NHS
The Princess Alexandra Hospital
NHS Trust

Quality Account 2018-19

Your **future** | Our **hospital**

respectful | caring | responsible | committed

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Part one

Introduction from the Chief executive officer

Welcome to our annual Quality Account 2018-19, in which I am pleased to share with you our progress and achievements in the last year and the difference that this is making to our patients and the people we care for.

We started this year, 2018-19, with the fantastic news that The Princess Alexandra Hospital NHS Trust (PAHT) was approved to come out of quality special measures following an inspection by the Care Quality Commission (CQC). The CQC rated us as having improved from inadequate to requires improvement with good ratings in the caring, effective and well-led domains. In March this year (2019) we again welcomed colleagues from the CQC for an inspection of six of our core clinical services. Many of the inspectors for these recent assessment visits had been part of the team who visited the year before and we were delighted to hear their positive comments about there being a noticeable improvement in the culture of the organisation.

This sense of change is a real reflection of the enormous effort, commitment and dedication shown by all of our people, both our frontline teams and also all those who work behind the scenes to support the clinical teams caring for patients. I am very proud of them all; it is their shared commitment and focus on getting it right for our patients and providing high quality care that makes such a positive difference to our patients and to each other. The results of the recent inspection and our rating will be announced by the CQC in the summer (2019).

It is well documented that when staff feel positive about their workplace, colleagues and roles they provide better care for patients. This year I was proud to see this commitment to patient care reflected in the results of our annual NHS Staff Survey. Comments from our people placed us in the top 25% of acute trusts across the country.

Our 5 Ps strategy, which encompasses our patients; our people; our performance; our places and our pounds continues to underpin our approach to quality improvement and our modernisation plans and ambitions. Putting quality first lies at the heart of each improvement our clinicians and teams across the organisation put in place. The changes to the way we provide patient care are facilitated and delivered through our quality first improvement methodology. Quality First projects continue to go from strength to strength and in 2019-20 will extend their reach further in supporting the modernisation of our professional and support services that provide vital support to our clinical teams in delivering high quality care.

This account gives a detailed insight into how these changes are being made; how we are delivering to national standards of care and how we are putting in place quality improvements in areas where we are not as strong and need to do better.

Managing successful change relies on team work and a shared commitment to improving patient care. Every day I am proud to see PAHT people making a difference to our patients and proud to be part of their energy and determination to continue to improve the way we care for patients now, in the year to come and into the future.

I commend this quality account to you, and I am, as always, grateful to the many people who have contributed to its content. I confirm that, to the best of my knowledge, the information in this account is accurate.

Lance McCarthy

Chief executive

Statement of Director's responsibilities in respect of the Quality Accounts 2018-19

The trust Directors are required under the Health Act (2009) National Health Service (Quality Accounts) Regulations (2010) and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year.

The Department of Health has issued guidance on the form and content of annual Quality Accounts which incorporates the above legal requirements.

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

- The Quality Accounts present a balanced picture of the trust's performance over the reporting period
- The performance information 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 Accounts, 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 Accounts are robust and reliable, conform to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review. The Quality Accounts have been prepared in accordance with Department of Health guidance.

The Directors confirm that, to the best of their knowledge and belief, they have complied with the above requirements in preparing Quality Accounts.

By order of the Board

Steve Clarke

Chairman

Lance McCarthy

Chief Executive Officer

Part two

About this report

What is a quality account?

Every year all NHS hospitals in England must write a report for the public about the quality of their services; this is called the quality account. The purpose of the report is to make the hospital more accountable to you and drive improvement in the quality of our services.

We look at our performance over the previous year, identify areas for improvement and publish this information. Through this we are making our pledge to you about the improvements to be made over the next year.

The report will tell you how well we did against the quality priorities and goals we set for the period of April 2018 to March 2019 and the areas we have improved through the year. It will also detail the priorities we have agreed for April 2019 to March 2020.

We will describe to you the areas where we have reviewed our patient care in order to evaluate the quality of services provided. This includes information and data about how PAHT compares with other service providers through reviews of data and audits.

The report will contain mandated information from our Board, along with statements from our commissioners and partners. We will provide a glossary of terms.

Governance arrangements

PAHT Quality Account is prepared in line with the Quality Accounts Toolkit guidance (2010-11). There are two additional considerations for inclusion in the 2018-19 report as advised by NHS England

- Provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how the trust ensures that staff who speak up do not suffer detriment.
- Include a statement regarding progress in implementing the priority clinical standards for seven day hospital services.

In addition the trust is required to:

- Provide a statement that evidences an improvement plan to reduce rota gaps for NHS doctors and Dentists (Schedule 6, Paragraph 11b of the terms and conditions of service for NHS doctors and dentists in training (England) 2016.)

The trust has engaged with the Health Care Groups (HCG) and corporate teams of the trust to develop the Quality Account. A timetable for the production of the quality account was presented and approved by the Quality and Safety Committee on 22 February 2019.

A draft of the report was shared internally with the Senior Management Team members for peer review and with external stakeholders (Clinical Commissioning Groups, Healthwatch, Health Overview and Scrutiny committees for both Hertfordshire and Essex) in addition to our trust auditors in May 2019.

The draft quality account was presented to the trust Quality and Safety and Audit Committees (both Board committees) for their review in May 2019.

The final draft document was presented to the trust board for final approval in June 2019.

Care Quality Commission rating

The trust is registered with the Care Quality Commission (CQC) and our current status is 'registered without condition'.

Our staff have used the CQC Inspection outcome from 2018 as the foundation upon which to critically examine our services and focus on how we plan and deliver the fundamental aspects of safe care and have taken decisive action to change everyday activities which have lead to significant improvements. Our dedicated staff have worked incredibly hard to deliver the improvements over the course of 2018-9.

The current CQC ratings for the trust is **requires improvement** and is detailed below**.**

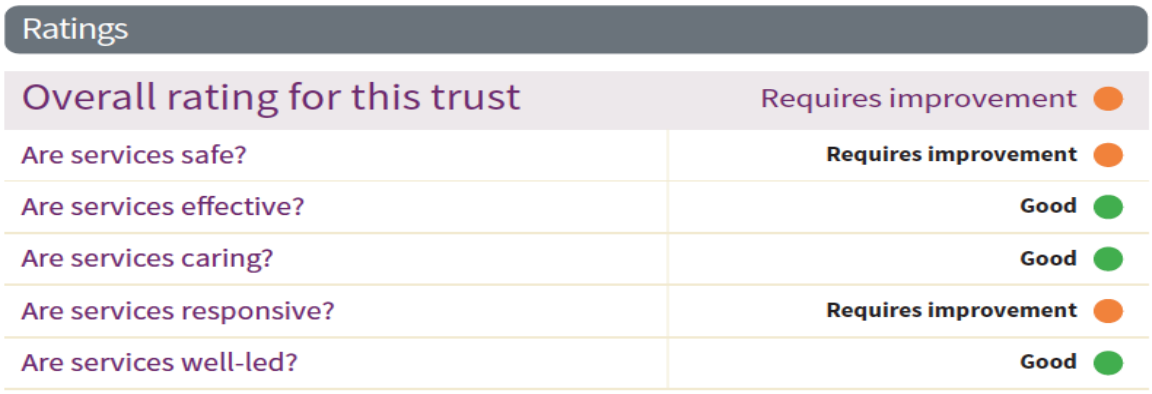


Figure 1: Current CQC ratings for the trust

Ratings for The Princess Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Mar 2018	Good ↑ Mar 2018	Good → ← Mar 2018	Requires improvement → ← Mar 2018	Requires improvement ↑ Mar 2018	Requires improvement ↑ Mar 2018
Medical care (including older people's care)	Requires improvement → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires improvement → ← Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement → ← Mar 2018
Surgery	Requires improvement ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Requires improvement → ← Mar 2018	Good ↑ Mar 2018	Requires improvement → ← Mar 2018
Critical care	Good ↑↑ Mar 2018	Good ↑ Mar 2018	Good → ← Mar 2018	Requires improvement ↑ Mar 2018	Good ↑↑ Mar 2018	Good ↑↑ Mar 2018
Services for children and young people	Requires improvement ↑ Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement → ← Mar 2018	Requires improvement → ← Mar 2018
End of life care	Good ↑ Mar 2018	Requires improvement → ← Mar 2018	Good → ← Mar 2018	Good ↑↑ Mar 2018	Good ↑↑ Mar 2018	Good ↑↑ Mar 2018
Maternity and gynaecology	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding 2016
Outpatients and diagnostic imaging	Good Jun 2016	N/A	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016

Table 1: Current CQC rating for all 8 core services

Following receipt of the CQC report in March 2018, the trust has worked hard to address the 33 recommendations made by the CQC.

- 17 actions MUST be completed to bring services into line with legal requirements. These actions related to six services and the trust overall.
- 16 actions SHOULD be undertaken either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services. These actions related to five services and the trust overall.

The latest CQC comprehensive inspection of the trust took place in March and April 2019.
The inspection focused on all of the domains; safe, responsive, caring, well led and effective and included six core services:

- Urgent and Emergency
- Medical
- Surgery
- Children and young people
- Maternity and gynaecology
- End of Life Care.
- We anticipate receiving the final report from the CQC in July 2019

Quality Improvement

Introduction to quality improvement

The trust is committed to a clear strategic direction to improve patient services underpinned by a trust wide quality improvement approach. This approach has been named Quality First.

Putting ‘quality first’ is the principal that drives the trust quality improvements.

The Quality Improvement Strategy was launched in February 2019. We define quality improvement as ‘working together in partnership to make the sustainable changes that will lead to excellence for our patients, people, places, performance and pounds.’

Quality First team

The Care Quality Commission refer to the ‘presence of a central team that leads the provider’s quality improvement approach’ as an indication that quality improvement is embedded across an organisation. Our central team is the Quality First team, led by a senior doctor, nurse and manager. The team work alongside our staff, patients and wider partners in health and social care focusing on the following key functions:

- Centrally coordinate quality improvement initiatives that deliver greater efficiency and productivity as well as reducing unwarranted variation.
- Support the delivery and realisation of our long term plan (Your future, our hospital), the trusts clinical and quality improvement strategies, lead quality improvement and organisational development to prepare the trust for our future health and social care campus.
- Support the strategic realisation of the clinical strategy.

The Improvement Partnership

The ‘Improvement Partnership’ is our program for enrolling, engaging, involving and developing our staff in Quality Improvement. The Quality First team runs leading change and leading

projects learning and development sessions with the objective of enabling staff to deliver successful quality improvement projects. When the staff member completes a quality improvement project (capturing project outcomes in a poster), they become PAHT improvement partners.

Quality improvement programme

The quality improvement programme has gained momentum in 2018-19. For the second consecutive year we have been awarded first prize as the champion trust from the Academy of Fabulous Stuff.

This was awarded to the trust as a result of delivering 70 improvement projects during 2018 and embedding quality improvement across the organisation.

Priorities for quality improvement 2019- 2020

Each year we assess our performance against previously identified quality priorities and patient outcomes; we make sure we take account of national reports, benchmarking and information gained from our regulators, patients and staff as well as learning from incidents, complaints and litigation cases.

This year the outcomes from the Care Quality Commission (CQC) inspection report (March 2018) has afforded us an opportunity to build upon our programme of improvement which is underpinned by the Quality First approach.

Our priority and aim is to improve our CQC rating, showing an improvement in our journey towards good to outstanding. Our latest CQC comprehensive inspection took place in March and April 2019. In 2019-20 the trust will focus on addressing the recommendations from the this CQC inspection once the report is received.

Priorities for quality improvement 2019-2020

Our four Quality Account priorities are identified in line with the quality elements of the trust five P Strategy: which covers our patients, our people, our performance and our places. These priorities will be monitored using the governance structure; through three sub committees of the Board and progress will be reported to trust Board.

The Quality and Safety Committee will oversee the objectives for our patients. The Workforce Committee will monitor our people objectives.

The Performance and Finance Committee will monitor our performance and our places objectives. In addition to the our pounds objectives which are not included within the quality account.

1.0 Our patients: aim to reduce mortality, improve HSMR and improve our patients experience.

- A reduction in the trust mortality rate as a result of the work completed through the mortality improvement board established in December 2018. trust aims to have a normal Hospital Standardised Mortality Ratio (HSMR) with no outlier alerts by 2021.
- A reduction in the length of stay by 10% for non-elective patients to support the flow of patients in, through and out of the hospital by April 2020.

- Improve by 10% the numbers of patients that are dying in their preferred place of death (as expressed at time of imminent death) by April 2020.
- Ongoing improvements in our care of patients' experience measured through a reduction of 10% in the number of formal complaints received from 206 to 185. An increase of 10% the numbers of successfully resolved PALs concerns from 2827 to 3109 by April 2020.

2.0 Our people: aim to improve nusing staffing and our staffs culture and well being

- Introduction of a talent management programme and newly appointed consultant development programme by January 2020.
- Continued improvement in staff survey results of experience being consistent with the trust's four values by April 2020.
- An ambitious programme to significantly reduce the registered nurse vacancy rate to between 10-15% by April 2020.
- Unconscious bias training to raise awareness of equality and inclusion issues in attracting, recruiting and retaining our people by January 2020.
- Implementing a new extranet website for our people by April 2020.
- Implementation of new trust website by October 2020.

3.0 Our performance: aim to improve our performance against the national standards

- Achieve all key access standards, including RTT (referral to treatment) and cancer wait times
- To improve our performance for timeliness of treating patients requiring urgent care to 90% by March 2020
- To commence the redesign of outpatient services, to modernise services in primary and secondary care. This is work planned to be within the trust transformation programme. The project for outpatients including the KPIs will be set through this process.

4.0 Our places: improve our clinical areas and critical functions

- To work with our partners to complete a pre consultation business case by the end of September 2019 for the preferred way forward for a new hospital
- To run a public consultation on the new hospital following the completion of the pre-consultation business case
- To complete a Strategic Outline Business Case for a new hospital by March 2020

Monitoring our progress

This year we will be strengthening our approach to monitoring compliance with regulatory standards as well as further embedding our approach to improving quality performance. We will continue to work with our staff, service users, health and social care partners as well as our commissioners, regulators and NHS Improvement to monitor our progress:

- Develop and deliver a schedule of peer quality inspections to review compliance with the fundamental standards of quality; alongside a range of staff from PAHT, the inspectorate will include members of the Patient Panel and colleagues from both commissioning groups.
- The monthly performance monitoring meetings with executive board members for al healthcare groups and corporate teams will continue. Using a constructive and supportive

approach, the presenting teams are encouraged to share their progress against agreed outcomes as well as identifying areas where support is required to achieve success.

- Where recommendations for improvement are made by regulatory bodies such as the CQC, these will be addressed using our existing 'model for improvement' methodology.
- The reporting process, including monitoring of progress, will include an executive led Quality compliance improvement group which will report progress to the Quality and Safety Committee, commissioning partners and the trust board.

Statements relating to quality of care provided

The trust provides a range of services to a local population of around 350,000 living in West Essex and East Hertfordshire. The majority of services are provided from the main hospital site in Harlow, but local hospitals in Bishop's Stortford and Epping offer outpatient and diagnostic services, see table 3.

The trust has 480 general and acute beds and provides a full range of general acute services, including; a 24/7 emergency department, an adult intensive care unit, a maternity unit and a level II neonatal intensive care unit (NICU).

Directory of our services			
Ambulatory Care	Dermatology	Intensive Care unit	Patient at Home Service
Ante-natal Clinic	Diabetic Medicine	Interventional Radiology	Pharmacy
Anticoagulant Service	Dietetics	Maternal and Foetal Assessment Unit (MAFU)	Physiotherapy
Audiology	Early Pregnancy Unit	Maternity	Post Anaesthetic Care Unit (PACU)
Birthing Unit	Emergency Department	Maxillofacial surgery	Pre Op Assessments
Breast Screening	Endocrinology	Medical Oncology	Radiology
Breast Surgery	Endoscopy Services	Neonatal Critical Care	Respiratory Medicine
Cardiac Cath Lab	ENT Clinics	Neurology	Rheumatology
Cardiology	Fleming Ward	NICU	Short Stay Unit
Care Of The Elderly Clinics	Frailty service	Obstetrics	Special Care Baby Unit
Chemical Pathology	Gastroenterology	Occupational Therapy	Speech and Language Therapy

Chemotherapy	General Medicine	Ophthalmology	Surgery Clinics
Clinical Decision Unit	General Surgery	Oral Surgery	Surgical assessment unit
Clinical Haematology	Genito-Urinary Medicine	Paediatric Ambulatory Unit	Theatres
Clinical Oncology	Geriatric Medicine	Paediatric Diabetic Medicine	Therapies
Colorectal services	GP Assessment Unit	Paediatric Oncology	Transfusion services
Colposcopy and hysteroscopy services	Gynaecology	Paediatrics	Trauma and Orthopaedics
Community Midwifery Team	Gynaecology Ambulatory Service	Palliative Care	Urology
Community Neonatal Team	Haematology Clinics	Pathology	Vascular services
Day Surgery	High Dependency Unit	Patient Appliances	

Table 2: Directory of trust services

The review of services and all associated data is undertaken through the trust Governance structure. This includes monthly Patient Safety and Quality Group, then through to the monthly Quality and Safety Committee which reports to the trust board.

Review of each services performance (in table 2) within the trust is monitored through the Performance and Finance Committee with external review undertaken by both Essex and Hertfordshire commissioners at the monthly Service Performance and Quality Review Group (SPQRG).

Prescribed indicators		
	Prescribed information	**Form of statement**
1.	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: **(a)** specified under the contracts, agreements or arrangements under which those services are provided or **(b)** In the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	During 2018-19 PAHT provided a range of health services listed in the directory of services, table 3. **a)** Services provided by the trust to local/main CCGs are commissioned under standard form NHS contracts. **b)** Non-contracted activity: Beyond services provided to main/local CCGs the Trust receives income for Non-Contracted activities with other Clinical Commissioning Groups. This income mainly relates to activity provided to CCGs that are not within the trust immediate catchment area and/or where activity does not require formal contracts to be in place. In 2018-19 this level of activity totalled £3.1m. **c)** Sub-contracted activity: During the year the Trust subcontracted a small number of services to private or other NHS providers. Services are generally subcontracted where either short term capacity constraints arise or specialist services are required. In 2018-2019 the main services sub-contracted were Urology (day case and OPD), Endoscopy surveillance and specialist clinical tests.
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	We have reviewed all the data available to them on the quality of care provided by the services listed in table 2.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1 represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the	In 2018-19, 90% of The trusts revenue was received for patient care activities relating to the services listed in table 2.

	provider for the provision of, or subcontracting of, relevant health services.	
2	The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period and which covered the relevant health services that the provider provides or subcontracts.	During 2018-19 48 national clinical audits and 4 national confidential enquiries covered relevant health services that PAHT provides
2.1	The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry two, that the provider participated in during the reporting period.	During that period we have participated in 94% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry two that the provider was eligible to participate in.	The national clinical audits and national confidential enquiries that the trust was eligible to participate in during 2018-19 are detailed in tables 19 and 20
2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in.	The national clinical audits and national confidential enquiries that we have participated in during 2018-19 are detailed in tables 19 and 20
2.4	A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that we have participated in, and for which data collection was completed during 2018-19, are listed 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. See tables 19 and 20.
2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of 18 national clinical audits were reviewed by the provider in 2018-19.
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	The actions undertaken in the trust are detailed in table 22.
2.7	The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.	The reports of 44 local clinical audits were reviewed by the trust in 2018-19
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	See table 22 for actions.

3.	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	The number of patients receiving relevant health services provided or subcontracted by PAHT in 2018-19 that were recruited during that period to participate in research approved by a research ethics committee 948.
4	Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services.	A proportion of PAHT income in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between NHS England – East of England Specialised Commissioning, West Essex Clinical Commissioning Group and any contract associates they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. **Not applicable**
4.1	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	Further details of the agreed goals for 2018-19 and for the following 12-month period are available in the CQUIN achievement section of this Quality Account on Table 16.
4.2	If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	
5.	Whether or not the provider is required to register with CQC under Section 10 of the Health and Social Care Act 2008.	PAHT is required to register with the Care Quality Commission. The current registration status is "registered without condition". The Care Quality Commission has not taken enforcement action against the trust during 2018-19.
5.1	If the provider is required to register with CQC: **(a)** whether at end of the reporting period the provider is: **(i)** registered with CQC with no conditions attached to registration **(ii)** registered with CQC with conditions attached to registration **(b)** if the provider's registration with CQC is subject to conditions, what those conditions are and	

	(c) whether CQC has taken enforcement action against the provider during the reporting period.	
6.	Removed from the legislation by the 2011 amendments	
6.1		
7.	Whether or not the provider has taken part in any special reviews or investigations by CQC under Section 48 of the Health and Social Care Act 2008 during the reporting period.	PAHT has not participated in any special reviews or investigations by the CQC during the reporting period.
7.1	If the provider has participated in a special review or investigation by CQC: **(a)** the subject matter of any review or investigation **(b)** the conclusions or requirements reported by CQC following any review or investigation **(c)** the action the provider intends to take to address the conclusions or requirements reported by CQC and **(d)** any progress the provider has made in taking the action identified under paragraph **(e)** prior to the end of the reporting period.	
8.	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider.	PAHT submitted records during 2018-19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was: 99.6% for admitted patient care 99.8% for outpatient care and 98.0% for accident and emergency care. This included the patient's valid General Medical Practice Code was: 99.9% for admitted patient care; 99.9% for outpatient care; and 99.7% for accident and emergency care.
8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: **(a)** the percentage of records relating to admitted patient care which include the patient's: **(i)** valid NHS number **(ii)** General Medical Practice Code **(b)** the percentage of records relating to outpatient care which included the patient's: **(i)** valid NHS number **(ii)** General Medical Practice Code **(c)** the percentage of records relating to accident and emergency care which included the patient's:	

	(i) valid NHS number **(ii)** General Medical Practice Code.	
9	The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT grading scheme.	PAHT Information Governance Assessment Report overall score for 2018-19 was standards not met and was graded red.
10	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.5	PAHT was not subject to the Payment by Results clinical coding audit during 2018-19 by the audit commission.
10.1	If the provider was subject to the payment by results clinical coding audit by the audit commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	
11.	The action taken by the provider to improve data quality.	PAHT will be taking the following actions to improve data quality; **1.** Monthly/weekly challenge of healthcare groups using the performance review process **2.** Monhtly report into the Performance and Finance Committee, with escalation through to trust board if required **3.** Weekly escalation through Access Board **4.** Fortnightly data quality operation meeting with healthcare groups

Table 3: prescribed indicators 1-11

Below are the core indicators which NHS England has requested are included in the 2018 -2019 Quality Accounts by all NHS trusts.

