced report of the quality of healthcare services that ENHT provides and is, to the best of our knowledge, accurate and fairly interpreted, is easy to read and well set out. The Quality Account clearly evidences the improvements made and highlights innovation achieved in 2020/21 despite the Covid-19 pandemic; and recognises where further improvements are needed.

During the course of 2020/21 ENHCCG have worked closely with ENHT, meeting regularly to review quality and safety, including risks relating to the pandemic. Due to the pandemic the CCG has been unable to undertake Quality Assurance Visits because of the risks of Covid-19 transmission.

Following the Care Quality Commission's (CQC) inspection in 2019, the Trust's rating has remained as 'Requires Improvement'. The Trust had a number of CQC Transitional Monitoring Approach reviews during 2020/21 which were positively received. The Trust continue to focus on their CQC Improvement Plan and progress is regularly reported to the CCG as well as Trust Board and CQC.

During 2020/21 ENHT has had mixed results in relation to quality, patient safety and patient experience. The CCG is pleased to see the progress in relation to Quality Improvement and looks forward to seeing improved patient outcomes as a result of the Quality Improvement initiatives being undertaken. This is particularly key in relation to recognition of deteriorating patients and Harm Free Care. The CCG remains concerned regarding the limited progress in relation to compliance with the sepsis six care bundle, including the timely administration of antibiotics, and venous thromboembolism (VTE) risk assessment. An improvement over the coming year is required.

Recognising that there have sadly been a high number of Covid-19 related deaths across the country including ENHT, it is positive that non-Covid-19 mortality rates have remained stable overall and SHMI data was in the 'lower than expected' range up to November 2020. Where any outliers are identified the Trust has worked pro-actively to identify any improvements required.

During 2020/21 the Trust reported 3 Never Events; this is the same as the previous year. ENHCCG are pleased to note the ongoing improvement work as a result of identified

learning and would expect to see a further reduction in Never Events occurring in 2021/22. We will continue to seek assurance that learning has been identified, and that relevant actions and improvements are being implemented to prevent reoccurrence.

Following the identification of a significant backlog of discharge summaries that had not been sent to primary care during 2018/19, the CCG recognises the continued focus that the Trust has had in relation to strengthening processes, improving the timeliness and quality of discharge summaries, and the improvements made to reduce the backlog. The CCG expects this to be an ongoing focus for 2021/22 and would like to see an additional focus on the timeliness of clinic letters sent to primary care.

Cancer performance was sustained over the course of 2020/21. The 62 day cancer target was achieved for all except two months, and the year-end position showed compliance with six of the eight cancer standards. The CCG is pleased to see the improvements continue to be made and would now like to see the Trust build on this in order to consistently deliver all 8 of the key cancer standards.

The 2020 annual staff survey results have shown mixed results; there have been improvements relating to staff safety, and there are several questions that have shown improvement compared with the previous year. However, overall the Trust remains below the national average in a number of areas, and results relating to reporting concerns and having these addressed, and bullying and harassment are disappointing. This does need to be an area of focus for the Trust over the coming year.

The CCG supports the Trust's 2021/22 quality priorities and is pleased to see that improving care of deteriorating patients, compliance with the sepsis pathway and improvements in compliance with VTE risk assessments are priority areas for the Trust.

Additionally, ENHCCG wishes to see ongoing improvement in the timeliness and quality of discharge summaries as well as an ongoing focus on staff wellbeing and improvement in the staff survey results. The CCG looks forward to receiving progress updates on other key areas of work such as the Trust's Medicine Optimisation Strategy.

We look forward to working with and supporting ENHT in developing new ways of working in light of the Covid-19 pandemic, as well as the ongoing development of the Integrated Care System and Integrated Care Providers, in order to provide high quality services for our patients. We hope the Trust finds these comments helpful and we look forward to continuous improvement in 2021/22.

Sharn Elton
Managing Director
East and North Hertfordshire Clinical Commissioning Group
June 2021

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

Steve Palmer, Chair Healthwatch Hertfordshire, May 2021

Quality Account 2021

2020 / 2021 has required all of us to adapt our ways of working. On behalf of the Hertfordshire Health Scrutiny Committee I would like to thank the East & North Hospital Trust for the services it continued to deliver during the pandemic and its response in recovery. We are aware of the challenges facing the NHS and will seek to continue working constructively with the trust.

Members of the committee have been appreciative of the support the East & North Hospital Trust has provided during this challenging period. The contribution from the trust has enabled the committee to maintain its overview of the health system in Hertfordshire. It enabled all our scrutiny members to hear about the impact on services and how it was seeking to address on-going needs and additional pressures. The East & North Hospital Trust has participated in committee meetings in December 2020 and March 2021; and contributed a briefing for members on hospital visiting during the pandemic (November 2020). The chief executive meet with the new HSC chairman and provided a very thorough overview of the impact of covid, challenges faced by the trust and future developments.

Despite the demands of the pandemic there has also been regular communication between the Health Scrutiny Committee, Scrutiny Officers and the East & North Hospital Trust over the last 12 months. The trust has supported the scrutiny process when approached and the Committee look forward to working with the East & North Hospital Trust in the future.

Yours sincerely

Dee Hart
Chairman Hertfordshire Health Scrutiny Committee

Annex 4 Statement of directors' responsibilities

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011, 2012, 2017 and 2020).

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

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

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

By order of the Board

29.06.21 Date .... Chair

29.06.21 Date .... Chief Executive