PAHT considers that this data is as described having been provided by NHS Digital and Dr Foster.

12	Standardised hospital mortality indicator	October 2017 – September 2018	National average	Improvement action plan
	(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and HSMR 122.8 – Higher than expected The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	**116.69: higher than expected** 3.26%	100 4.06%	The trust's mortality falls into the 'higher than expected' range when compared to national data baseline. The trust is continuing to conduct actions in line with our Morbidity and Mortality Strategy, which includes learning from all deaths. The trust has set up work streams for improving patient outcomes which will feed into a mortality improvement board aiming to deliver improving standards and achieve an as expected rating in the future. This process is being supported by the quality first team. This is an area of success in year however we will continue to deliver training for staff to understand and implement more robust documentation leading to improved clinical coding. Our clinical coders will continue to attend the wards regularly to discuss queries with clinicians. This ensures that coding difficulties can be resolved before the notes leave the wards.

Indicator 12 and Table 4: Prescribed core indicator - standardised hospital mortality indicator source of data NHS Digital

Please note 13-17 are not applicable to an acute trust.

18. Patient Reported Outcome Measures (PROMs)

PROMs are measures of health outcomes in patients undergoing planned surgical procedures. In year the data collected for varicose vein and groin hernia has ceased following a consultation. The procedures that data collection continues for are hip and knee replacements. In England all patients having these two procedures should receive a questionnaire both before and after surgery.

Improvement rate by procedure and measure for April 2018 - March 2019

PAHT	National
EQ5D index Hip replacement: 90% Knee replacement: 83.3%	EQ5D index Hip replacement: 91.1% Knee replacement: 82.9%
EQ-VAS Hip replacement: 70% Knee replacement: 81.3%	EQ-VAS Hip replacement:71.1% Knee replacement: 59.9%

Indicator 18. Table 5: trust data on patient reported outcome measures
Source of data NHS Digital

19. PAHT considers that this data is as described as it is part of the Integrated Performance Report and audited trust data.

19	% of patients re-admitted within 28 days November 2017 – October 2018	National Average Updated 2013	Improvement action plan Published data for national comparsion ceased in 2013
Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period **(i)** % of patients 0-15 years of age **(ii)** 16 years and over	PAHT 0-14years 5.1% observed PAHT 15 or over 8.9% observed	National Acute (non specialist) 8.1% observed lowest 5.8% highest 10.5% National Acute (non specialist) Aged 0-14 9% observed lowest 4.1% highest 14.4% National Acute (Non Specialist 15 or over 8.0% observed Lowest 5.8% Highest	NHS Digital has suspended the updating of this information from December 2013 pending a review of the methodology. PAHT intends to undertake the following actions to improve our percentage and so the quality of our service 1. Identify on our electronic patient administration system the patients who are repeat admissions. This small group of patients are monitored and any trends identified for the relevant speciality to take note and action as required. 2. Priority referral to home team (who are familiar with patient and are able to make the best plan for the patient 3. Internal Professional Standard that patient should be seen within 30 minutes of referral by

		10.8%	decision maker to review if admission is needed or if alternative method of care is appropriate

Item 19, Table 6: trust data on percentage of patients readmitted within 28 days
Source: Dr Foster

20. PAHT considers that this data is as described as it is part of the integrated performance report and audited trust data that shows that as a result of changes implemented in year we were successful at making it easier for PALs concerns and general enquiries to be raised. Logging and tracking of the concerns to a successful resolution was difficult due to staffing vacancies.

20	Trust's responsiveness to the personal needs of its patients	2017 -2018	2018-19	Improvement action plan
	Number of PALS cases resolved	2923 cases received Of those received: 53% were resolved within 48 hours 77% within 2 weeks 96% within 2 months Lowest number per month: 197 Highest number in a month: 290	2801 cases received Of those received: • 38% resolved within 48 hours • 68% within 2 weeks • 86% within 2 months Lowest number per month: 157 Highest number in a month: 273	PAHT intends to undertake the following actions to improve our percentage and so the quality of our service Actions already completed: 1. Supported the development of an information and signposting hub in main entrance to enable access to information and proactive support from specialist and voluntary sector teams. 2. Patient Experience Week completed during April 2019 with significant involvement from across local 3. Voluntary sector providers New actions to be implemented • Fill vacancies in the Patient Experience team by June 2019. • This will enable the team to log all of the cases which are outstanding and increase activity on 2018-2019

Item 20, Table 7 : trust responsiveness to personal needs
Source: trust held data on Datix

21. PAHT considers that this data is as described as it is part of the Integrated Performance Report and shows that performance of our staff who would recommend to friends and family our trust to receive care greater then the Department of Health expected target. The trust with the best performance data has scored 100% and the worst performing trust scores 30%.

21	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	July – September 2018	Trust's nationally set target for this question	Improvement action plan
	Friends and Family Test - staff	76% of staff 695 staff responded	DoH target is 67%	PAHT intends to undertake the following actions to further improve our percentage score of staff who would recommend the trusts as a provider to care for their family and friends and the quality of our service. Actions already completed: • Continue to provide information and briefings to all staff through our Tuesday meeting and weekly email communications New actions to be implemented • Focus to mprove communications with all staff around survey to ensure more respondents.

Item 21, Table 8: Staff Friends and Family test results
Source: NHS Choices

21.1 PAHT considers that this data is as described as it is part of the Integrated Performance Report and audited trust data shows that performance of our patients who would recommend the trust to their family and friends for care exceeds the national average. The trust with the best performance is achieving 100% score and the worst performance trust is scoring 64%.

21.1	The percentage of patients who would recommend the trust as a provider of care to their family or friends.	Average for 2017-18	National average	Improvement action plan
	Friends and Family Test – patients	96.48	National average is 93.2%	PAHT intends to undertake the following actions to further improve our percentage score of patients who would recommend the trusts as a provider of care to their family and friends. New actions to be implemented are the Implementation of Patient Experience Minimum Standards actions to include: • Implementation of Talk to Me campaign across all HCGs • Development of sensory ambassadors • A volunteer on every ward, every day with buddying so that staff support volunteers and monitor experience. • The electronic feedback system will go live with a patient app, staff app and ward level, wall mounted touch screen feedback devices

Item 21.1, Table 9: Patients Friends and Family Test results
Source: NHS Choices

23. PAHT considers that this data is as described as it is part of the Integrated Performance Report and audited trust data shows that our performance exceeds the national target as a result of our robust practices and proceedures. The best trust performance is 100% and the worst scores 69%.

23.	March 2017	December 2018	National target	Improvement action plan
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	98.7%	98.33% trust internally set target is 98%	95.25% England National target is 95%	PAHT intends to undertake the following actions to further improve the percentage of patients who are risk assessed for venous thromboembolism Actions already completed: • Continue failsafe check lists at ward level. • Continue using the VTE risk assessment proforma. • Patient leaflets available in clinical areas. • Patient safety thermometer includes a question about preventative (prophylaxis) medications being given. • Process for poor

Item 23, Table 10: percentage of patients risk assessed for VTE
Source: NHS Digital

24. PAHT considers that this data for c.difficile infections reported amongst trust patients shows that our infection control practices and procedures are robust and we have low rates of infection when compared with acute trusts. The best performing trusts have no infections and are specialist surgical centres and the worst performing trust had 366 infections.

24. The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	**Number of cases** **April 2018 – Jan 2019**	**PAHT Target for April 2018 - March 2019**	**Improvement action plan**
C-Diff - cases on national surveillance database C-Diff - cases attributable to PAH (total less successful appeals) Rate per 100,000 bed days for PAH = 7.9 (data published by Public Health England)	trust apportioned cases 5 13 cases in total of which 8 were successfully appealed	9	PAHT intends to undertake the following actions to further improve our performance and management of C.Difficile infections. Actions already completed and ongoing: • Continue with personal protective equipment and hygiene by clinical staff. • Monitor compliance • Continue responsible use of antibiotics • Timely isolation of patients • Continue thorough cleaning and monthly cleaning and hygiene code audits • Continue hydrogen peroxide decontamination

Item 24, Table 11: C.difficile rate per 100,000 bed days
Source: NHS Choices

25. PAHT considers that this data as described is part of the Integrated Performance Report and shows that our number of severe harm incidents is higher then the national average, and our incidents resulting in deaths being lower then the national average for the reporting period. A comparsion of incident reporting rate with national data for inciddents per 1000 bed days being 44.5. the trust data is 48.5 per 1000 bed days.

The number and where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	The total number of incidents from 1 April 2018 to 31 March 2019 was 7162
Number of severe harm / serious incidents and incidents resulting in death	29 severe harm Incidents at time of data submission to NRLS. 4 death on NRLS at time of data submission.
Severe Incident National **Average from 1 April 2018 to 31 March 2019**	0.29%
Severe harm Incident trust **Average from 1 April 2018 to 31 March 2019**	0.40% Severe harm incident rate per month averages 2.4
Incidents resulting in death **National Average 1 April 2018 to 31 March 2019**	0.25 %
Incidents resulting in death. **PAH average**	0.06%
Incident reporting rate **National Average from 1 April to 30 Sept 2018**	PAHT data 48.5 incidents per 1,000 bed days The national data for organisations within trust cluster (Acute non specialist) is 44.5 incidents per 1000 bed days.

Item 25, Table 12: Rate of safety incidents
Reference for national data is as provided for acute (non-specialist) organisation in the NRLS organisation patient safety report on six months data from 1.4.2017 to 30.09.2017 - data is only provided on severe harm levels not serious incident numbers.

PAHT has implemented a mortality improvement board and multiple additional actions detailed in 27.3 and 27.6 to aim for a normal Hospital Standardised Mortality Ratio (HSMR) with no outlier alerts by 2021, this will improve our percentage and the quality of our service.

26. Statement on seven day hospital services - as a trust we are working towards implementation of seven 7 day services.

Our assessment of the current position against the clinical standards for a seven day service is:

- Time to first consultant review –90% (within 14 hours)
- Access to diagnostics - 93%
- Access to consultant directed interventions - 90%
- Ongoing consultant review - 90%

27. Hospital deaths – two alternatives proposed for presenting this data

Hospital deaths: 2018-19		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
27.1	Total in year	273	288	280	233	1195
27.2	Total number of case reviews completed by clinical teams	74	89	91	126	380
27.3	Estimated number of deaths where case review identified problems with the care provided	6	4	2	2	14

Item 27, table 13: hospital deaths in 2018-9

The trust has several processes whereby a review of care given for all patients that die is undertaken. This includes mortality and morbidity reviews, responding to Dr Foster alerts, national audits in which we have participated, in addition to Maternal Newborn and Infant Clinical Outcome Review (MBRACE) and Learning Disability Mortality Review programme (LeDeR) reviews using an adapted mortality and morbidity review tool for use across all services.

The trust has developed concise and comprehensive root cause analysis investigation templates that are used for all trust investigations.

The trust began piloting the Medical Examiner (ME) role in February 2019 and the patient reviews are completed using electronic software. Formal appointments to the ME role will be made in June 2019 with Her Majesty's Coroner in attendance. A lead Medical Examiner role will also be appointed over the summer with a planned starting date of the autumn 2019.

The trust is working in partnership with our regulators the CQC and NHSI and will continue to collaborate going forward in the review of any unexpected deaths in particular services.

27.4 – A summary of learning from deaths case reviews and investigations identified in 27.3

- **Maternity/obstetric incidents**
  Further actions will be implemented on conclusion of the ongoing review of perinatal mortality. In addition the trust is now included in Healthcare Safety Investigation Branch (HSIB) the national action plan to make maternity care safer in line with the National Maternity Safety Ambition (2015) aimed to half the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth by 2025.

- **Slip, trip and falls**
  Undertake lying and standing blood pressure monitoring for patients who are at risk, review drug interactions. The trust is mindful that as we encourage mobilisation of patents to prevent deconditioning there will be an increase in the number of falls.

- Suboptimal care of deteriorating patients
  Ensure staff escalate patients of concern to senior clinicians both medical and nursing, ensure senior staff undertake clinical reviews and monitor for compliance against NEWs2 guidance.
- **Diagnostic incidents**
  Ensure clinical information provided at time of request details urgency of requirement for clinical investigations.

27.5 Actions are in place to address the learning from the deaths reviewed in 27.3 and itemised in 27.4.

27.6 What is the impact of the actions you have implemented?

In addition the trust has also initiated the following actions in direct response to the learning from deaths through mortality and morbidity reviews, responding to Dr Foster alerts and national audits in during 2017-18:

- **Medicalisation**: The trust has introduced treatment escalation plans for patients who have been identified and assessed as in the last year of life. The use of the new plan is ensuring that staff talk to the patient and their family/carers early about the prognosis, treatment options and outcome of their illness resulting in personalised care. This ensures the patients have a say in how much ongoing treatment they want, this will include discussing the full range of treatment options. The patient or their family and the doctors then set a ceiling on the level of treatment to be given.
- **Clinical coding improvement**: The trust continues to have coders and consultants working collaboratively to review the notes of all patients who have died. This ensure the trust has detailed the correct diagnosisand treatment given.
- **Improved diagnosis of COPD:** This has been addressed through the provision of education and training for our local GPs and junior doctors and is part of a project focusing on improving the patient outcome.
- **Standardisation of care:** The trust is introducing treatment bundles (which are separate items of treatment and care given for a particular diagnosis) and introduced this for patients being treated for fractured neck of femur (hip) chronic obstructive pulmonary disease, pneumonia, sepsis, acute abdomen, fluid and electrolyte management.
- **End of life pathways:** During 2019 the trust will be expanding the end of life team to ensure delivery of a seven day service and to achieve the six standards from the care of the dying audit. We are working collaboratively with our community partners to aid the discharge home for patients who want to spend their last days of life in their own homes will continue.
- A review of the smoking cessation pathway and serial scans on mothers who smoke has been implemented. A Smoking cessation midwife has been appointed.

27.7 How many case reviews have been completed in 2018-2019 relating to care given in 2017-18: **three**

27.8 From the case reviews can you estimate the numbers of deaths as result of problems in care given to patients in 2017-18: **one**

27.9 A revised estimate of the number of deaths during the previous reporting period detailed in **27.3** (14) and the additional case detailed in 27.8 (1) is a total of 15 patients. The total number of deaths identified in 2018-9 found to have been the result of care or service issues is: 0.02%.

28 The Gosport Independent Panel Report recommended trusts develop mechanisms for staff to speak up, provide feedback to staff who speak up and ensure they do not suffer detriment.

Our trust has two Freedom to Speak up Guardians (FTSUG) and their purpose is to work alongside the trust's executive and senior leadership teams to help support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely without the fear of any repercussions.

The FTSUG's receive training, guidance and support from the National Guardians Office and are an independent and impartial source of support and advice to all staff at any stage of raising a concern.

Staff are advised that they are able to raise concerns in a safe and confidential way and an agreement of how the concern will be taken forward is established with the staff member.

Concerns raised relating to bullying and harassment will be addressed via the trusts dignity at work policy and themes arising from reported cases alongside staff survey results are actioned through Health Care Group staff survey improvement plans.

The FTSUG produce quarterly reports identifying the work that they have undertaken and emerging themes. This is reviewed by the boards Workforce Committee. During 2018 the FTSUG supported over **65** cases to reach an outcome.
The focus over the next year will be:

- To develop FTSU Champion roles within each healthcare group to help support and raise awareness for becoming a robust, open and transparent organisation
- To support the relaunch of the "In Our Shoes" campaign – giving staff the opportunity to learn from each other to help future development
- To continue to support staff council – this is open to all levels of staff across the organisation and will help create a safe and open forum for discussion.

29. The trust has rota gaps for middle grades in most specialities. This is due to a short fall in trainees provided by Health Education England as well as vacancies in non-training posts. This is a national problem; the trust is mitigating this by:

- Prioritising acute and on call cover
- Daily review of the on call cover
- Active recruitment programme for middle grade doctors including overseas recruitment
- Smarter electronic roster planning by the human resources support team
- Improved ratio of doctors employed via NHSP bank rather than from agencies (80% of doctors are employed via the bank)
- Increased use of locum short term contracts rather than ad hoc cover
- Using an inter-ward buddy system to support staff

- The increasing use of physicians associates
- A pilot ward cover system for Surgery

Statement on relevance of data quality

PAHT continues to progress improvements in data quality:

- Regular reporting on data quality issues to the Access Board via the trust's fortnightly Operational Data Quality Group with oversight by the Performance and Finance Committee and Board of Directors.
- We continue with clinical validation of medical records coding to ensure the accuracy of data for national and local benchmarking.
- The use of data quality risk registers to manage data quality risks-issues and monitor the actions the trust takes to mitigate those risks.
- The Data Quality dashboard is published weekly to support monitoring and operational resolution of data quality issuesNHS Data Quality Maturity Index overall the Trust scored 97.5% (July-September 2018) and the trust compares favourably with other local acute trusts.

Data quality, metrics and processes

NHS number and general medical practice code validity

PAHT submitted records during 2018-19 as at February 2019 to the Secondary Users Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data (2017-2018 in brackets):

Which included the patient's valid NHS number was:

- 99.6% (99.7%) for admitted care
- 99.8% (99.8%) for outpatient care
- 98.0% (98.3%) for accident and emergency care

Which included the patient's valid general medical practice code was:

- 99.9% (99.9%) for admitted patient care
- 99.9% (99.8%) for outpatient care
- 99.7% (99.8%) for accident and emergency care

Information Governance (IG) position statement

The Data Security and Protection Toolkit (DSPT) replaced the previous Information Governance toolkit (IGT) in April 2018.

The new toolkit does not feature levels 1, 2 and 3. To meet the new standard, organisations were required to respond to 'all' evidence items which are identified as mandatory in order to confirm the associated 'assertions'.

As of the 27 March 2019 publication date, 23 out of 100 mandatory evidence remain red. The trust therefore published its 2018-2019 DSPT as 'Standards Not Met', but with a view for NHS Digital to upgrade this to 'Standards Not Met (Plan Agreed)' through an improvement plan submitted as additional evidence within the DSPT. Timelines for compliance of the above outstanding areas range from 1 April to 31 July 2019.

The General Data Protection Regulations (GDPR) came into force on the 25 May 2018, and with robust preparation the trust implementation plans became business as usual processes, which work in conjunction with the updated Data Protection Act 2018.

Clinical coding audit

Clinical coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes that reflect the care that has been provided to our patients. The accuracy of this coding is a fundamental indicator of the accuracy of patient records. The results should not be extrapolated further than the actual sample audited.

In 2018-19 the Information Governance (IG) toolkit has been replaced by the Data Security and Protection Toolkit, which still encompasses the same framework for clinical coding audit. Going forward the percentage accuracy scoring requirements for a trust are as follows (Figure 1).

Acute trust	Mandatory	Advisory
Primary Diagnosis	>=90%	>=95%
Secondary Procedure	>=90%	>=95%
Primary Procedure	>=90%	>=95%
Secondary Procedure	>=80%	>=90%

Table 14 : Expected clinical coding performance

In the 2018-19 audit, a total of 200 finished consultant episodes across a range of specialities were reviewed. The accuracy rates reported in line with the accuracy scoring requirements are displayed in Figure 2.

Acute trust	2018-19	Level of attainment
Primary Diagnosis	91%	Mandatory
Secondary Procedure	93.2%	Advisory
Primary Procedure	95.2%	Advisory
Secondary Procedure	91.3%	Advisory

Table 15 : Actual clinical coding performance

PAHT meets the targeted Data Protection and security toolkit attainment mandatory level for primary diagnosis and Advisory level for secondary diagnoses, primary procedures and secondary procedures. Coding error rates are below the NHS national average of 8.7% for diagnosis and 6.8% for procedure coding as measured by the PbR assurance framework (2011-2012 Assurance Programme). The trust will continue to improve its accuracy of coding, and will be focusing on improvements to address recommendations made as part of this audit.

Part three

Achievements and challenges in 2018-2019

Each year we assess our performance against the previous year's quality priorities, taking into account national reports and emerging themes.

Our patients objectives 2018-19: reduce mortality and improve the trusts HSMR - partially achieved.

Our focus	Our achievements
Reduction in the number of unexpected deaths. Reducing Hospital Standardised Mortality Ratio (HSMR) from 116.	Our 12 month average HSMR is 121, this classed as higher than expected. A positive indicators that our work programme focusing on reducing mortality is on the right track shows the last six months available data has only 1 month where our HSMR is higher than expected. The remainder are as expected
Reducing the number of mortality outlier alerts from 12 by 50% to 6.	Outlier alerts recieved: 7; this is a 42% reduction
Reducing mortality from Acute Kidney Injury (AKI) by 10% from 12.5%	Mortality from Acute Kidney Injury: HSMR for AKI is 131 with a rate of 15%, this has increased
Ensuring 90% of patients meeting the sepsis criteria would be screened for sepsis by 1/10/19.	Timely Identification of Patients with Sepsis In the Emergency Department (ED): 85% of patients were screened (by 1 October 2018). 86% of patients screened (by 31 March 2019) Across the ward areas for inpatients: 100% of in patients screened across the inpatient wards (by 1 October 2018) 90% of inpatients screened across the wards (by 31 March 2019) (Achieved).
Ensuring 90% of patients identified as having sepsis would receive appropriate treatment within 60 minutes by 1/10/10	Treatment of sepsis within 1 hour In the ED: October 2018: 91% treated March 2019: 94% treated (Achieved) In the ward areas for inpatients 100% treated by October 2018 100% treated by March 2019 (Achieved) Sepsis champions identified (Achieved)

Our patients objectives 2018-19: improve our patient's experience - partially achieved

Our aims	Our achievements
Ensure patients receive personalised care and are satisfied with their experience	With regard to personalised care: Local surveys assist in showing an improvement on areas identified from the annual National Inpatient Survey. We have set objectives to improve our performance in • Confidence and trust in nurses

	• Care and privacy in discussing my condition • Discharge support from health or social care With regard to patient satisfaction: evidence from 2018-19 shows a decrease in the total number of complaints received, a decrease in the number of cases upheld by the Ombudsman and in addition evidence from local surveys shows that satisfaction has improved. This includes the Friends and Family test (FFT) data which shows that we achieved the highest score to date across all services at 96.6%.
Improve inpatient survey results ensuring we reduce and eliminate questions that were rated in lowest 20%. Ensure 10 questions are placed in the top 20%. (please note the measurement completed by the National Survey in year has changed In 2017 survey marks out of 10, in 2018 survey marked as a %	The Trust improved its performance on the 2018 Survey with fewer questions scoring below what is expected compared to last year. Of 71 questions only 10 were lower than expected compared to 18 last year. (The way this survey is scored has changed in year so we can no longer say that a question was scored in the lowest or highest 20%. Instead of this we can say the score was below or above the expected range.)
Ensure the following questions are rated in top 20%: Question 27: Confidence and trust in nurses (scored 8.7 in 2017) Question 39: Care and privacy when discussion my condition (scored 8.6) Question 54: Discharge support from health or social care professionals (scored 6.6 in 2017)	Although our local surveys showed the response to all three of these questions had improved, the national inpatient survey showed no significant change
Reduction in complaints received from 229 by 10% to 206 or less	Reduction in the number of complaints by 10% to 206 (Achieved)
Increase the number of PALs concerns successfully resolved by 10%	The trust performance in resolving PALS cases at a local level has deteriorated in year. This was due to an increase in the volume of work and staffing vacancies that resulted in not all enquiries being logged.

Our people objectives: recruitment and retention of registered nurses - achieved

Our aim	Our achievements
Increase the numbers of registered nurses and reduce the vacancy rate	Our vacancy rate reduced from 28% to 25.9% of registered nurses (RN) across the trust. We are working to significantly reduce RN vacancy rates further following implementation of a focused nursing recruitment campaign scheduled for deployment throughout 2019 In addition, we have worked to improve our retention rates and have seen a reduction in leavers from 17.3% to 14%

Our people objectives: staff experience will be consistent with the trusts strategy and values - partially achieved

Our aims	Our achievements
Every member of staff will feel the trust values are demonstrated and evidenced from our national staff survey results.	Staff experience consistent with the trusts values Improved response rate for staff survey 2018 with PAHT scoring better in 15 questions compared to last year and no significant different to last year for 67 questions
Improved trust scores against these four questions Question 17: staff experiencing discrimination from patients and service users will improve (scored 94%) Question 17b: staff are not experiencing discrimination from manager or colleagues (scored 91%)	Improved trust scores against these four questions Question 15a (previously question 17): staff experiencing discrimination from patients and service users will improve (scored 94%) Question 15.b (previously Q17b): staff are not experiencing discrimination from manager or colleagues (scored 92%)
Question 18a staff had training and development (scored 71%) Question 18b staff reported training helped me to do my job (scored 80%)	Question 20 (previously Q18a) staff had training and development (Score 69%) Question 18b staff reported training helped me to do my job – no longer asked
Question 18c training helped me stay up to date professionally (score 82%)	Question 18c training helped me stay up to date professionally – no longer asked Question 19 Staff had mandatory training in last 12 months – no longer asked
Question 19 staff had mandatory training in last 12 months (score 97%)	Replaced the three questions no longer asked with the staffs comments on the value of their appraisal Question 19a appraisal/performance review: organisational values definitely discussed (scored 47% - 1% increase) Question 19b appraisal/review definitely helped me improve how I do my job (scored 26% - 1% increase) Increased compliance with statutory mandatory training from 84% to 93% Increased compliance with annual staff appraisal from 78% to 92% Mental health support including Mental Health First Aiders with over 20 staff trained and mental health awareness day run over the three hospital sites to support our staff Staff introduced and embedded Successful Event in a Tent 2018 which included a wellbeing day, our amazing people awards and long service awards.

Our performance objectives: improvement in the Emergency department (ED) four hour access standard - partially achieved

Our aims	Our achievements
Improve the numbers of patients that receive timely treatment in the ED	Delivering the four hour standard has remained a challenge this year. We saw progress in improving performance in early Autumn. Due to increase in demand this has not been able to be sustained. The trust performance improved to 74%. This is a 3% improvement in year. The numbers of patients attending has increased by 8.8% since November 2018
Reduce the time for patients arriving by ambulance to be handed over to trust staff	Reduced ambulance delays to our target performance of >80% of patients accepted in less than 30 minutes: Improved from 75% to 84% <20% of patients handed over after 30 minutes: Improved from 25.2% to 16% Having access to a Hospital Ambulance Liaison Officer (HALO) since autumn of 2018. The changes in year have been delivered by • Ensuring patients are on the correct pathway of care to either GP services, Emergency nurse practitioners in the Minor injury area or the Majors treatment area. • Opening a 20 bed clinical decision unit • Recruiting paramedic staff to support effective discharge of patients from ED Continued work with the Emergency Care Intensive Support Team (ECIST) to embed changes to ensure all internal systems and processes are optimised. Realigned the inpatient wards in year to provide additional beds and adjacencies of locations.
Reduce length of stay for conditions outside the benchmark of best practice	Reduced length of stay (LOS) for outlier conditions and variations: Cardiology: LOS 10.3 days (Mar 18) to 8.0 (March 19) General Surgery: LOS 2.9 days (Mar 18) to 2.4 (Mar 19) Respiratory: LOS 8.6 days (Mar 18) to 12.3 (Mar 19). Further work is underway in Respiratory Medicine to identify alternative pathways reviewing how acute and primary care teams can work closer together to support patients with long term conditions. The number of days for a patient to be discharged once medically fit to proceed with ongoing health

	and social care support has reduced by 40% through working closely with system partners; delivering better than the national standard for performance.
Timely transfer of critical care patients to wards	Transfer of critical care patients to inpatient wards has improved in year Delays of up to 24 hours: reduced from 21-23 per month in April 18 to 15 in March 19 Delays over 24 hours: reduced from 17 per month in April 18 to 5 in March 19

Our performance objectives: improve performance against access standards - partially achievement

Our aims	Our achievements
Deliver RTT incomplete standard by June 2018	Delivery of RTT incomplete performance was achieved by July 2018 after the elective care suspension of 2017-18. This has been maintained for remainder of 18-19 (achieved)
Consistently deliver the cancer national standards	Delivery of the national cancer was challenging due to workforce issues in key specialities. This has been partially achieved.
Extend one stop diagnostic services already available in breast and urology to other key specialities	Extended one stop diagnostic services to specialities managing general surgery patients on a cancer pathway and to vascular surgery.

Our performance objectives: ensure the trust is inspection ready to obtain a good at the next CQC trust inspection - unknown as Inspection outcome expected July 2019

Our aims	Our achievements
Deliver progress against the 33 objectives detailed in the CQC report received in 2018 (Must and Should complete items)	Progress is reported monthly. The trust has delivered 82% of objectives as either implemented and fully embedded in practice, achieved or not graded.
Implement and deliver a CQC preparation plan	Within the trust progress is shared through monthly Quality and Safety Committee, Patient Safety and Quality Groups to ensure the teams working across our clinical areas are aware of our progress. The reports are also placed on the trust intranet for people to review. Quality Compliance Improvement group was established to ensure organisational readiness for the next inspection. The trust has set up peer review inspections of our wards and departments with a wide variety of staff in attendance: Patient panel, our commissioning colleagues and a wide variety of hospital clinical and non-clinical staff. Results are shared with the wards at the end of the inspection and an action plan for improvement is developed if required.
Improve services graded as Requires	Our Quality First team have worked with staff

Improvement	members to embed a consistent approach to quality improvement across the trust. This year the trust shared over 70 completed quality improvement projects led by our staff. As a result of this work the trust was awarded the national Fab Change champion trust for the second successive year. The inspection of our clinical services commenced in March. We anticipate receiving the CQC report by mid July 2019, the report will demonstrate areas where we have made an improvement

Our performance objectives: clinical areas and critical functions to be refurbished - partial achievement

Our aims	Our achievements
Complete a clear risk assessed, prioritised and costed list of Estates works plan to be approved by the trust Board	The six facet survey was completed (risk assessment). This identified a significant increase in backlog maintenance currently assessed as £105m Eleven significant backlog maintenance projects completed to the trust's highest estate risks of drainage, refurbishment of clinical environments, work to prevent water ingress to patient areas, security and infrastructure
Bring the orthopaedic fracture clinic back onto the Harlow site	Work is underway to develop the orthopaedic fracture clinic on harlow site expected to be completed by January 2020
Refurbishment of our cancer care facilities	Business case will be developed to provide the cancer care facilities
Create an onsite education facility	This will be linked with the cancer care facility
Refurbish the lifts	Tender process completed. Work expected to be completed by September 2019
Complete work to upgrade the electricity systems	Tender process to commence in Spring 2019
Address regulatory and urgent works as required	PLACE 2018 survey results delivered a significant improvement with the trust exceeded national averages in a number of areas. Two new maternity theatres opened in November 2018 A new ward (Charnley), with 27 additional beds opened in January 2019 The critical care unit is being refurbished to insert additional sinks and one extra isolation area, work expected to be complted by August 2019

CQUIN achievement 2018-19

The Commissioning for Quality and Innovation (CQUINs) payment framework encourages care providers to share and continually improve delivery of care. In 2018-19 the trust continued delivery

of the second year of the 2 year scheme published by NHS England in 2017. This included addressing changes to thresholds where appropriate and ensuring that the scheme continued to support local areas on activities that would contribute to developing integrated care systems.

The increased focus on prioritising Sustainability and Transformation Partnership (STP) engagement to reinforce the critical role of local partners in delivering system wide objectives continued in the 2018-19 CQUINs, with this element being assigned 1.25% of the total financial value for the year. The remaining 1.25% is assigned to clinical quality and transformational indicators which aim to improve quality and outcomes for patients including reducing health inequalities, encouraging collaboration across different providers, and improving the working lives of NHS staff.

Table 16 and 17 detail the actual schemes and their potential financial value. Following submission of quarter 4 data, actual achievement will be confirmed by mid-June 2019.

CCG CQUIN Schemes	Associated Financial Value (£'000)	2018-19 CQUIN achievement	2018-19 Actual (£'000)
1. NHS Staff Health and Wellbeing	**£422**	**67%**	**£281**
2. Reduction in impact of serious infections	**£422**	**56%**	**£234**
3. Improving services for people with MH needs who present to A and E	**£422**	**100%**	**£422**
4. Offering Advice and Guidance	**£422**	**0%**	**£0**
5. Preventing ill health by risky behaviours	**£422**	**70%**	**£294**
STP involvement	**£2,110**	**100%**	**£2,110**
Total	**£4,220**	**79.18%**	**£3,341**

Table 16 : CQUIN achievements in 2018-19

NHSE CQUIN Schemes	Associated financial value (£'000)	2018-19 achievement forecast out turn	(£'000)
1. GE3 Meds optimisation	**£158**	**82%**	**£129**
2. CA2 SACT			
3. NHSE Non Specialised CQUIN Oral Health	**£44**	**100%**	**£44**
Total	**£202**		**£173**
Grand total	**£4,422**	**79.46%**	**£3,514**

Table 17: NHS England CQUINS in 2018-19

CQUIN plans for 2019-20

Published guidance for the Commissioning for Quality and Innovation (CQUIN) scheme for 2019-20 introduces a radically different approach to CQUIN. Instead of setting new goals CQUIN will simply highlight evidence based good practice that is already being rolled out across the country, drawing attention through the scheme to the benefits for patients and providers, and in doing so allow those benefits to be spread more rapidly.

CQUIN is being given fresh clinical momentum, whilst prioritising simplicity and deliverability. Broad clinical consensus exists over each included method, following wide engagement with national programmes to select from existing interventions in support of the Long Term Plan.

Alongside the new approach to the selection of areas for CQUIN, the payment rules for indicators within the CCG scheme have been simplified, allowing greater transparency over performance and earnings, based on achievement between lower and upper adoption goals for each supported intervention. 2019-20 is the first year of this new approach, and it is expected that there will be a process of refining and improving from 2020.

In 2019-20, the trust will be commencing work on the following new schemes:

- Antimicrobial resistance to improve adherence to national antibiotic guidance in the treatment of lower UTIs and elective colorectal surgery.
- Preventing hospital falls to improve older inpatients receiving key falls prevention actions.
- Same day emergency care which aims for eligible patients to be managed in a same day setting for pulmonary embolus / tachycardia / community acquired pneumonia patients
- Trauma - to establish the validity of the current reported TARN position, identify potential causes of the deterioration and seek to establish and implement individual action plans with each Trauma Unit to address the areas highlighted.

Our staff

Without doubt, the trust's staff are our greatest asset, regardless of their role. In 2018 the Care Quality Commission rating for staff caring was **good**; the inspectors witnessed staff delivering care that was compassionate, involving patients in decision making and providing good emotional support to patients and those close to them. The trust recognises the value of a committed, dedicated workforce and over the last year has continued to support individuals to develop and improve with the following approaches:

Education - learning, leadership and development

To deliver sustainable and quality services, our staff need to be well trained, professional and valued. In 2018-19 the trust launched Our People Strategy which describes the steps we are taking to develop a diverse and inclusive culture where staff feel engaged, have scope to grow and develop, are empowered to transform how services are provided and committed to delivering outstanding care. We support our staff to ensure core (statutory/mandatory) training compliance is maintained at our target rate of 90%, and we will continue to offer a diverse range of delivery options, and work with our STP partners to develop a training passport. We have continued to strengthen and grow our resuscitation training provision to include more advanced

and specialist courses (both internally, and for external income generation). We continue to make effective use of our funding and with support from Health Education England, for the provision of Continued Professional Development (CPD).

Organisational development and engagement

An organisational development and engagement strategy is being developed and will include:

- A Staff Engagement Steering Group, plus local groups to help create a feedback loop to improve culture and leadership, linked to improvements from our 2018 Staff Survey results.
- Staff appraisal – pay progression - talent management/succession planning – An updated appraisal scheme with improved focus on staff wellbeing.
- Supporting staff to achieve and maintain 90% compliance of our staff having an up to date appraisal.
- A Behaviour Charter which will include updated values and behaviours workshops.
- Local and trust-wide awards/Long Service Awards
- Staff Council to generate and test staff ideas

Unsung hero of the year - Winner

Carol Jordan
Associate theatre practitioner

Individual of the year - Winner

Dr Pratik Solanki
Senior clinical teaching fellow

Learner of the year - Winner

Eva Nkansah
Lead biomedical scientist

Living the values – Respectful award Winner

Curtis Beeson
Head porter

Management, leadership and team building

Strong management, leadership capabilities and team working across all levels and areas are required in order to deliver the size of the agenda facing the trust. During 2018-19 we have supported over 600 staff to access a wide range of internal and external leadership and management development opportunities. We also welcomed three new NHS graduate management scheme trainees to the trust.

Moving forward, a leadership and management development steering group will be established to develop a leadership framework, with a range of learning opportunities to support this, including:

- Unconscious bias sessions for all managers/leaders
- Leadership and management development programmes and short courses
- Team building/team development
- Coaching/mentoring
- 5 o'clock leadership network

Equality and Inclusion Steering Group (EISG)

The trust established an equality and inclusion steering group in April 2017 which has gone from strength to strength throughout 2018 with champions for each of the nine protected characteristics. The EISG has worked to agreed terms of reference and has contributed to a number of successes including:

- New trust policy on equality and inclusion
- Production of a new equality and inclusion statement
- Launch of equality and inclusion charter
- Co-ordination of Black History Month celebration (2x)
- Production of an equality and Inclusion calendar – to make reference and observe were necessary religious and diversity events to represent our diverse workforce
- Contribute to and support equality and Inclusion actions in relation to the staff survey results
- Appointed equality and inclusion champions for all nine protected characteristics
- Launch of the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning plus (LGBTQ+) network
- Launch of the Black, Asian and Minority Ethnic (BAME) network
- Steering group members and equality and inclusion champions have completed the Managing Equality and Diversity ILM Level 4 Award Accredited Programme
-

The work of the Equality and Inclusion Steering Group has provided a solid foundation on which to build and with an increased focus on inclusive leadership there is confidence that the trust will continue to commit to learning and to being the employer of choice. We will continue to focus on inclusive leadership throughout 2019-20.

Multi-professional education

The trust continues to support non-medical pre and post registration students in partnership with affiliated Universities; providing practice placements for student nurses (Adult, Child and Mental Health), midwives, Operating Department Practitioners ODPs), a range of Allied Health Practitioners (AHPs) and staff on apprenticeship pathways (Associate Practitioners, Training Nursing Associates).

All students will continue to be supported by trained mentors, practice educators and practice facilitators as the trust implements the new Nursing Midwifery Council (NMC) standards, due to commence in September 2019.

Apprenticeships, vocational education and Schools/College liaison

The trust is developing a new apprenticeship strategy, implementation plan and policy which will be launched during 2019. This will be overseen and directed by a new apprenticeship and student steering group, aiming to maximise our return on investment from payments made to the statutory apprenticeship levy. The trust aims to achieve our public sector apprenticeship target (2.3% of workforce) by 2020. Work continues on developing existing apprentices; identify existing roles and exploring new posts that can be offered as new apprenticeship opportunities. To date the trust has:

- Supported and facilitated 40 apprenticeships, supporting managers with workforce planning to enable inclusion of these roles.
- Provided training and assessment for achievement of the care certificate to all newly appointed Health care assistants, Maternity care assistants and Theatre practitioners
- Supported and facilitated Maths and English skills for staff via Harlow College
- Supported individuals and teams with career pathway planning

With the aim of identifying the workforce of tomorrow, the trust has improved links with local education; creating a presence in schools as students consider their career options. Being present when careers are considered and maintaining supportive links has been achieved through a range of approaches

- Coordination and attendance at local careers fairs and events, reached out to over 2800 local young people.
- Coordinate and deploy the trusts team of 17 health ambassadors
- Support further education colleges and schools with the delivery of their health related curriculum
- Work with local primary schools on their programmes to raise aspirations and outcomes for their pupils
- Work in collaboration with local organisations to support local young people, providing 183 work experience placement from approximately 600 requests.
- Provide programmes for potential Medical students including mock interview practice with FY1's.

Medical education

The trust welcome approximately 120 new trainee doctors of all grades and specialties who arrive on placement to from Health Education England each year. We continued to build on the improvements to induction and training implemented in 2017-18. Our new junior doctors committee will continue to help us to direct this work to ensure that trainee experience is excellent. We have improved our pastoral/emotional support to colleagues in training as part of our ambition to become a placement provider of choice.

Our first seven student physicians associates joined the trust in 2016 and we have successfully employed two from this cohort. In 2017 we welcomed a second group of six student physicians Associates and all six were offered employment opportunities within the trust commencing August 2018. In September 2018 we welcomed a further group of eleven student physicians

associates who are currently rotating through various specialties within the trust. We look forward to further developing this successful programme in 2019-20.

Staff Survey – 2018 Results

The annual NHS Staff Survey and the quarterly Staff Friends and Family Test are crucial barometers of how our staff view their workplace. The feedback is useful in helping us to highlight improvements that will make the hospital a better place to both work and be treated.

The results reflect the continued good progress we have made over the past twelve months to improve the quality of care we provide. However, as we already know, there is more we need to do to improve the experience of people working here and we are committed to doing exactly that.

We are now amongst the best performing trusts in the country for:

- The quality of staff appraisals
- Support given to staff by immediate managers
- Our safety culture

What staff told us has improved:

- Staff are more satisfied with the recognition they receive for good work and feel more valued
- Staff are more satisfied with their level of pay
- Many staff agree that the trust acts on concerns raised by our patients/service users and uses feedback from patients/service users to make informed decisions
- Most staff feel that they have been supported to receive training, learning or development identified in their appraisal
- More staff continue to positively rate their experience of their appraisal, including discussion of our trust values and how valued they felt
- Over half of our staff feel that they have opportunities for flexible working patterns
- Many staff see care of patients being the trust's top priority
- More staff would recommend the trust as a place to work and a place to receive treatment
- More staff feel that communications between senior managers and staff is effective
- More staff feel that they are treated fairly when involved in an error, that the trust takes action to learn from incidents and makes changes.

What we need to improve

- Availability of adequate materials, supplies and equipment to support staff in their roles
- Having enough staff at the trust
- Staff working additional hours
- Some staff experience violence, harassment and abuse from staff, patients and visitors which is unacceptable
- Continued focus on improving staff health and wellbeing, in particular around stress management, and feeling pressure to come into work when not well enough

The trust is committed to making further improvements across all of these areas with the overarching aim of improving staff satisfaction. This is particularly important if we are to deliver our quality improvement plan, which focuses on enabling outstanding care for all of our patients,

all of the time. Staff feedback from one member in year stated:

"I have been working in the trust for over 18 years. I was part of the first cohort of overseas nurses which was scary at first, but the staff at the trust are incredibly friendly and helped me a lot. We offer many opportunities for our staff to grow and develop their career. As a trust, everyone works hand in hand to achieve our goals."

Staff Friends and Family Test results 2018-19

This national survey is made available to all staff employed in the organisation on a quarterly basis. Two questions are asked in quarter 1, 2 and 4, however slightly different questions are asked in quarter 3 as part of the annual national staff survey. The questions are:

1. How likely are you to recommend this organisation to friends and family if they needed care or treatment?
2. How likely are you to recommend this organisation to friends and family as a place to work?

Results for 2018-19 show continued progress, and for both questions we met the Department of Health (DoH) targets in all 3 quarters measured.

Question	DoH Target %	Q1 2018	Q2 2018	Q4 2019
1	67%	78%	76%	75%
2	61%	65%	61%	62%

Table 18: Staff family and friends results

The organisation is monitoring the results of this feedback, and linking it to our national staff survey results, and will continue to progress improvements for the benefit of our patients and staff.

Research Development and Innovation

Active studies 2018-19	
Commercial	**Academic**
27	78

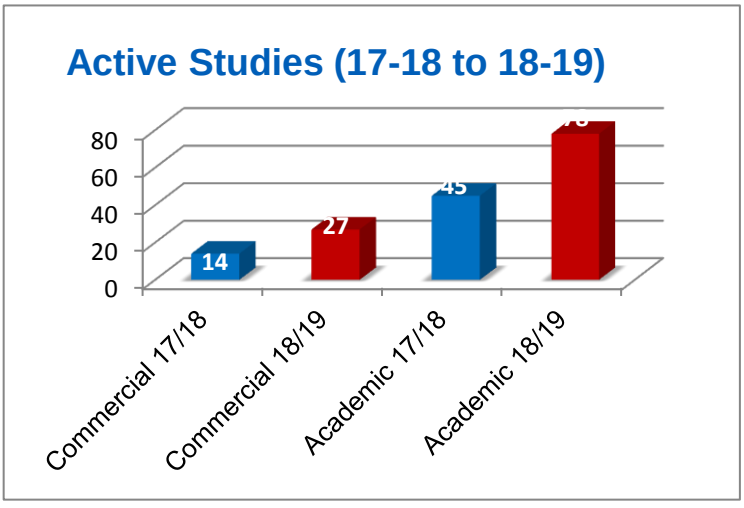
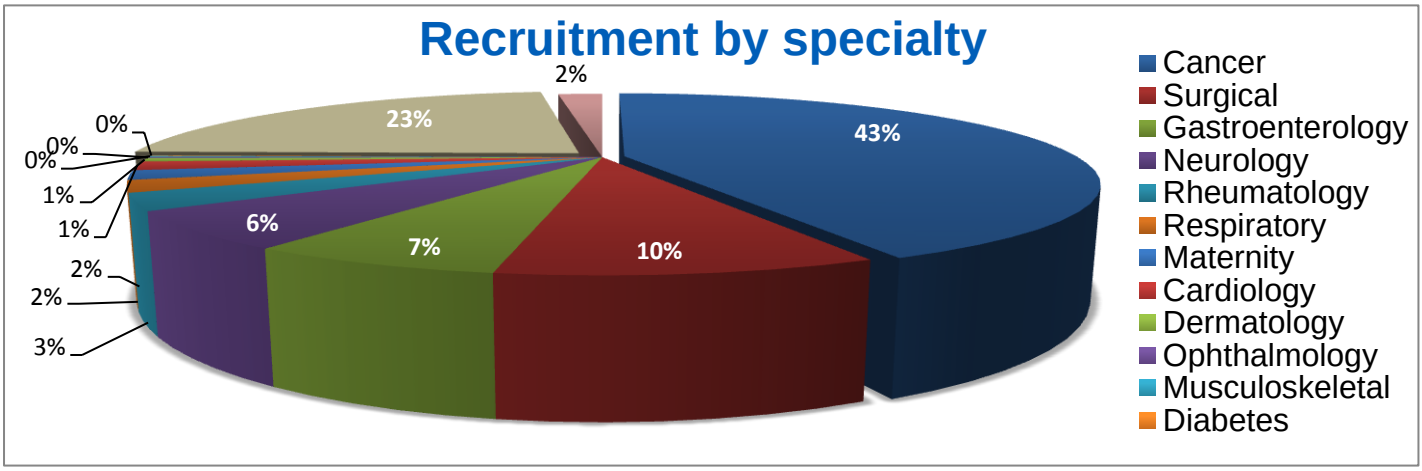
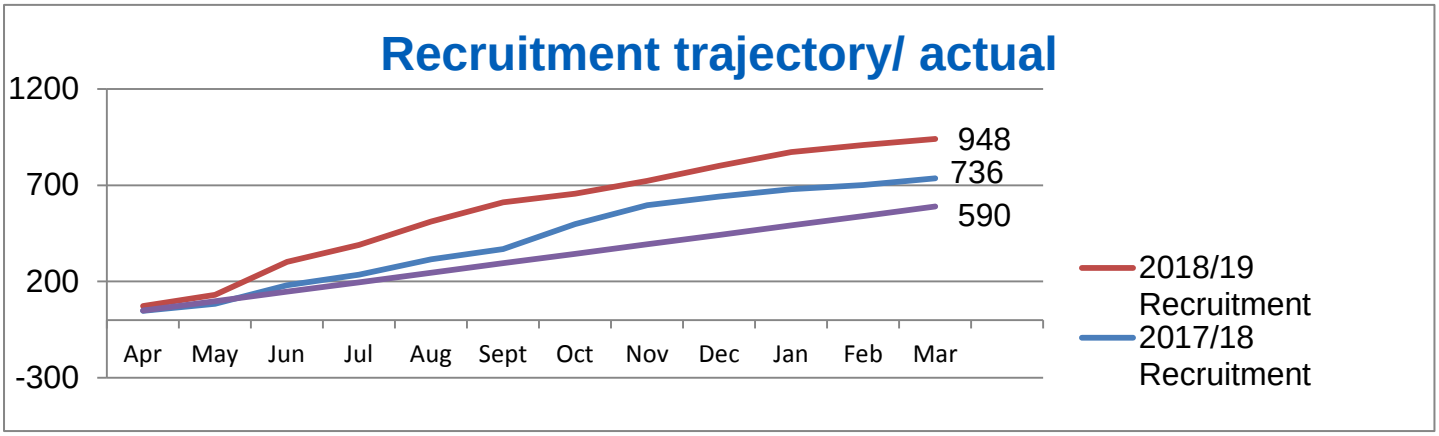


Figure 2: Active research studies Recruitment target 2018-19

In the beginning of 2018-19, it was agreed with North Thames Clinical Research Network that PAHT recruit a target of 590 participants into National Institute for Health Research (NIHR)

portfolio adopted trials. Nearing the end of the financial year, the number of participants recruited into research is 948 as of 27 March 2019 see figures 3 and 4.





Incident management, sharing the learning and safety improvement

Patient safety is a priority and we continuously work to ensure that incidents are managed effectively and most importantly that we learn and share the improvements from them.
A patient safety incident or adverse incident is defined as 'any unintended or unexpected incident which could or did lead to harm for one or more patients receiving NHS funded care'. This includes all terms such as adverse incidents, adverse events and near misses, where an incident was recognised and averted.

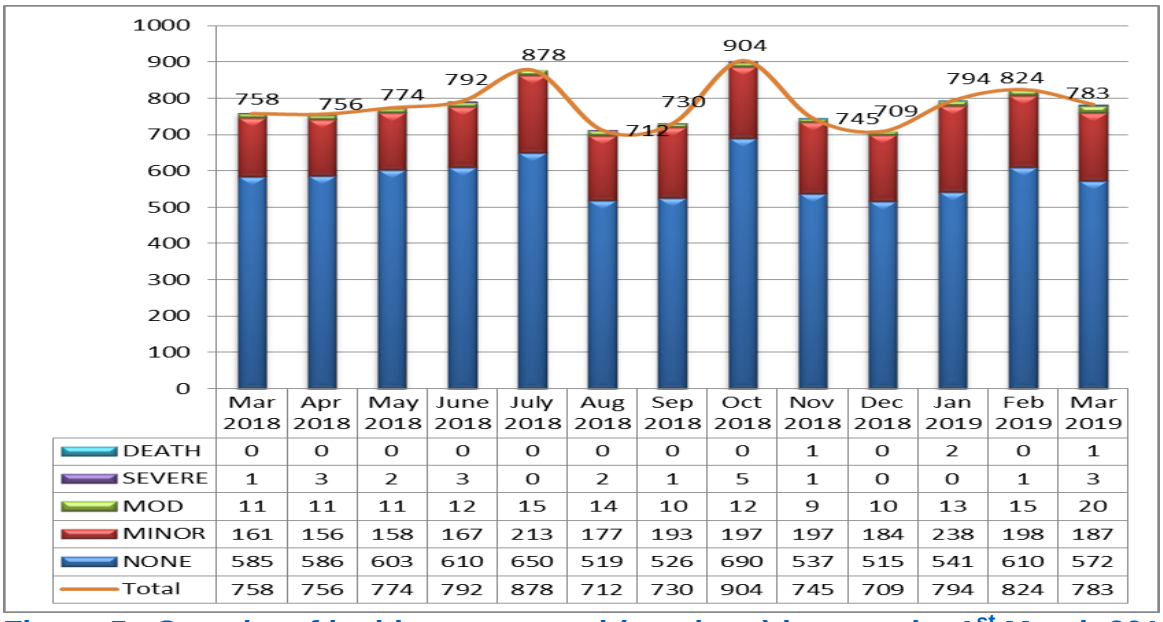
- During the year April 2018 to March 2019, a total of 9371 incidents were reported on the trust's incident management system (Datix), as having occurred in PAHT. This is a 2% reduction when compared with 9580 over the same period in the previous year. The trust is reporting, on average, 781 incidents per month, this demonstrates a good reporting culture which is deemed a positive step when coupled with low levels of patient harm. This developing positive culture was evidenced in our staff survey (2018) which demonstrated inmprovement in the following two key metrics: many staff agree that the trust acts on concerns raised by our patients/service users and uses feedback from patients/service users to make informed decisions, secondly more staff feel that they are treated fairly

when involved in an error, that the trust takes action to learn from incidents and makes changes.

The majority of incidents reported were low or no harm incidents (9186) representing 97.99% of the total incidents for this period. The remaining 188 incidents (2.01%) resulted in either moderate or severe harm. There were 163 moderate harm incidents (1.7%); a reduction from 3.9% in the previous year. There were 25 incidents were the harm was assessed as severe (0.27%).

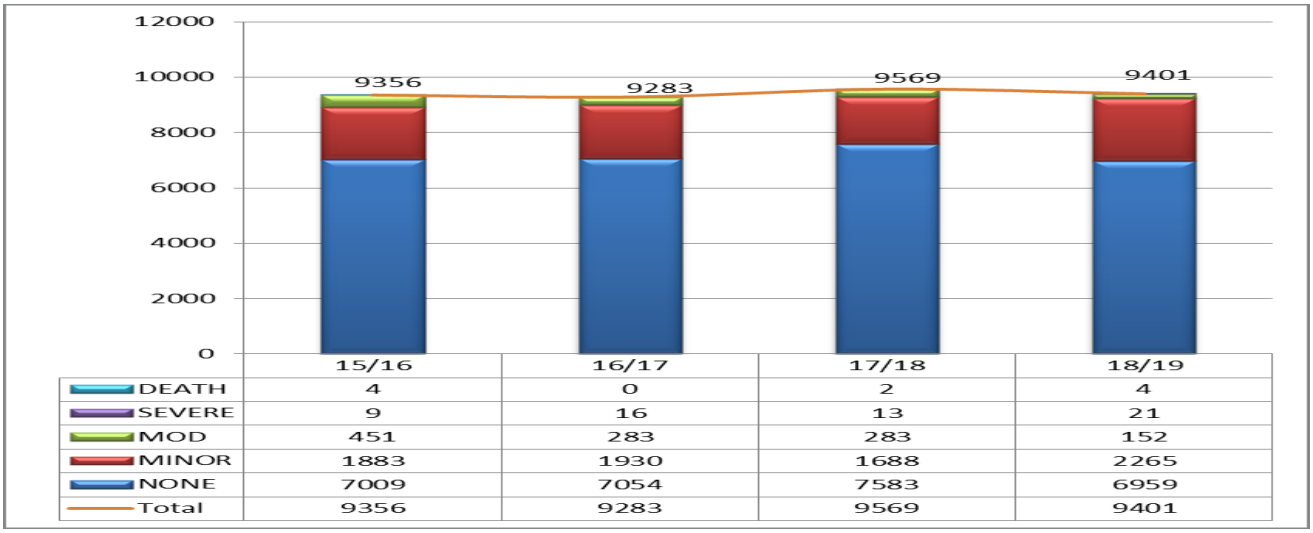
All these incidents are reported to the National Reporting and Learning System (NRLS) to enable learning and comparison with similar sized organisations to occur.

We have been working hard to ensure that staff receive feedback following the closure of an incident; currently we are achieving this for 80% of all incidents.



	Mar 2018	Apr 2018	May 2018	June 2018	July 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
DEATH	0	0	0	0	0	0	0	0	1	0	2	0	1
SEVERE	1	3	2	3	0	2	1	5	1	0	0	1	3
MOD	11	11	11	12	15	14	10	12	9	10	13	15	20
MINOR	161	156	158	167	213	177	193	197	197	184	238	198	187
NONE	585	586	603	610	650	519	526	690	537	515	541	610	572
Total	758	756	774	792	878	712	730	904	745	709	794	824	783

Figure 5: Severity of incidents reported (numbers) by severity 1st March 2018 to 31 March 2019



	15/16	16/17	17/18	18/19
DEATH	4	0	2	4
SEVERE	9	16	13	21
MOD	451	283	283	152
MINOR	1883	1930	1688	2265
NONE	7009	7054	7583	6959
Total	9356	9283	9569	9401

Figure 6: Four year comparison of severity of reported incidents (2015 – 2019)

Themes from Serious Incidents (SIs)

There have been 39 serious incidents (SIs) at the trust during 2018-19 declared through the Strategic Executive Information System (StEIS) and reported externally in year. This excludes SIs that have been de-escalated by the CCG as the investigation demonstrated that there were either no care or service delivery problems or following the discovery of further information, they were found to not meet the SI threshold.

The SI framework encourages discussion and review of incidents on a case by case basis including a discussion on the level or degree of harm caused.

The trust ensures that an open and honest review and discussion of all SIs takes place through the Serious Incident Group (SIG). The group is chaired by either the Chief medical officer or the Director of nursing and midwifery and is scheduled every day from Monday to Friday to limit any delays and to enable open and frank discussion whilst the details of the incident are fresh in the minds of our staff.

All potential serious incidents are presented and discussed to identify whether they meet the national SI framework requirements. The most frequently reported SI topics during this reporting period were

- Treatment delay meeting SI criteria (14 incidents)
- Diagnostic delay meeting the SI criteria (4 incidents)
- Maternity/obstetric incident meeting the SI criteria for mother and baby (4 incidents)

Never events

There were no never events in 2018-19. The last reported never event was 2015-16

Sharing the learning events

The trust's Patient Safety and Quality teams worked with relevant experts across the trust to organise and facilitate four sharing the learning events during 2018-2019:

- **12 April 2018:** Focus on sepsis and Acute Kidney Injury (AKI) – presentation on blood cultures in sepsis, a simulation session and two interactive games to support learning.
- **11 July 2018**: Two audit presentations – negative appendectomy rate and clerking standards. A review of mortality by the Chief medical officer and a presentation on consent and legal cases by the trust's Legal services manager
- **12 October 2018**: Presentations from each of our healthcare groups covering: serious incidents, anticoagulation, neutropenic sepsis, gastrointestinal bleeds, morbidity and mortality, CQC musts and should completed actions. The Quality First team presented adopting a quality improvement approach to embedding and sustaining change.
- **10 January 2019:** A journey from a quality initiative to research to intellectual property with external presenters as well as presentations from Quality First and the trusts Library team.

Being Open and Root Cause Analysis (RCA) investigation skills training

The trust continues to invest in RCA investigation training as well as supporting staff through the provision of training on Being Open and Duty of Candour conversations with patients and families. In 2018-19 the trust provided Being Open/Duty of Candour training for 10 staff and RCA for 64 staff.

Clinical effectiveness

The trust is required to participate in national audits to ensure that we are taking every opportunity to learn and improve. During the period 1 April 2018 to 31 March 2019, we participated in 94% of the national clinical audits and 100% of the eligible national confidential enquiries (NCEPOD Studies), applicable to NHS services that PAHT provides.

The national clinical audit and NCEPOD Studies that the trust participated in during 2018-19 are as indicated in tables 19 and 20.

Name	Participation	% cases or number submitted
Adult community acquired pneumonia	Yes	18 cases sumitted in year
Bowel cancer (NBOCAP)	Yes	164 submitted during 2018
Cardiac Rhythm Management (CRM)	Yes	176 cases submitted in year
Case Mix Programme (CMP)	Yes	315 cases submitted in year
Diabetes (Paediatric) (NPDA)	Yes	110 cases submitted in year
Epilepsy 12	Yes	Data collection running between 2018-2020.
Elective surgery (National PROMs Programme)	Yes	607 cases submitted
Falls and Fragility Fractures Audit programme (FFAP) – inpatient falls	Yes	No cases met the criteria for submission
Falls and Fragility Fractures Audit programme (FFAP) – National Hip Fracture Database	Yes	356 cases submitted in year
Feverish children	Yes	139 cases submitted in year
Inflammatory Bowel Disease (IBD) programme	No	
Learning disability mortality review programme	Yes	100% (11 cases)
Major trauma audit	Yes	200 cases submitted between 1 January to 31 December 2018
Maternal, new-born and infant clinical outcome review programme	Yes	100%
Mandatory surveillance of bloodstream infections and clostridium difficile infection	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National audit of breast cancer in older people	Yes	100%
National audit of dementia	Yes	100% 64 cases submitted (during 2018)
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Asthma Chronic Obstructive Pulmonary Disease (COPD) audit programme– adult asthma secondary care	Yes	Data collection continues commenced November 2018

National asthma and COPD – chronic obstructive disease – secondary care	Yes	195 cases submitted in year
National clinical audit for rheumatoid and early inflammatory audits	Yes	78 cases submitted in year
National comparative audit of blood transfusion - management of massive haemorrhage	Yes	100%
National comparative audit of blood transfusion - use of fresh frozen plasma and cryoprecipitate in neonates and children	No	Rarely transfuse these products trust has opted out of participation.
National diabetes (adult): pregnancy in diabetes	Yes	100%
National diabetes audit : foot care	Yes	100%
National diabetes – adults – NaDIA-harms-reporting on diabetic inpatient harms in England	No	
National diabetes – adults – NaDIA – inpatient – reporting data services in England and Wales	Yes	40 cases submitted in year
National Emergency Laparotomy Audit (NELA)	Yes	71 cases for 17-18 18-19 submission is in progress to lock down January 2020
National diabetes audit national core diabetes audit	Yes	Data submitted via primary care
National end of life care audit	Yes	100%
National heart failure audit	Yes	Data submission continues with audit ongoing
National Joint Registry (NJR)	Yes	91% during 2018
National Lung Cancer Audit (NLCA)	Yes	190 cases submitted in year
National maternity and perinatal audit	Yes	100%
National Neonatal Intensive and Special Care (NNAP)	Yes	100%
National ophthalmology audit	Yes	40.1% (16-17 aata as recorded in report published 2018)
National vascular registry	Yes	62 Cases
Non-invasive ventilation - adults	Yes	Ongoing as data collection continues until 30 June 2019
Oesophago-gastric Cancer (NAOGC)	Yes	86 submitted Data submission in progress
Prostate cancer	Yes	250 cases submitted in year
Reducing the impact of serious infections (antimicrobial resistance and sepsis) – antimicrobial consumption	Yes	100%

Reducing the impact of serious infections (antimicrobial resistance and sepsis) – antimicrobial stewardship	Yes	100%
Seven day hospital services self-assessment survey	Yes	100%
Surgical site infection surveillance	Yes	589 cases submitted for 2018
Serious hazards of transfusion	Yes	100%
Vital signs in adults (care in emergency departments)	Yes	142 cases submitted.
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	39 cases submitted

Table 19: National Clinical Audits in which the trust is eligible to participate

NCEPOD Study Title	Participation	% cases submitted
Cancer in children, teens and young adults	Yes	No applicable cases
Perioperative aiabetes	Yes	No applicable cases
Pulmonary embolism study	Yes	100%
Acute bowel obstruction	Yes	100%

Table 20: summary of NCEPOD studies that the trust was eligible to enter data for

The reports of a number of national clinical audits were reviewed by PAH during 2018-19. Examples of action taken to improve the quality of healthcare provided can be found in Table 21

Name of national audit (Quality Accounts)	Actions completed / achievements
Fractured neck of femur	• Pain relief is provided to the majority of patients within an hour of arrival. • 85% achieved whereas the national median is 30% • Aim to improve time to assessment.
National Audit of Breast Cancer in Older People (NABCOP)	• Edmonton frailty scale already in use to assess patients over 75 years and to guide decision making and referral to other support services. • PAHT is ahead of the audit but will continue to focus on assessing the needs of patients over 75.
National comparative audit of blood transfusion programme - management of massive haemorrhage	• Currently awaiting completion of interface electronic Blood tracking (collection process only), • Introduction of lab checklist to assess the necessity, urgency of transfusion and the risk of potential overload (weight and consent, Hb transfusion triggers)

	• MBL care bundle posters are displayed in key areas and MDT rooms, Adult MBL call activated (2222). • Training:- **a)** Blood groups and RhD included in training **b)** TACO checklist included in training **c)** Bedside checklist lanyards issued at registered BT training sessions **d)** Increased compliance in BT Training from 29% in Jan 2017 to 89% in Feb 2019 **e)** Blood Link trainers trained to promote correct transfusion processes • Transfusion prescription pathway in draft form (TACO checklist will form part of the pathway) • Rationale and prescription guidance displayed on JPAC for medical staff when requesting Beriplex and Anti-D • Pursuing full electronic blood tracking system. • Continue to develop iron service. • Complete new anti-D pathway.
Myocardial Ischaemia National Audit Project(MINAP)	• Development of the ACS pathway. Using NICE guidelines to standardise practice, and give the best evidence based care to patients.
Mandatory surveillance of bloodstream infections and clostridium difficile infection	• This is monitored continuously and PAHT continues to have a low incidence of hospital apportioned C.diff and MSSA, and at the time of writing this report has had no MRSA Bacteraemia since July 2014 • Ongoing data collection and sharing of results both in and out of the organisation.
Serious Hazards of Transfusions (SHOT)	• Massive blood loss care bundle posters are displayed in key areas and MDT rooms, adult MBL call activated (2222). • Placed the massive blood loss care bundle on the trust doctors app • MBL care bundle copyrighted and presented to the Regional Transfusion Committee and Regional Trauma Network. Also presented to The Association for the Study of Medical Education (ASME) titled “An interprofessional model to implement massive blood loss guidelines” • January 2018 we introduced paediatric trauma and catastrophic bleeding SIM training • Promote SIM training • Engaging with Air Ambulance regarding trauma and major haemorrhage events to support earlier interventions in the pre hospital care

	setting such as; blood on board, reversal agents for anticoagulants and patient warming and training in blood transfusion.
National Audit of Care at the End of Life (NACEL)	• "Tea trolley" approach to teaching sessions has been completed across the wards to highlight when documentation should be used for patients approaching end of life. • 2 new documents have been introduced to assist staff for a "daily clinical review" sheet and a "care after death" sheet
Learning Disability Mortality Review Programme (LeDeR)	• All deaths of people with learning disabilities have been reported to LeDeR in a timely manner in accordance with the requirements. • All deaths are reviewed locally by a consultant as part of our mortality review • The trust has implemented a revised DNACPR form and Treatment Escalation Plan (TEP). with micro-teaching sessions covering the completion of the TEP forms. • End of life training is covered by the learning disabilities team within their clinical update and induction programme
Diabetes (Paediatric) (NPDA)	• Good compliance with majority of key care processes inclusive of BMI, BP, Hba1c measurements. Benchmarked favourably against national standards.
Neonatal Intensive and Special Care (NNAP)	• Improvement on the number of babies on mother's milk at discharge, consultation with parents and parents on ward rounds.
National maternity and perinatal audit	• High BMI anaesthetic clinic in place • Local policy in place → All women 40 years or over are offered a consultant appointment • Continence specialist midwife in post. • All PPH's >2L are reviewed and required actions taken by the consultant on call during that period. All cases are summarised and presented at multi-disciplinary audit every six months • All term babies under 2.5kg are reported and monitored on the monthly maternity dashboard • BFI midwives in post. Skin to skin contact is regularly audited by the BFI lead midwife • PAHT has a co-located midwifery led birthing unit.
National audit of dementia	• There was a notable improvement in the following areas; **1.** Discharge planning documentation and discussions more robust. **2.** Improved awareness of delirium and

	recording of assessment. **3.** Nursing documentation particularly recording of risk assessments
National diabetes audit - foot care	• The launch of the diabetes foot care MDT in November 2017
National Diabetes Audit - Inpatient Audit (NaDia) -reporting data on services in England and Wales	• Yearly participation in audit to benchmark our service complete. Introduction of new diabetes IP service
National diabetes audit national core diabetes audit	• New out patient proforma developed that records BMI and smoking status as well as other key care processes • All patients that attend diabetes clinic to have urine microalbumin test completed (unless completed in last year), • Offer structured education to all patients that attend diabetes clinic
Oesophago-gastric cancer (NAOGC)	• PAHT meets targets of 100% of patients discussed, all HGG identified and discussed, lower rates of diagnosis through emergency admissions and recommended targets for chemotherapy. • Through weekly PTL meetings and monthly Cancer Board meetings and breach reports, the pathways and processes, as a whole and for individuals are under constant scrutiny
Adult community acquired pneumonia	• New pathway for management of pneumonia has been developed.
Lung cancer (NLCA)	• Fast track pathway audit has improved pathway management with no significant internal breaches. • Highlighted delays in PET scans have been addressed • New EBUS service at PAHT has shortened wait for this test and reduced travel for patients. • Recorded high workload for two lung clinical nurse specialists has led to recruitment of third nurse
Name of national audit (Quality Accounts)	**Actions completed / achievements**
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)- Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	• Trust is meeting the BPT (Best Practice Tariff) and has made significant improvements in care and care bundles.
Bowel cancer (NBOCAP)	• Overall improvement noted between 2015-16 and 2016-17. Above national average for pre-treatment TNM. Higher than national average for recording performance status. This

	is a huge improvement on the previous year. • Third clinical nurse specialist has been recruited

Table 21: examples of actions / key successes taken to improve the quality of healthcare relating to National Audits

The reports of 44 local clinical audits were reviewed by PAHT during 2018-19. Examples of actions completed / planned / achievements in the quality of healthcare provided can be found in Table 21

Local audit	Actions completed / planned / achievements
Re-audit suspected neutropenic sepsis 'door to needle time'	Significant improvements have been made in the recognition of patients at risk of neutropenic sepsis and subsequent prescribing of antibiotics within one hour of presentation to ED.
Audit on colorectal cancer cases reported in cellular pathology	The pathology department at PAHT meets and exceeds the standards recommended by the College in all of the areas
Re-audit audiology follow up after meningitis	Re-instated and relaunched of the checklist in line with NICE guidance
The voice of the child	**1.** Improved record keeping to demonstrate the voice of the child /young person is being incorporated during assessment **2.** Involvement of other practitioners who know the child **3.** Share the learning **4.** Re-audit planned
Inpatient catheter insertion	**1.** Indications for insertion written down and mostly appropriate/valid. **2.** Good percentage (78%) of patients had IP TWOC. **3.** 89% of patient discharged had documentation on TTA's
Management of patients with cutaneous CSS re-audit to ensure compliance with BAD guidance	In the first cycle of the audit, compliance with British Association of Dermatologists guidance for cSCC management was assessed and areas for improvement identified. The use of stickers with tick boxes to ensure compliance was introduced. In the re-audit the effectiveness of this intervention was checked. The use of stickers has significantly helped in increasing compliance with BAD guidelines. Providing patient's examination and information leaflet as well as documenting SCC size and prognosis were improved.

Alcohol audit	Use of new alcohol assessment form resulted in sufficient positive data being obtained. Amount of positive cases recorded has increased by 14% from previous audit.
Early recognition of dementia in the high risk patient	The following actions have been implemented • Delirium to be recognised as an organ failure and a data base made that is easily accessible • As part of the National Audit of Dementia, 78 patients notes were reviewed which has highlighted a significant improvement in delirium screening and assessment • Delirium awareness week was held in July 18 • Delirium conference held on 5 November • Delirium training now being explored as part of mandatory training but has become part of induction training, preceptorship training, Band 6 development programme, Band 7 development programme, junior doctors teaching and consultant grand round. • Delirium resource folders to be developed for ward areas • Delirium care plan to be produced • Delirium project group established supported by Quality First team • Dementia clinical nurse specialist to visit other areas of best practice to network and explore ideas for further improvement • Delirium screening tools/paperwork under review • Delirium policy/pathway under review
Procedural sedation in the Emergency Department	A standard driven policy and a procedural sedation proforma have been introduced for adult patients requiring procedural sedation in the ED that has been completed in all cases. The audit demonstrated the ownership of procedural sedation in ED by emergency medicine physicians, with no complication or adverse event resulting from procedural sedation, including oxygen desaturation, apnoea, and cardiac arrest or absent pulse. Comparing the evidence against meeting quality standards recommended by the Royal College of Emergency Medicine, we notice significant improvement for each standard.

Table 22: examples of actions completed / planned / achievements following review of local clinical audit reports

Information and technology achievements

In 2018-19 our NHS Wi-Fi for guests, public and staff was extended into St Margaret's and Herts and Essex Hospitals. Patients no longer need to rely on pay for TV/Internet access as they are able to use their own devices across the trust. Our NHS Wi-Fi is accessed by 19,697 unique users and consumes some 8.3 Terabytes of data every month.

During the year we have updated our radiology and imaging solutions. This ensures that we have the fastest solution possible for our clinicians to retrieve the images and improve the reporting turnaround time so as to improve patient safety, quality and outcomes.

We have implemented an Electronic Prescribing and Medicines Administration (EPMA) solution across the trust. Electronic carts have been made available in all areas to enable clinicians to complete the prescribing process at the bed side making the most of the inbuilt patient safety features.

We have continued to proactively secure our technical infrastructure and have engaged in five NHSDigital Cybersecurity pilot schemes. Members of the Information Technology (IT) team have attended external cybersecurity training, achieving accreditation.

We successfully deployed a replacement order communications solution to facilitate the electronic ordering of pathology, radiology and cardiology tests. The solution is being rolled out into primary care and community.

The My Care Record interoperability programme has continued to deliver benefit to clinicians and patients by providing access to the patient's electronic GP and hospital record, when consent is provided. A successful pilot of the patient's hospital events data has recently concluded and pilots with Essex County Council Social Services currently being documented.

Clinical reporting dashboards have been developed around antibiotic prescribing and the timeliness of observations on the wards. The information provided has supported discussions with clinical staff about different ways of working and transforming the way we work to benefit our patients.

Nursing and midwifery recruitment and retention

The challenges associated with recruitment of nurses against a backdrop of a national shortage are well documented nationally and remain a focus for the NHS and PAHT.

In 2018-19 we reviewed our recruitment plans to ensure that we meet our current and future nursing workforce gaps which currently sit at 25% of all nursing posts. The recruitment plan makes opportunity of all routes including local, national and international programmes. We have strengthened our support of the overseas programme and have condensed our very successful Objective Structured Clinial Examination (OSCE) process used to assess an individuals knowledge that we use to supports our overseas nurses practical training course for their nursing registration from 3 months to 4 weeks. We have also introduced two clinical practice educators to support new recruits in practice when qualified to ensure our nurses make the transition to UK hospital nursing seamlessly.

We are continuing to support home grown students into nursing, working closely with our partner University providers at the University of Hertfordshire, Anglia Ruskin and the University of Essex to increase the number of practice placements for student and midwifery students as

well as developing the new nursing degree apprenticeship programme. We are also supporting staff to undertake top up programmes and in 2019 we are supporting 18 assistant practitioners to undertake the 20 month top up programme to become registered nurses. We continue to offer student nurses and midwives in placement with the trust automatic employment providing they meet all of the standards required in their training and placement assessments.

The numbers of student nurses who take up a permanent post at the hospital on qualification has historically been less than 25% and so we are working on how to increase the number. One of the ways we are doing this is by ensuring the balance of numbers of placements for student nurses is higher at local universities rather than those further away as we know students are more likely to take up a permanent post closer to home. We are also in the process of recruiting a lead nurse for Recruitment and Retention whose role will be to maximise the opportunities and best practise actions that will recruit and retain nurses to the trust. The post holder will also work closely with the Associate director of nursing for medicine who has been part of the NHSI retention support programme to ensure we maximise the learning from this national work stream.

In May 2019 the first of the new nationally introduced, nursing associate's will qualify and become registered practitioners with the NMC. At PAHT we have three trainees due to qualify in May in this new role, with a further 14 in training. The new role will look after a cohort of patients under the delegation of registered nurses but have extended skills in assessment and reviewing plans of care as well as undertaking clinical skill and giving some medications. Further work will continue with clinical areas and undettake Quality Impact Assessments to review where the nursing associate will have the most positive impact on the skill mix of the nursing team and where the new roles will be best deployed.

We continue to offer flexibility to nurses who want to expand their experience whilst remaining at PAHT with rotation programmes. These are tailor made for individual nurses based on the type of clinical experience they would like and are in addition to the offer we have to any nurse already employed in the trust who can transfer into other vacant posts providing they can demonstrate their compliance with all standards of practice in the area where they are working. As we start to fill our vacancies formalising rotation programmes will be paramount.

Planned care standards

PAHT continues to deliver the Referral To Treatment (RTT) and Diagnostic national standards consistently. The delivery against the National Cancer Standards in 2018-19 has been challenging, with only intermittent delivery in Q3 and Q4.

Referral to Treatment (RTT)

Performance against the RTT incomplete standard has been recovered following the national elective care suspension with the final 52 week waiter treated in Feb 2019, due to patient choice.

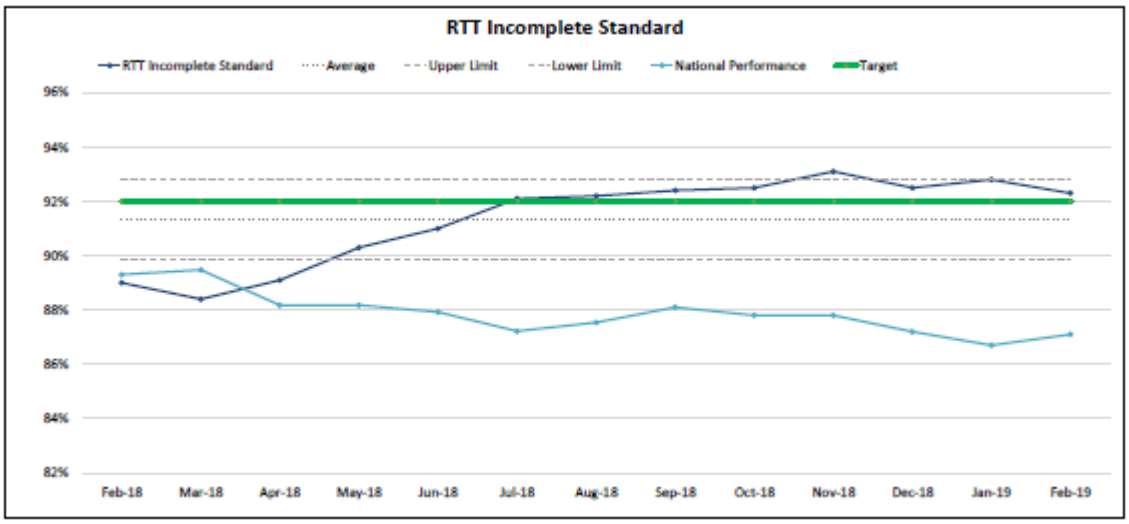


Figure 7: referral to treatment performance

Cancer

Delivery of the National Cancer Standards was challenging during 2018-19 due to workforce issues across the medical workforce of key specialities. The trust continues to be committed to the delivery of all National Cancer Standards and plans to have returned to consistent delivery in Q4 2018-19 and maintain delivery in 2019-20.

Performance and service development is monitored via the trust's performance governance structure via the access and cancer boards.

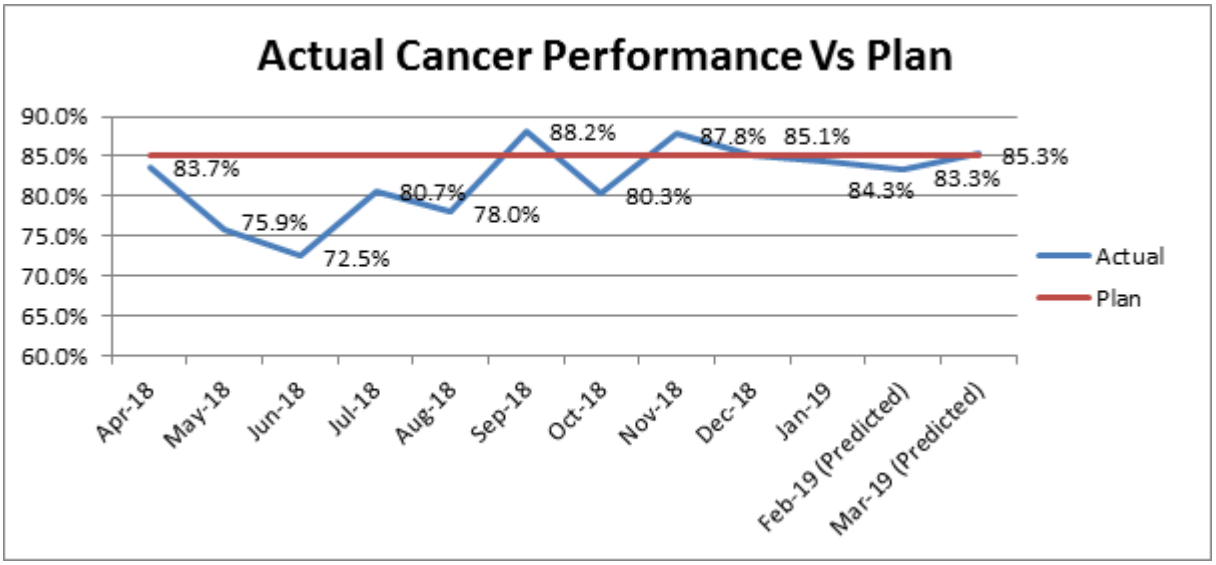


Figure 8: cancer performance

Diagnostics performance

The trust has achieved the 99% diagnostic wait target every month for the last four years. This means that over 99% of all patients waiting for a diagnostic examination have this completed inside 6 weeks of the referral being made. We are proud of consistently maintaining this performance despite a 5% growth in demand, year on year.

Diagnostic performance

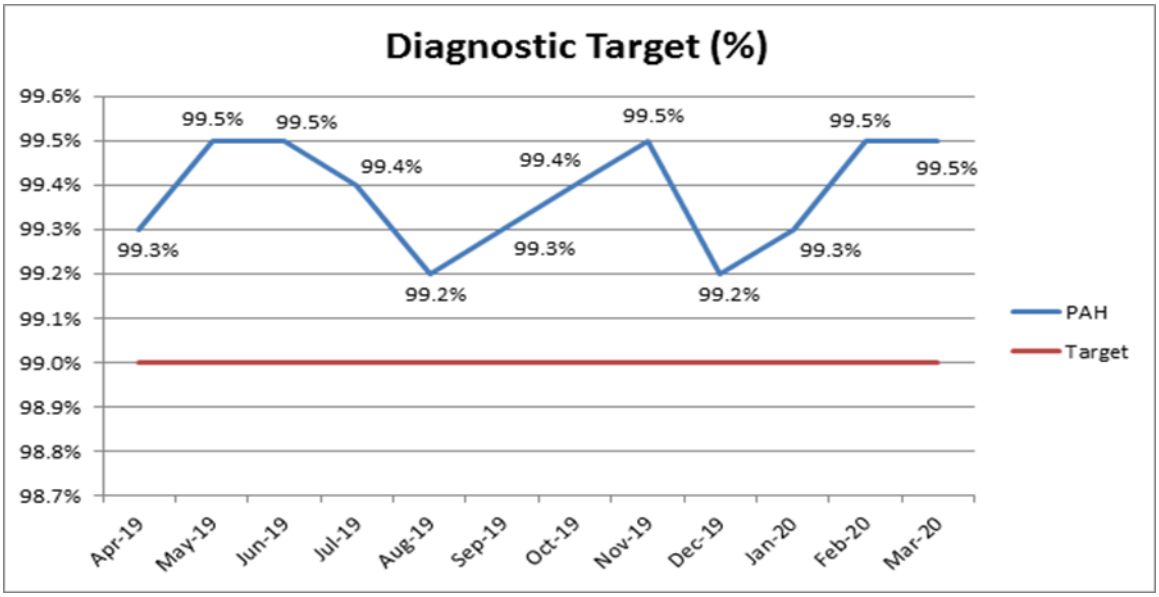


Figure 9: diagnostic performance

Our maternity service supported the birth of 3732 babies in 2018-19. Women are offered the choice of giving birth in the consultant led obstetric unit, the midwife led birthing unit or at home under the care of the community midwifery team.

Work on the new maternity operating theatres was completed and up and running since February 2019. Importantly, the new facilities mean that women within the maternity department who require a surgical operation will no longer be transferred to the general operating theatres in the main hospital. The new operating theatres provide the necessary facilities for women in the maternity department.

Training and development

As the result of a successful bid for money from Health Education England, in 2018 a wide range of staff including 79 midwives, five consultants, nursey nurses, registered nurses and maternity care assistants undertook training in the following

- Resilience training
- Neonatal Life Support (NLS)
- PROMPT training (which we will now be taught in-house)
- Childbirth emergencies in the community
- Maternal critical care
- Human factors.

Additional funds provided by our local maternity system have secured 60 places for midwives and obstetricians to attend a one day Cardiotocography (CTG) master class. We are also supporting two midwives to undertake their Masters degrees.

Listening to service users
Maternity Voices Partnership (MVP) formally Maternity Services Liaison Committee was relaunched in 2018 and is attended by women who have recently given birth or are due to give birth within our maternity department. The chair of the group is a local national childbirth antenatal teacher. At the partnership we ask our women to share their experiences. Our aim is to use the partnership to help shape service improvements going forward. The meetings are also attended by the matron for community services and one of the professional midwifery advocates.

Supervision and support for staff
We have four Professional Midwifery Advocates (PMA) in post at present. The role of the PMA involves the deployment of the A-EQUIP model of midwifery supervision, supporting and developing the advocacy role of midwives, supporting and guiding them through actions that will benefit women and their families. We have also funded three further midwives to undertake the PMA training course later this year to help further build the PMA team.

Health promotion
Work continues with our smoking cessation aidwife and the focus on health promotion has broadened with the introduction of a healthy lifestyle midwife which supports women with not only smoking cessation but also weight management and general positive lifestyle choices.

Service improvement
We gained baby friendly initiative (level 3) accreditation in July 2018.
Following better birth recommendations we have successfully implemented our pilot schemes for continuity of care for some cohorts of women with the plan to expand this in time.

Bereavement services
We continue to offer a specialised bereavement service supporting those women who suffer a pregnancy or new-born loss and we are committed to achieving the targets detailed in the national saving babies lives document.

Gynaecological services
We offer both inpatient and outpatients services – including a ‘walk in’ assessment and an early pregnancy unit. In 2018 we introduced the ‘Lily room’ which ensures privacy and dignity when braking bad news to women experiencing early pregnancy loss. This initiative was in direct response to feedback from service users.

Our children’s services

Children’s services has had an exciting and challenging year with many positive changes. We have continued to successfully recruit nurses, greatly improving our vacancy position. This has greatly reduced the use of temporary staff such as bank and agency.

Dolphin Ward
We are especially proud of our practice development nursing team who have been instrumental in creating a regional preceptorship programme which saw 35 newly qualified nurses from across the region meeting together for their first days’ training in January 2019. Our next goal is to seek university accreditation for the training programme.

Staff morale has flourished on the ward and this is reflected in the falling levels of short term sickness, positive staff and patient feedback as well as feedback from internal quality reviews and inspections.

We have made some physical changes on the ward; relocating the school room, locker room, store cupboards and linen room. This has resulted in a less cluttered environment and with a purpose built storage; stock control has improved, making it easier for staff to locate items they require.

The Harlow District Council chairman nominated Dolphin Ward as one of her charities for the year and we have received amazing support including several thousand pounds for the ward.

Paediatric Emergency Department

The Department has now been open for just over a year. Whilst there have been some challenging times due to staff authorised leave, we have managed to maintain staffing in the ED with the support of agency and bank workers. To ensure that staff have the necessary skills to care for the children attending the emergency department, we have revised our clinical assessment documentation and provided new skills and competency training.

Paediatric ambulatory care

The paediatric ambulatory care unit opened in April 2018 and is now running five days per week with plans to open seven days per week once we have fully recruited the necessary staff. Currently the unit is open for until midnight, two days per week. Ambulatory services were previously provided on Dolphin ward; the new purpose built unit is delivering an improved patient experience, enabling a more efficient use of the inpatient beds on Dolphin ward and improved emergency admission flow to the ward.

Neonatal Intensive Care Unit (NICU)

We are especially proud of the results we received from our National Peer review of NICU which was positive and praised the staff team for their diligence and quality of service provided.

In 2018-19 the unit has not been as busy as previous years, with lower occupancy levels. This may in part be due to the lower than expected number of deliveries in our maternity unit and more babies receiving transitional care with in the post-natal wards.

Through the charitable fundraising efforts of the Land Sheriffs we have been able to send every member of the NICU team on the Family and Infant Neurodevelopment (FINE) training programme in order to help us on our way to fulfil the neonatal standards as identified by the charity BLISS.

Paediatric outpatients

We have recruited an allergy nurse specialist who is now managing the outpatient team as well as running nurse led services for our children, she presented at National Conference this year and has supported the team in getting the outpatient area reorganised which is now more children friendly.

Pharmacy – improving medicine safety

Medicines are the most common intervention in medical care, accounting for around 10% of NHS expenditure.

Progress on the Hospital Pharmacy Transformation Plan (HPTP): skill mix review

Our aim is to reconfigure staffing so that an increased percentage of pharmacist and technician time is spent in direct contact with patients.

Our dispensary is now led by pharmacy technicians; accredited technicians carry out the checks formerly done by pharmacists. Stores are managed by a senior assistant. Progress transforming the function of our team is displayed in the table below:

Staff group	2016-17	2018-19 (current performance)
Pharmacists	60%	75%
Technicians	10%	30%

Table 23: transformation progress in pharmacy: percentage of staff time spent in patient facing activities

Independent prescribers

25% of eligible pharmacists have been trained as non-medical prescribers with six more in training. These pharmacists are taking on extended roles assisting with prescribing medicines in specialist clinics and writing prescriptions for patients to take home (TTAs) thereby facilitating prompt discharge from hospital.

Extended ward pharmacy service

Following a pilot in 2017-18, the extended pharmacy service is now established on five wards. These wards have, on weekdays, a pharmacist all day, as well as additional technician time and assistant top-up of stock medication.
This has resulted in:

- Improved 24 hour medicines reconciliation rates; 71% on wards with full time pharmacist or specialist pharmacist cover compared with 47% on other wards.
- Daily review of inpatient charts; which improves the discharge prescription (TTA) provision. Managing ward stock requests and putting away the weekly medicines; optimising safety.
- Assisting with the weekly controlled drug checks and fridge temperature monitoring; meeting regulatory standards.

Weekend ward pharmacy service

Since October 2018 a pharmacy service has been provided at weekends (six hours/day Saturday and Sunday) on the acute admissions ward. This service includes medicines reconciliation,
in-patient orders and TTAs. This has been achieved by offering adjusted contracted hours to new pharmacists starting in the trust and reduces medication delays for new patients.

Specialist pharmacist roles

Now embedded in critical care, gastroenterology and rheumatology to support patient care. These individuals are highly valued by the respective medical teams. Funding for a specialist dermatology pharmacist post has been agreed and we are actively recruiting to the post. The specialist posts in gastroenterology and rheumatology (as well as the long standing oncology post) have driven the successful switch to biosimilar biologics contributing significantly to the saving of £544K (year to Jan 2019) in the top 10 drugs.

Improved pharmacy performance

Two hour TTA turnaround increased from 71% (Dec 2017) to 83% (Dec 2018).

Medication safety

The most recent report from NHS Improvement, for incidents occurring between 1 April 2018 and 30 September 2018, showed that the proportion of reported incidents that were medication incidents was 11% for this trust. This is average for acute (non-specialist) trusts in England. The following have been achieved as part of the medication safety programme:

- **Training** including safe prescribing, antibiotic management and anticoagulant management for medical staff. Prescribing assessments for junior doctors and new non-medical prescribers are in place. Introduction of mandatory medicines management update training for registered nurses.
- **Incidents** Weekly review of medication incidents by senior pharmacist and nurses. A summary of prescribing incidents is presented at grand round, surgical friday and to specialist teams as required. A monthly summary of medication incident trends is presented to the Patient Safety and Quality Committee to ensure that learning is shared with all clinical staff groups.
- **Medicines Management and Incident Committee** meets monthly to review incident trends, patient safety alerts and to approve documents relating to medicines.
- **The trust weekly staff bulletin** Includes a 'medication safety tip of the week'.
- **Storage** Regular audits on storage of medicines across the organisation has led to the introduction of an improved system for checking expiry dates of medicines in wards and departments. Work has also taken place to ensure that rooms in which medicines are stored are maintained at the appropriate temperature, thereby meeting quality control requirements.
- **Anticoagulants** A Multidisciplinary steering group ensures that the use of anticoagulants is optimised and risks are minimised. All anticoagulant incidents are reviewed at the daily 'Oversight' meeting.
- **Patient safety alerts** All actions completed.
- **National medicine shortages** A system is in place to ensure that relevant staff are alerted and aware of alternative medicines that can be prescribed until supplies can be obtained.

Antimicrobial stewardship

The approach is both pro-active (antibiotic guidelines, formulary and restriction, pathways for treatment and prophylaxis), and reactive (antimicrobial prescription review, audit, feedback).
The following has been embedded in practice:

- Establishment of antimicrobial stewardship group as per NICE guidelines (NG15), taking into account the resources needed to support antimicrobial stewardship across all care settings.
- Provision of regular feedback to individual prescribers in all care settings through:
  A regular programme of audit, feedback, surveillance, education and review of patient safety incidents related to antimicrobial use.

- Promotion of local antimicrobial local guidelines, using shortest effective course and most appropriate route
- Monitoring and evaluating antimicrobial prescribing and how this relates to local resistance patterns. Reduction in piperacillin-tazobactam and carbapenem prescribing

Electronic Prescribing and Medicines Administration (EPMA) and Chemotherapy Management System (CMS)

EPMA has been implemented across all inpatient areas. EPMA allows monitoring of drug expenditure savings and antibiotic usage.
CMS has been implemented in Oncology (70% of all oral and injectable chemotherapy). The CMS system supports safe administration of chemotherapy through barcode bedside scanning of chemotherapy drugs before administration.

Plans for the next 12-36 months

Infrastructure

Robot: The business case for a replacement of automated dispensing system (robot) is continuing with the aim to have a new robot in place in the coming year. Technical Services (chemotherapy production) unit is underway with the aim to have a new unit in place during 2020-21.

Education and training

- To introduce mandatory medicines management training for all clinical staff to ensure safe prescribing and administration of medicines to reduce harm to all patients.
- To progress training as per the priorities set out in the HPTP (Independent prescribing for pharmacists, medicine management and accredited checking for technicians).

Infection prevention and control

The prevention and control of healthcare-associated infections (HCAIs) is key in the provision of high-quality, safe healthcare. We are proud of the robust infection prevention and control (IPandC)

measures that we have in place to reduce HCAIs. These measures include steps to manage antimicrobial resistance as well as controlling outbreaks of infection. IPand C is an integral part of the trust's risk management strategy and fundamental to the provision of the best clinical care.
Public Health England (PHE) mandatory surveillance programme data is provided below, presented as case numbers for PAHT. Cumulative trust apportioned cases (referred to as 'post 48 hr' for bacteraemia; 'post 72 hr' for C difficile) are shown as red bars, with non-trust apportioned (pre 48 hr for bacteraemia; pre 72 hr for C difficile) as yellow bars.

MRSA bacteraemia: We have had zero cases of trust apportioned MRSA bacteraemia and no cases since 2014.

C difficile: The trust continues to perform extremely well against the challenging C difficile Trust apportioned trajectory of nine cases annually for 2018-19. Trajectories are set nationally by the Department of Health based on performance during previous years, and are non-negotiable. We remain amongst the top performing of all trusts nationally, improving again on last year. We ended this 2018-19 financial year on a total of 13 cases on the national PHE data base. Of

these 13 only five of the cases are considered to be trust-attributable and eight of 13 cases were successfully appealed at the West Essex HCAI Scrutiny Panel demonstrable evidence that there were no lapses in care given to patients that contributed to the C difficile infection.

As a district general hospital with a large elderly population, a busy Emergency Department and many winter pressures, this is a remarkable achievement. It demonstrates true MDT (multi-disciplinary team) working, with sustained commitment to infection prevention and control procedures. All C difficile root cause analysis meetings are chaired by the trust Director of infection prevention and control (DIPC) and attended by the medical Consultant who cared for the patient, with matron, ward manager, pharmacy (antimicrobials) and facilities input. Lessons learned are then disseminated for wider trust learning.

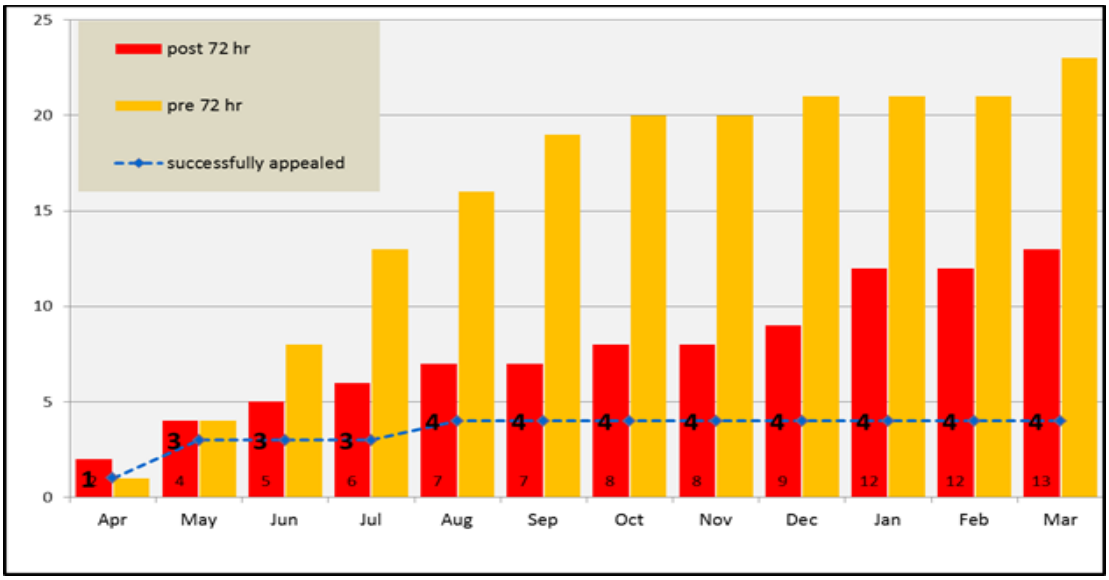


Figure 10: cumulative case numbers of C. difficile at PAHT for 1 April 2018 – 31 March 2019

MSSA bacteraemia: The trust remains one of the top performing NHS organisations in England for our low trust apportioned MSSA blood infections (bacteraemia). Good asepsis in relation to Intravenous lines (IV) lines has contributed to these low figures.

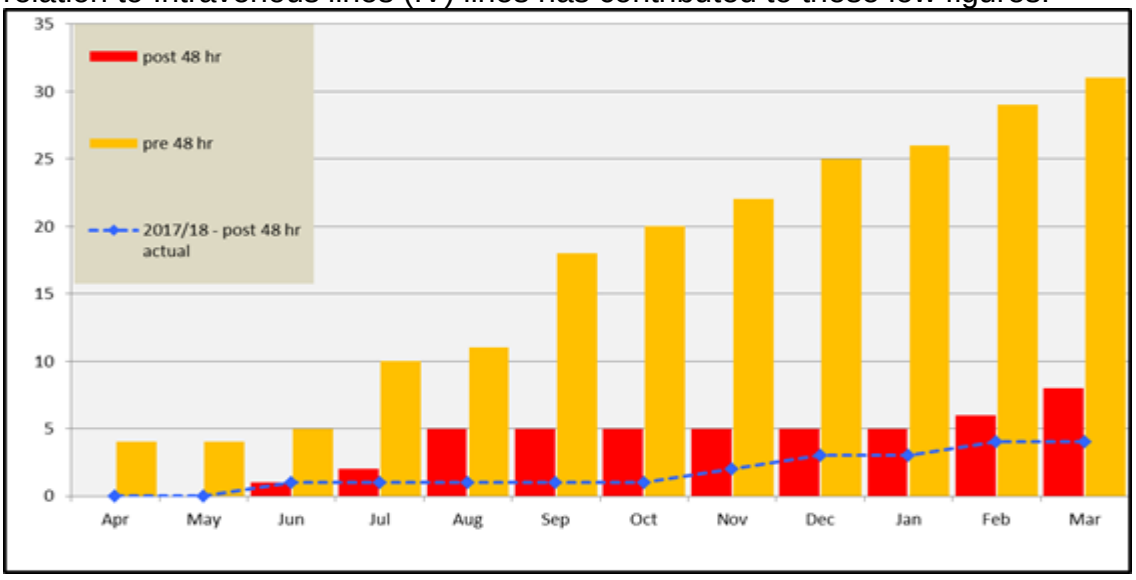


Figure 11: cumulative case numbers of MSSA bacteraemia at PAHT for 1 April 2018 – 31 March 2019

Gram negative blood stream infections: - From April 2017, there has been an NHS ambition to halve the numbers of healthcare associated gram-negative blood stream infections (GNBSIs) by 2021. A healthcare associated gram-negative BSI is a laboratory-confirmed positive blood culture for a gram-negative pathogen in patients who have received healthcare in the community or hospital in the previous 28 days.

At PAH we can demonstrate evidence of well-informed leadership, planning and clinical interventions to address this initiative. We have evidence of assessment against the Health and Social Care Act: Code of Practice, we have DIPC / Infection Prevention and Control Team (IPCT), senior management and increasing clinical ownership of gram negative blood stream Infections

Our strategy for GNBSIs includes proactive training, antimicrobial stewardship (AS) and our policies ensue choice and duration of treatment is monitored through our governance arrangements. .

In addition we have clinical and operational leads working collaboratively to resolve problems, and have patient safety walkabouts which include review of urinary catheters and device monitoring in the form of a body map, hydration checks, hand hygiene checks, and antibiotic prescribing. We have appointed a nurse to help the IPCT with clinical staff training specifically with catheter insertion and management; this nurse has in turn been trained by the trust clinical nurse specialist in urinary catheter management.

Work is in progress to provide patients who leave hospital with a urinary catheter and those catheterised in the community, with a catheter passport documenting details of the catheterisation. We have evidence of completion of audits of compliance with catheter insertion, management and care. The existing detailed guidance on insertion and care of catheters has also been reviewed.

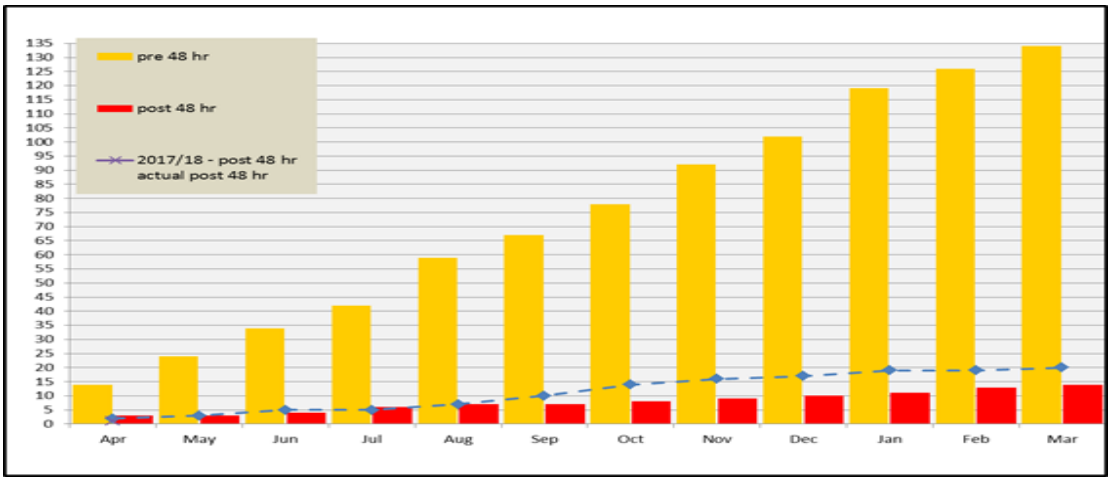


Figure 12: cumulative case numbers of E-coli bacteraemia at PAHT for 1 April 2018 to31 March 2019

In 2018-2019 case numbers for both trust apportioned and non-trust apportioned GN BSI cases by a total of 34 cases, reducing all these in-patient admissions. This is because GNBSIs are managed in hospital regardless of primary or secondary care origin of the infection.

Graph below demonstrates that we have successfully reduced our trust apportioned cases of pseudomonas aeruginosa BSI to just one case all year (red bar). Focus on reducing catheter associated infections and treating the primary source of gram negative infection with optimum antimicrobial therapy as informed by laboratory sensitivity profiles, has helped us achieve reductions in all gram negative BSIs.

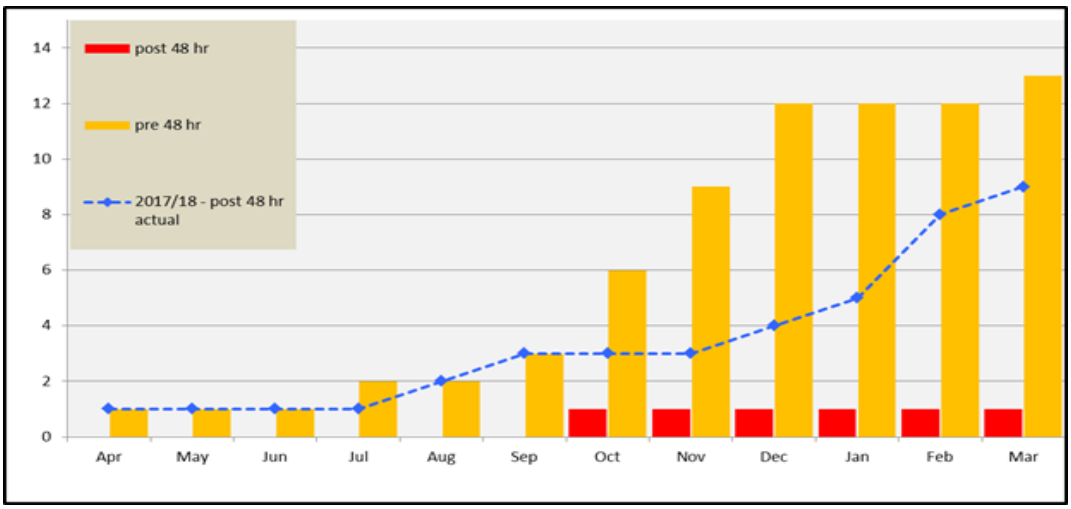


Figure 13: cumulative case numbers of Pseudomonas bacteraemia at PAHT for 1 April 2018 to 31 March 2019

Infection prevention and control incidents and outbreaks

IPC incidences occur sporadically in hospitals; the trust has robust surveillance measures in place to ensure early identification of incidents and outbreaks to ensure they are managed in in a timely and appropriate way to minimises the risk of transmission to patients, visitors and staff. There is also excellent engagement from other specialist teams in the trust when required.

Norovirus

Six norovirus outbreaks have occurred in the trust in 2018-19. These outbreaks resulted in partial or complete closure of wards. Mostly these were isolated incidents; however there were four wards closed at the same time at the height of the norovirus outbreak in January 2019. The trust has robust systems in place for the management of outbreaks with daily meetings for the duration, led by the IPCT and supported by clinicians and senior managers.

Vancomycin Resistant Enterococci (VRE)

The trust has had a period of increased incidence (PII) of VRE affecting patients on critical care. This PII was declared as an outbreak and control measures have been ongoing with a comprehensive multi-disciplinary team approach, including members of the trust's executive team, Public Health England and CCG representation at weekly outbreak control meetings. Five of the patients who were colonised with VRE were treated with linezolid as a precautionary measure and VRE colonisation has not caused any adverse clinical impact on patients. Control measures have been multi-factorial and the number of new positive cases has reduced significantly.

MRSA transmissions

A PII of MRSA transmission affected one medical ward in 2018-19. There were 18 patients affected between March and November. All patients were colonised with MRSA and none of them went on to develop a clinical infection. Outbreak control meetings were held and control

measures were multi-factorial. In December, the PII was officially declared as over as there had been no further transmissions in over 28 days which is the approved definition of the end of an outbreak/PII.

Improving care for vulnerable patients

Patients with a learning disability or autism

Learning Disability (LD) Steering Group

The steering group continues to meet quarterly with a non-executive director as the chair of the group. The steering group oversees the work of the learning disabilities team and the completion of the learning disabilities work plan.

Learning from incidents and complaints

The LD team continue to review all complaints, incidents and deaths to ensure that any emerging themes are identified and that there have not been any instances of diagnostic overshadowing or instances where the level of care was variable solely due to the patient's learning disability and/or autism.

Reasonable adjustments

One of the main elements of the work plan is the implementation of reasonable adjustments. Reasonable adjustments are a legal requirement and, in general, the trust implements them well. However, there is always more that can be done including better recording and auditing of the adjustments. The LD team have been working on this during the year and this work will continue.

Patients with dementia

We are committed to improving the care of our patients living with dementia, those who have suspected dementia as well as supporting families and carers. A number of initiatives have been introduced and others are planned to ensure that the trust becomes a centre of excellence for dementia care in accordance with "Living well with dementia": A national dementia strategy (DH 2009), the Prime Minister's dementia challenge (DH 2011) and NICE Guidelines (NICE CG42 2006). In the last 12 months the trust has made progress in the following areas:

Dementia champions

The trust currently has 47 dementia champions with a further 9 to complete the course in May 2019. The role of a dementia champion is to support best practice.

The Quality Mark

The Quality Mark for eder-friendly Hospital Wards is a subscription-based quality-improvement programme for individual hospital wards, led by the Royal College of Psychiatry. The Quality Mark process aims to support wards to focus on delivery of good-quality, essential care for older people.

Lister ward were awarded the Quality Mark in 2016 and the committee have confirmed the award should be maintained until May 2019; Ray ward achieved the Quality mark in 2018.

Further wards are working through the process to achieve the Quality Mark.

Delirium work

Delirium is an acute confusional state which occurs in 30-50% of hospitalised geriatric patients: patients with dementia are particularly vulnerable

- Improvement in local audit; National Audit Dementia results pending.
- Developing simulation training in delirium and dementia.
- Development of resources to support best practice.

Working together to improve the lives of our staff and their relatives/friends affected by dementia

- Successful in bid for money to purchase reminiscence software
- The developing work of the dementia sensory garden, working together with the Alzheimer's Society to develop this project further inviting persons living with dementia in the community

The purpose of the project is to landscape and transform the existing garden in Gibberd Ward into a dementia friendly sensory garden. Gibberd ward is situated at the rear of PAHT and in 2017 was completely refurbished and redesigned to be a dementia friendly ward for patients living with dementia and/or who are at end of life.

Research has shown the huge benefits to the health and wellbeing of patients living with dementia who have access to a sensory garden. The smell of cut grass, the scent of flowers and herbs etc. Has been shown to stimulate happy memories, promote cognitive function and stimulate conversation, and help alleviate the "isolated "feeling so often experienced by patients during a hospital stay.

Our two Gibberd garden volunteers, both with early stage dementia, have been volunteering in the Gibberd garden since September 2018. Being able to come to the garden twice a week to plant flowers, paint the shed and clear the weeds has been an enormous help and lifeline for them. We are determined to continue this initiative and expand the number of volunteers helping in the garden as it has and continues to prove that people living with dementia still have a huge amount to offer.

Improving the hospital stay for our patients living with dementia

- Working together with the Alzheimer's Society to implement "singing for the brain" in PAHT.

Training

The trust remains committed to ensuring that all staff has sufficient knowledge to enable them to appropriately care for patients who are vulnerable either due to learning disabilities/autism and dementia. Awareness training remains mandatory for all clinical staff and is covered in the clinical update study day and trust induction programme for all new starters.

The trust also runs a Virtual Dementia Tour (VDT) training session. To date over 600 staff have attended this with very positive feedback from all attendees and many staff going on to becoming dementia champions as a result of the VDT experience.

Reducing the number of hospital falls

Falls in 2018 showed an increase over the calendar year when compared with the previous period. The majority of the increase came in no harm and minor harm falls incidents that reflects our initiatives to encourage greater levels of mobility in our inpatients.

Our focus this year has been to preventing deconditioning and this means an increase in total falls is expected as we are asking staff to support an increase in mobility for our patients. This results in more opportunities for falls to occur.

Despirte the overall increase incidences of moderate or severe harm continue to remain low with less than 2% of falls resulting in this level of harm which is better than the national comparisons provided by NHS I (2.5% nationally).

The focus on preventing deconditioning is critical and long-overdue across healthcare, as we have historically been primarily concerned with getting patients 'medically fit' for discharge. However this approach can result in a patients 'physical fitness' being neglected resulting in a loss of function, an increase in their acuity and an eventual loss of their independence. This directly impacts on measures such as mortality, length of stay and discharge delays. However a deconditioned patient whilst undoubtedly the subject of harm, rarely is recognised as such. Instead we record the downstream effects of deconditioning such as pressure ulcers, harmful falls and stranded patients.

So the work now is to raise awareness of this more insidious harm, and importantly try to prevent it by increasing patient activity on our wards. Whilst there may be more falls, there are also other benefits including prevention of other harm events and an improved patient experience.

	Minor harm	Moderate	None	Severe	Total
Total 2017-18	263	21	813	1	1098
Total 2018-19	347	30	879	2	1258

Table 24: Falls by Severity 2018-9 vs 2017-8

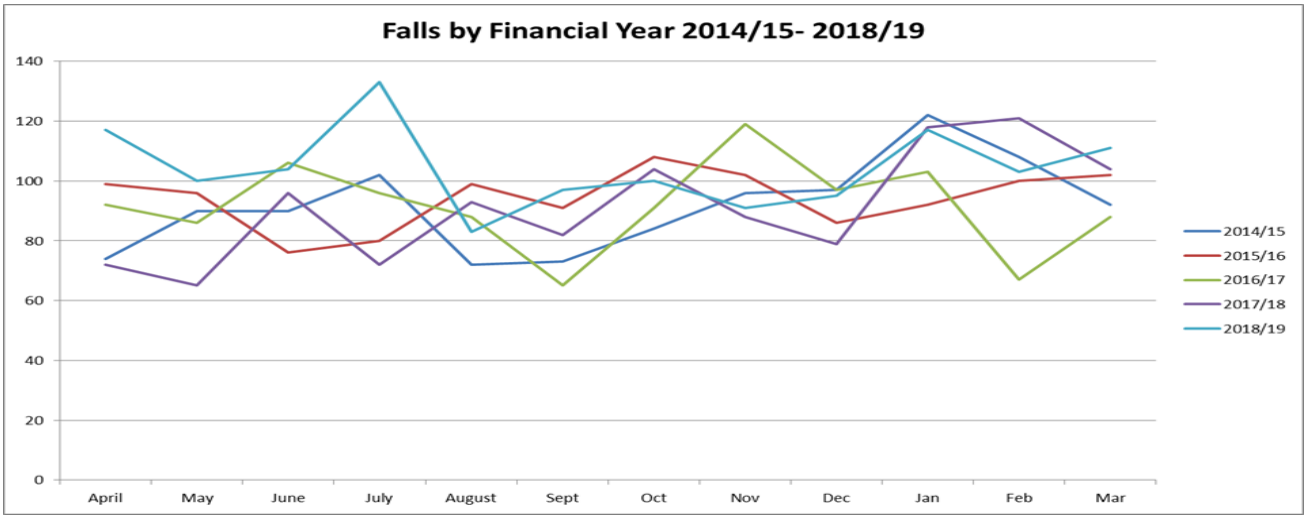


Figure 14: 5 year comparsion of falls incidents and harm

Scrutiny panel learning: All in hospital falls were a patient sustains a moderate or serious harm are investigated and the findings scrutinised. Common themes are identified and used to inform quality improvement projects. The themes this year have been as follows:

- Lying and standing BPs are not completed routinely or proactively
- A theme from the outcome of all our harm investitations is that for patients (that are not profoundly unwell) and admitted to the hospital will decondition whilst they are inpatients. This will result in them experiencing harm if they have a fall. Going forward this will now be explicitly recorded and quantified as part of our new investigation process

Improving pressure ulcer care

Our improvement work is delivered through our Agents for Nutrition and Tissue Viability (ANT's) programme which continues to thrive and we have now trained over 312 staff. Of the 312 staff, who have completed the programme 222 are still working in the trust, a retention rate of 71%. The training programme has also been opened up to our local community trust to facilitate networking and a system-wide approach to pressure ulcer reduction.

There have been changes nationally over the last six months on how trusts should measure their pressure ulcer data. These changes have now been fully embedded however they make comparison with previous years difficult. We now collect and report all hospital acquired pressure ulcers and those present on admission. This includes categories one-four, unstageable and deep tissue injuries.

The data demonstrates that the number of patients admitted with existing pressure ulcers remains high.

Hospital acquired pressure ulcers 2018-2019						
Hospital acquired: catergory one	Hospital acquired: catergory two	Hospital acquired: catergory three	Hospital acquired: catergory four	Hospital acquired: unstageable	Hospital acquired: DTI	Total
49	129	13	2	16	118	327

Pressure ulcer present on admission to hospital 2018-2019					
Hospital acquired: catergory two	Hospital acquired: catergory three	Hospital acquired: catergory four	Hospital acquired: unstageable	Hospital acquired: DTI	Total
503	103	65	61	87	819

Table 25: Pressure Ulcer data for 2018-19

We have implemented the new pressure ulcer guidance issued by NHSI in June 2018. Avoidable/unavoidable decisions have now been removed with a closer focus on learning from incidents. Our scrutiny panel process has also been overhauled to fall in line with the new information and ensure that key learning is focused at ward level.

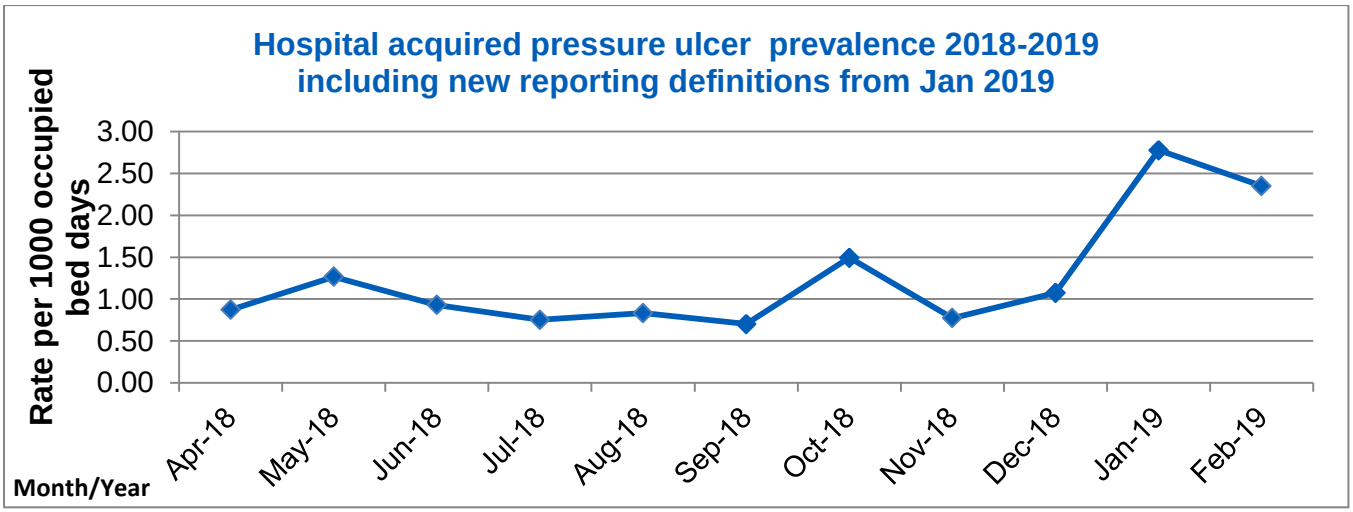


Figure 15: Hospital acquired pressure ulcer prevalence 2018-19

This increase since January 2019 is due to the addition of deep tissue injuries to our reporting in line with the new NHSI standards.

Safeguarding

Safeguarding adults

The trust has an established safeguarding adult scrutiny panel which meets monthly to review all safeguarding cases. The meetings are chaired by the nursing leadership team and include representation from Essex and Hertfordshire social work teams. Our objective is to ensure investigations are completed in a timely manner following a robust process. This allows the trust to identify challenges and recurring themes. Representation from clinical teams enables shared learning across the health and social care system, improving partnership working with local authorities. Our social care partners have the opportunity to express views in a

constructive and supportive manner and we are able to reflect on possible improvements for the benefit of patients, their families and carers.

Domestic abuse

Over the year the safeguarding team has worked in partnership with Safer Places and the Daisy Project. This is a health Independent Domestic Violence Advisor (IDVA) service which increases the opportunity for victims of domestic abuse to disclose abuse within a health care setting such as the emergency or maternity department at the time of an episode of domestic abuse. The IDVA supports the education of the clinical staff around domestic abuse and we have created a clear referral pathway integral to the continuing success of the services and to increase in referrals.

The team has recruited into the vacancy safeguarding adult practitioner with continued development of this post to meet the needs of the service and support the lead nurse - safeguarding adults. An additional midwifery safeguarding position is being piloted to support the named midwife with the increasing identification of vulnerable pregnant women.

Safeguarding children

Child Protection (CP) Medicals: the safeguarding children team support the provision of child protection medicals ensuring all requirements are met according to the Southend, Essex and Thurrock Procedures (2018). This does not include child sexual abuse medicals as a specific Essex wide care pathway is followed.

Supervision

Safeguarding supervision is provided via a 'Hub and Spoke' strategy to staff that have direct contact with children and young people. This includes midwives, paediatric staff working in ED, out patients and the children's ward. We now have 15 supervisors to support the supervision strategy which will be re-launched within the Family and Women's (FAWS) healthcare group in April 2019. Included as supervisors are five adult nurses aimed at supporting a new supervisory initiative focusing on adult patients.

Ad-Hoc supervision continues to be offered by the team and is available to all staff across the trust with any adult or child safeguarding problem – this includes on a professional or personal level.

Safeguarding referrals

Safeguarding referrals made by PAHT staff are monitored and stored for auditing purposes. The team have oversight of both children and adult referrals for quality and outcome assurance. Making referrals features in the safeguarding training with a robust referral pathway available on the Alex Intranet and in most clinical areas across the trust.

Training

A safeguarding training mapping exercise for 2018-19 was completed to ensure all staff eligible for safeguarding training receive the appropriate programme according to their role and responsibilities. This reflects the new national guidance from NHS England in 2019. It takes into account differing skill and competency requirements for staff.

The safeguarding adults team undertakes training that includes the Mental Capacity Act along with a bespoke practical training on the application of the Mental Capacity Act Assessment.

MCA is also included in the Level 3 safeguarding children training in respect of 16/17 year olds and parents presenting with risk-taking behaviour, mental health or learning disability problems.

Adequate training opportunities are available to ensure every staff member can achieve their training compliance for the year and an e-learning module has been introduced to support staff for 3 yearly training for both adults and children. The trust supports the provision of Safer Places training to give guidance to staff that can support patients who disclose domestic abuse.

Patient experience and engagement

Patient Experience includes the service you use when you need to make a complaint, raise an immediate concern or provide positive feedback. This service is based at the front of the hospital and is referred to as the Patient Advice and Liaison Service or PALS. The team respond to around 2500 to 3000 concerns, queries or questions raised by patients, families or carers every year. The team, as can be seen in the green line below, also receive thousands of compliments about the work of our staff.

Patient engagement is the work of our multiple patient groups and voluntary services. We have one lead patient group who we call the Patient Panel, 24 people are members of this group and come from all over our catchment area which serves 350,000 people have their views represented on this group. The Panel works with other local patient groups of whom we know there are many, with hundreds of members to engage our local population. The panel also produce an annual report which can be found online at www.pah.nhs.uk which describes how they support continuous improvement in our services. Some examples of how both teams have done this over the last 7 years can be seen below.

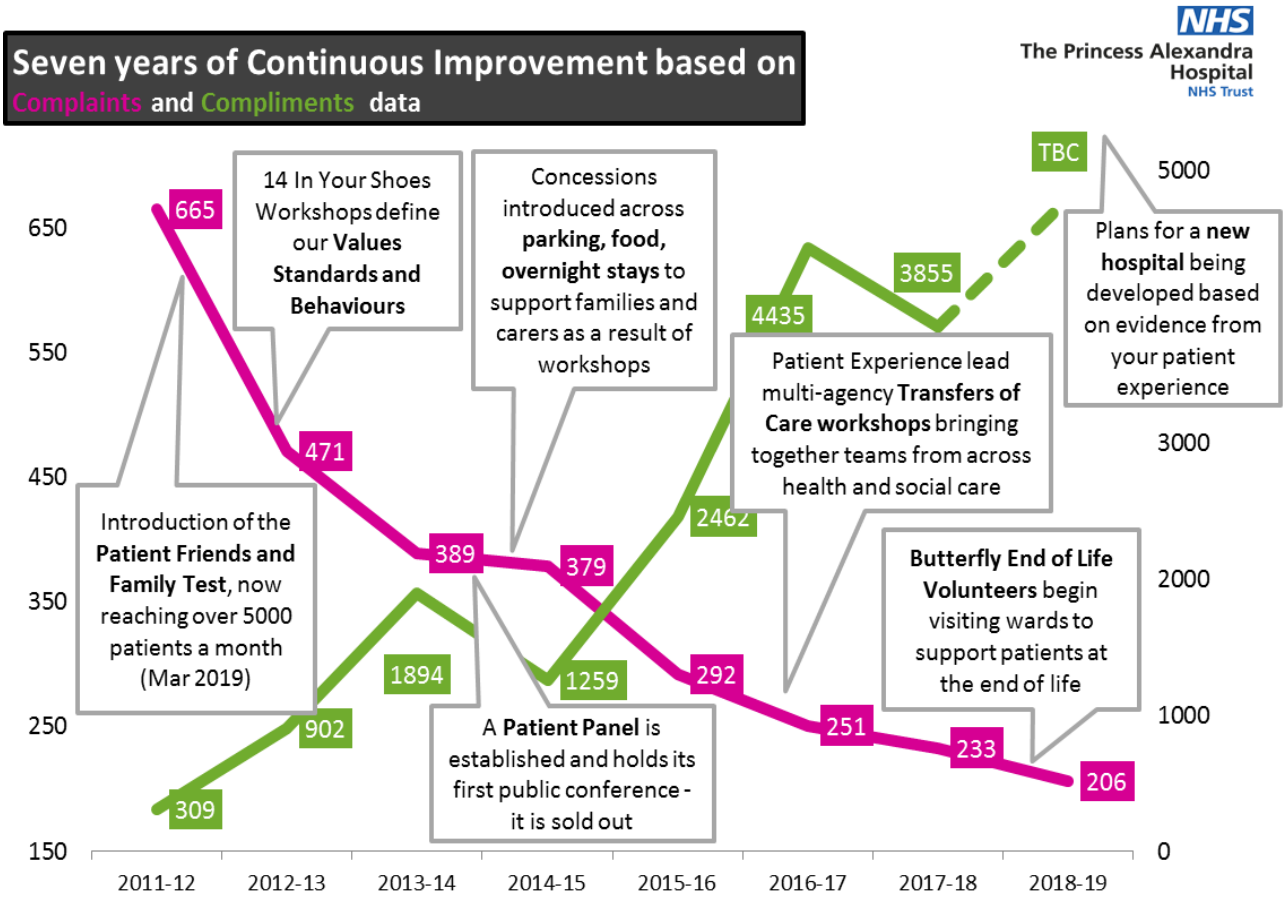
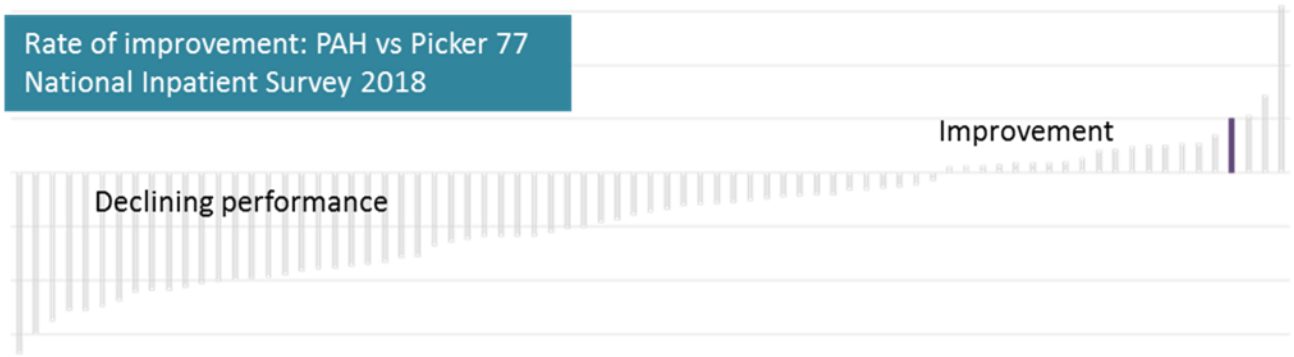


Figure 16: Seven year comparsion of patient experience

Highlights over the past year:

- The trust was recorded as the fourth fastest improving nationally from early data comparing it to 77 other trusts based on early evidence from the National Inpatient Survey 2018.
- This is as a result of far fewer questions being rated outside of the expected range, where previously 17 questions rated outside of the expected range, now only 10 are outside of this range, these relate to:
    - questions 20 and 21, being offered a choice of food and support with meals;
    - questions 30,32, 37 and 43 having a named nurse, staff working well together, someone to talk to about worries and fear and getting timely attention,
    - questions 49 and 62 about doctors and nurse providing information to carers and notice of discharge and lastly
    - questions 70 and 71 whether patients are asked about quality of care or provided information on complaints processes



Highlights over the past year:

- Complaints numbers have fallen to 206 in 2018-19, that's a fall for seven years in a row as can be seen in the downward sloping line in figure 16.

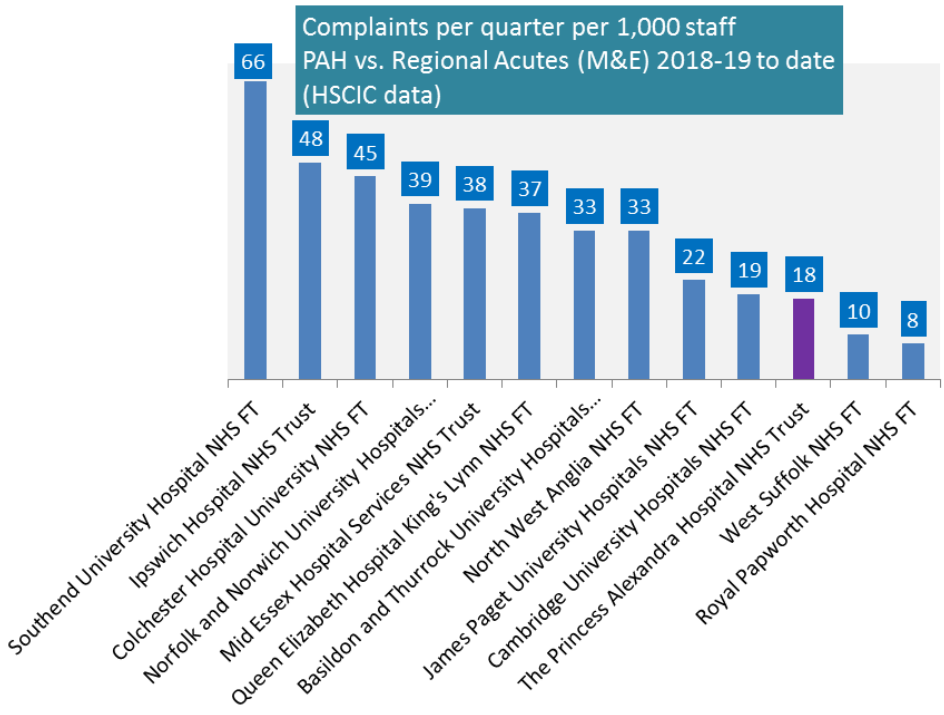


Figure 17: Comparsion of numbers of complaints revieeved by trusts in the East of England

As a result of this evidence the trust conducted a benchmarking exercise to compare PAHT to other hospitals in the region and it appears that we have one of the lowest rates of complaints in the region after West Suffolk FT and Royal Papworth FT.

- 2801 PALS cases were resolved in 2018-19, fewer than the 2925 resolved in 2017-18 but with some records still to be completed as well as thousands of compliments.
- The trust has developed a patient experience concepts course for frontline staff which has been well received, this came about as a result of staff in bookings teams around the trust being required to make highly sensitive calls to convey difficult information about the urgency of an appointment for example and needing the language and lines to support a better conversation. This is being rolled out across bookers in all outpatient services focussing on telephone manner and managing difficult conversations.

- PAHT was the first trust in England to introduce a brand new volunteering role, the butterfly end of life volunteers in partnership with the Anne Robson trust. This is a unique role where volunteers spend time with patients who are at the end of life but with no family, friends or visitors.
- Following on from this the butterfly volunteer project were winners of Harlow Soup a community crowd-funded event where teams pitch their project. Kate and Jo who are volunteers won £613.86. Over 100 members of the local community attended and voted.

Figure 18: PAHT butterflies the winners.

- The Herts and West Essex Local Maternity System have supported several Whose Shoes maternity services improvements events. Of the many new pledges being developed, PAHT are taking forward work on reasonable adjustments for expectant parents who may have a learning disability, alongside the 40 pledges made by leaders across the maternity service at PAHT in an event in November 2018.
- On 19 February a second meeting of the Addison's Support Group took place developed by a clinical nurse specialist for diabetes and endocrinology and supported by the Patient Panel. 23 patients and their carers attended, with some carers and partners present, many of whom provide 24 hour care for their loved one.
  Participants were offered teaching sessions on the use of syringes, how to better identify adrenal insufficiency and other signs and symptoms to watch out for. This is one example of a group which will be offered affiliated group status to the Patient Panel across the region in order to better represent the view of the local community.
- A non-exhaustive list of other groups involved include:
  - The Stroke Support Group
  - Proactive, a Prostate Cancer Support Group
  - Connect, a Stoma Group
  - Breathe Easy – a British Lung Foundation Group
  - Diabetes and Addison's Disease Patient Group
  - Harlow Healthcare Forum
  - FAB Breast Cancer Fundraising Group
  - The Love your Liver Group
  - A Gastro IBD Support Group
  - The Eye Unit Patient Group
  - Maternity Voices Partnership
  - The Learning Disabilities Steering Board

Section 18 report

Every year, the trust must make a statement under the NHS Health and Social Care Act 2009 about how many complaints it received, their subject, the issue they raise, whether or not they were well founded and any actions taken. This is published in a separate section of the website and also noted here:

Complaints received

The trust received 206 complaints in 2018-19 of which 18 wee not upheld, 19 fully upheld and 10 partially upheld. With the remaining 59 incomplete as still in process.

Subjects of complaints

The most frequently occurring themes were medical care expectations (76), communication (43) and nursing (30).

Actions taken

Actions are taken over the year; table 29, represents just some of that work as some actions are routine, some are less significant. Those listed below are complete, significant and demonstrate a clear connection from the concern raised to the change the organisation has made.

What happened?	How did the trust respond?
A patient's daughter had concerns about the care and communication her late mother received. Additionally she also had difficulty entering the ward outside of visiting hours and wanted this to be resolved for her and for others who might experience the same event.	As a result of this feedback, this ward introduced carers cards. The card allows families and carers subsidised or free parking, an opportunity to stay overnight and support to visit at non visiting hours if needed. All staff had an opportunity to discuss the importance of contacting patients relative's when deterioration occurs in timely way with one point of contact, with preferences for how contact should be made noted consistent with GDPR and staff were reminded that families visiting patients should not be turned away from the department even outside of visiting hours if needed. The learning following a face to face meeting was shared with a wide range of groups including ward and emergency department staff.
A patient was concerned about delays in investigations and treatment following her miscarriage.	As a result of this complaint immediate changes were made to inductions for new medical staff so that all doctors now receive additional training on potential complications associated with the early stages of pregnancy in any environment where they may be working. The case study was also presented to the obstetrics and gynaecology clinical meeting for

	learning and improvement.
A patient was raising concerns about the delays and treatment he received in Emergency Department when attending with urinary retention.	The Emergency Department recognised that additional support was needed for all staff from the clinical educator. As a result the trust developed and introduced catheter champions to liaise with the clinical educator and urology nurse specialists. As a result of this the team receive regular training using the 49 step cleanliness check which is to be reviewed to ensure completion by a surgical matron. The case study was created and shared at the surgical healthcare group patient safety and quality meeting.
A patient had a test at PAHT and paid privately as covered via his health insurance. He was raising issues regarding the manner he was pursued by the finance member of staff.	As a result of this work a new training module has been developed, patient experience concepts. This is led by the Head of patient experience, initial evaluations have been very positive and adapted to be delivered across all frontline telephone responders such as radiology bookers and outpatient appointment department booking staff.
The father of a patient raised issues regarding delays, misunderstanding and miscommunication during his son's treatment in children's Emergency Department and associated ambulatory care.	Upon reviewing the complaint it was clear that there were gaps in providing timely patient information for this family. As a result of this the children's Emergency Department team worked with the family to develop a parent information leaflet and appointment card. In addition, these processes have been changed and a new process for electronic booking of paediatric ambulatory unit appointments has been introduced.

Table 26 examples of actions taken following complaints in 2018-19

Our amazing Patient Panel

The Patient Panel is a group of local people, patients, ex-patients and carers, recruited to be 'critical friends' of the hospital. They represent the views of patients in all areas and levels of the hospital, seeking ways to improve services by challenging existing practices, and bringing about

changes by working in co-production with hospital teams. Some of the areas of work which the Patient Panel have participated in the last year include

The complaints reference group

The purpose of the group is to monitor the quality of written complaint responses by taking a randomised sample and reviewing them from a patient perspective. The group checks to see that actions identified by the hospital to stop reoccurrence of problems have been taken.

Patient Led Assessment of the Care Environment (PLACE)

This year's annual survey of the hospital environment was, for the first time, carried out by the Patient Panel and other lay members from Healthwatch Essex and Hertfordshire without any hospital staff involvement. This gave a purely patient led perspective on the environment.

Patient Panel involvement

Members of the panel serve as lay members at over 30 hospital committees, together with many working groups. The panel has made contact with existing patient groups (Watford, Ipswich andHinchinbrook) and this year have helped to set up new groups (Norwich).
The Panel has assisted the formation of hospital-based focus groups for patients with specific conditions such as Addison's disease.

Panel members have participated in senior staff appointment boards, and delivered training for consultants in the application process for clinical excellence awards.

There has been regular commitment from panel members in supporting surveys, peer reviews and ward inspections, supporting the trust in monitoring quality compliance with regulatory standards.

One panel member focuses specifically on all aspects associated with hospital food and patient mealtimes.

Another panel member has worked with our Quality First team and the surgical speciality to develop criteria-led discharge with the aim of helping patients to be discharged from the ward in a more timely manner.

Pre-Hospital Emergency Medicine (PHEM)

The Panel supported individual staff members on developing proposals to change rules on including local area ambulance staff to be allowed access to information on the patients they have treated, to maintain their professional training and expertise. This has now been agreed here at the hospital and is planned for introduction across the East of England.

2018 Conference - “It Matters to Me”

This year's conference looked at cancer services from the first visit to the GP. The Panel were aided financially by the Sustainability and Transformation Board (STPs) who, in partnership with Macmillan, offered £1,200 to promote and identify issues rising from the National Cancer Survey.
Students from Harlow College helped by undertaking a survey of GP's and producing a short film. The three key action points arising were the need for information on medication, helping young cancer patients to live as normal as school life as possible, and the needs of minority groups.

Publications

The Patient Panel produces an Annual Report, which will be distributed throughout the East of England. Articles for local newspapers were written by the Panel to optimise the press coverage

for the trust. The articles explained the work of different teams in the hospital including hospital food, organ donation and infection prevention and control.

A patient information leaflet about having an anaesthetic was produced and will be available in large print and easy read to give to patients due to have surgery.

Secretary of State

The Patient Panel met with the Secretary of State for Health, asking him to consider inviting patients to participate in the co-production process for the NHS 10 year plan.

Optimising the hospital environment

Charnley ward

In 2018 the trust finalised plans to provide 27 additional adult inpatient beds in order to enhance the services available to our patients. In partnership with Portacabin, the trust collaborated to deliver a new and innovative approach which ensured that the new ward was positioned adjacent to the main hospital building but with no loss of essential patient car parking spaces. Charnley ward; a wonderful and modern facility for general surgical patients, was delivered on target and officially opened on Friday 11 January 2019 by Rt Hon Robert Halfon, MP for Harlow who was joined by the Chair of Harlow Council, Cllr Maggie Hulcoop and guests from partner organisations, patient representatives, including the Patient Panel, and staff.

Figure 19: pictures of Charnley ward

Ward Refurbishment programme:

As part of the trust's ongoing drive to improve standards of care with ensuring uitable environments for our patients and visitors, we have refurbished two wards John Snow and Harold wards in addition to our High Dependency Unit and our main theatres.

New maternity theatre

The provision of a new additional operating theatre for the maternity department was successfully achieved and opened for use in 2018-19. Adjacent to the labour ward, the two operating theatres will ensure that women using the services have access to a clinical environment that conforms to the highest healthcare standards.

Figure 20: pictures of new Maternity theatrtes

Car Park alternation: Driven by the need to accommodate the trust's patients and visitors, the Estates directorate was able to increase patients and visitors parking capacity by over 250 spaces. This was achieved allocating offsite staff parking facility and redesigning the existing parking spaces we had.

NHS
West Essex
Clinical Commissioning Group

Statement from West Essex Clinical Commissioning Group

West Essex Clinical Commissioning Group is responsible for commissioning of acute health services from PAHT for the citizens of West Essex.

We would like to congratulate all staff at PAHT for their continued hard work and dedication throughout the last year to maintain standards of care and ensure patients and their families are cared for safely and competently.

The Quality First team have been instrumental in supporting staff and leading projects to improve the quality of care. Having a senior led, central team to promote quality improvement and assist staff to use scientific methodology demonstrates PAHs commitment to quality care for patients and staff.

In the trust has identified sixteen priorities for 2019-20 under the following headings:

- Our patients
- Our people
- Our performance
- Our places

It is clear how these priorities will be monitored and how achievement will be measured.

The prust has reported against last year's quality priorities (2018-19), it is clear from the narrative whether these priorities were fully achieved or not.

The trust has provided more than the required information in the learning from deaths section. Learning and changes to practice as a result of the trusts review of patients deaths is clearly articulated.

There are clear statements on seven day services, junior doctors hours and the arrangements in place for the support of staff who wish to raise any concerns about patient care and how these are managed.

The trust has identified many departments and speciality teams within which improvements have been made in the last year, notably the dementia friendly sensory garden for Gibberd Ward, the achievements of the butterfly volunteers and the new ward across the car park for surgical patients.

The patient experience section and the "you said we did" section of the account demonstrates the trusts responsiveness to patient and carer feedback.

There remain improvements to make and recruitment trajectories to be achieved, but the trust is focusing on all the elements required to improve these fundamentals in order to ensure quality can be improved for patients and their families.

The integrated working with staff and the high esteem with which the patient panel are viewed is very clear in the quality account.

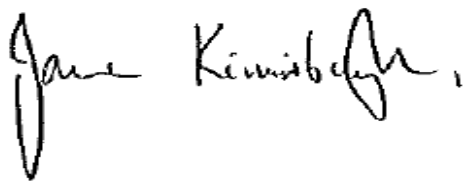
We are grateful that the trust has included in the report the governance arrangements for producing the quality account, so it is clear to patients and families how this complex document is created. We are also grateful that a glossary of terms has been included.

We confirm that we have reviewed the information contained within the account and checked this against data sources where these are available and it is accurate in relation to the services provided. Some of the data that is required to be include for example, a comparison of the trust results to the highest and lowest scores of other organisations has not been included, we expect this will be addressed in the final version.

The explanation of the trust view of why certain data sets are as they are has not been fully explained, so it is unclear why the specific results have been achieved. We hope this will be rectified in the final version of the report.

We have reviewed the content of the account; it complies, on the whole, with the prescribed information as set out in legislation and by the Department of Health.

We believe that the account is a fair, representative and balanced overview of the quality of care at the trust. We will continue to collaborate with and support the trust to achieve good quality care and treatment for the people of west Essex.



Jane Kinniburgh
Director of Nursing and Quality
West Essex Clinical Commissioning Group.

May 2019

East and North Herts Clinical Commissioning Group's Response to the 2018-19 Quality Account provided by PAHT

East and North Herts CCG (ENHCCG) has reviewed the information provided by PAHT and we believe this is a true reflection of the trust's performance during 2018-19, based on the data submitted during the year as part of the on-going quality monitoring process.

During 2018-19 ENHCCG has met regularly with both the host commissioner, West Essex CCG (WECCG), and PAHT to review progress in relation to the quality of services provided.

A key focus for PAHT during 2018-19 has been to improve the rate of mortality for patients at PAHT, the CCG recognises the significant amount of work that the Mortality Improvement Board have identified and that there is strong executive level leadership on this important work. The CCG have been actively involved with the patient safety group and the mortality improvement board and this has provided the necessary assurance to ENHCCG that the plans to reduce hospital mortality are robust and clinically lead. The CCG expects to see this high level of attention maintained through 2019-20 to bring about the reduction in mortality rates that are needed.

PAH has well-established 'Quality First' team which has been instrumental in supporting the on-going work following the publication of the CQC's visit which rated PAH as 'Requires Improvement, the CCG are assured of the work that has been undertaken and awaits with anticipation for the outcomes of the most recent inspection in January 2019.

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

ENHCCG also notes the trust's focus on its workforce, particularly in relation to staff wellbeing and recruitment and retention of registered nurses. Maintaining safe nurse staffing levels is essential, the CCG notes the work undertaken by the trust, in particular the ambitious aim to recruit more overseas nurses by December 2019. The CCG acknowledges the reduction in the registered nurse vacancy rate; however, there is clearly more work to be done to achieve better registered nurse cover at PAHT and the CCG will continue to monitor progress at the Quality Review meetings.

Whilst PAHT has continued to perform well in relation to referral to treatment times, the CCG recognises that the fluctuation in cancer performance due to workforce issues in some specialities and expects the trust to return to its previous consist delivery of this standard in 2019-20. We note that performance in relation to the A&E 4 hour target has been disappointing. We do expect to see improvement in this area during 2019-20.

The CCG supports the trust's 2019-20 quality priorities and is pleased to see that reducing mortality rates and a commitment to deliver on an ambitious programme to significantly reduce the Registered Nurse vacancy rate in particular.

Overall, we acknowledge the continued emphasis on quality and patient experience undertaken during 2018-19 and wish to see this work continued and built upon during 2019-20.

We look forward to working with and supporting PAHT in further developing and monitoring the quality of services it provides for patients. We hope the trust finds these comments helpful and we look forward to continuous improvement in 2019-20.

Beverley Flowers
Chief Executive
May 2019

Response to PAHT Account 2018-19 from Healthwatch Essex

Healthwatch Essex (HWE) is an independent organisation that works to provide a voice for the people of Essex in helping to shape and improve local health and social care. We believe that health and social care organisations should use people's lived experience to improve services. Understanding what it is like for the patient, the service user and the carer to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it.

We recognise that Quality Accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by PAHT. In this case, we have received quality of feedback about services provided by the hospice, and so offer only the following comments on the PAHT Quality Account.

- HWE recognises the CQC report that PAHT has been rated overall as a 'Requires Improvement' organisation. It is also recognised to see that PAHT was rated as 'Good' on areas of Effectiveness, Well lead and for the Care given.
- HWE is impressed by the PAHT approach to management, leadership and team building which continues to promote engagement with staff.
- HWE also recognises the Equality and Inclusive steering group (EISG) which is bring useful Insight and engagement.
- HWE recognises the recruitment drive and the improvement on recruitment and the new approach to retaining trained nurses.
- HWE recognises the approach around Medical Education, training doctors and the apprenticeship scheme will allow PAHT to recruit, train and retain the staff required for the hospital.
- HWE recognises the investment in IT at the hospital which includes Radiology and electronic prescribing. Also the investment in hospital Wi-Fi will have a solid and positive impact for patients.
- HWE like PAH values the feedback and insight gathered from the Staff survey. Solid and positive feedback and some strong recommendations for improvement.

- HWE is impressed with the overall approach to Dementia care for Patients, Staff, Carers and families.
- HWE recognises the great effort undertaken by the complaints and compliments team. HWE would still like to see continued reduction on complaints but are assured by the approach taken by staff and senior management to learning from the complaints.

- HWE welcomes the excellent report by the Patient panel which again shows the true value of patient voice and Lived Experience. The volunteers clearly play a solid role within PAH and are valued and used in the most productive way.
- HWE commends the PAHT patient panel for their excellent conference' It matters to me' which is an excellent example of patient engagement.

Listening to the voice and lived experience of patients, service users, carers, and the wider community, is a vital component of providing good quality care and by working hard to evidence that lived experience we hope we can continue to support the encouraging work of St Clare Hospice.

Dr David Sollis
Chief Executive Officer, Healthwatch Essex
21 May 2019

Healthwatch Hertfordshire's response to PAHT Quality Account 2019

Healthwatch Hertfordshire welcomes the opportunity to comment on PAHT Quality Account.

We would like to make the following comments:

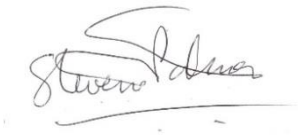
- The Quality Account provides a clear description of what quality is and how the 'Quality Improvement strategy' underpins the trust's approach to drive forward improvements. We support the quality priorities for 2019-20, particularly the continued focus in reducing mortality rates to improve patient outcomes as this remains a concern. Priorities for staff ('our people') encompassing recruitment, leadership and wellbeing are also recognised as key to providing an outstanding service for patients.

- It is good to see that complaints have continued to fall. The Quality Account demonstrates how the trust learns from complaints, for example through the Complaints Reference Group which also ensures that the patient perspective has been taken into account. PALS (Patient Advice and Liaison Service) performance however has deteriorated due to a number of factors which the trust is working through to resolve. We hope to see improvements to this service shortly.

- We are pleased to have been welcomed as a member of the Patient Experience Group and the Patient Panel. We also participated in the Patient Led Assessment of the Care Environment audit which for the first time in our experience was completely run by external assessors and without staff. This is in part thanks to a very proactive patient panel at PAH who have a strong voice and are recognised by the trust for their valuable contribution to improve the quality of patient experience.

- There are number of ways that the Trust uses volunteers to make a significant difference to patient experience. Of particular note are the Butterfly End of Life volunteers who support end of life patients who have no family or friends to visit them. PAHT was the first trust in England to introduce this new role in partnership with the Anne Robson trust.

We look forward to working with PAHT in the coming year to continue to improve patient experience and outcomes.



Steve Palmer
Chair Healthwatch Hertfordshire
May 2019

The trust has kept the Essex HOSC informed on the estate challenges being faced and the strategy and preferred option for a hospital rebuild. A recent site visit to PAHT to see some of these challenges was really appreciated by HOSC members. The trust has also supported the Essex HOSC in its recent review of A&E and seasonal pressures with a further follow-up discussion planned. The Essex HOSC expects to continue working closely with the trust in the coming year on both these and other issues.

In view of the number of quality accounts the HOSC is invited to review each year, only a very limited review can be undertaken. Through HOSC discussions with PAHT and feedback from local members, it is clear that the trust faces significant demand pressures which can impact particularly on responsiveness. Local members have highlighted some issues with the booking of outpatient appointments which could have been acknowledged in the report although we believe senior management are already aware of the issues.

The committee is aware that local Healthwatch also reviews Quality Accounts and is content that they can represent the patient and public voice and comment accordingly.

Thank you for the opportunity to comment

Jill Reeves
County Councillor
Chairman, Health Overview Policy and Scrutiny Committee

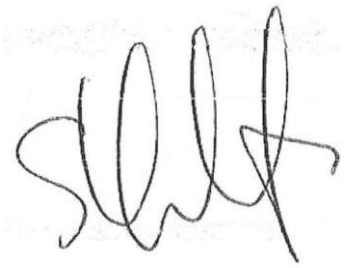
Seamus Quilty
County Councillor
Bushey South

County Hall
Postal Point: CH0147
Pegs Lane
Hertford
SG13 8DE
Tel 01992 556557
email:
seamus.quilty@hertfordshire.gov.uk

4 June 2019

I can confirm that there has been regular communication between the Health Scrutiny Committee, Scrutiny Officers and the trust over the last 12 months. The trust has supported the scrutiny process when approached and the Committee look forward to working with the trust in the future.

Yours sincerely,



Seamus Quilty
Chairman
Hertfordshire Health Scrutiny Committee

Independent auditors assurance report

Independent auditors' limited assurance report to the directors of The Princess Alexandra Hospital NHS Trust on the annual Quality Account.

This report is produced in accordance with the terms of our engagement letter dated 29 April 2019 for the purpose of reporting to the directors of The Princess Alexandra Hospital NHS Trust (the 'trust') in connection with the Quality Account for the year ended 31 March 2019 ("the Quality Account").

This report is made solely to the trust's directors, as a body, in accordance with our engagement letter dated 29 April 2019. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 to enable the board of directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the trust's directors as a body, for our examination, for this report, or for the opinions we have formed.

Our work has been undertaken so that we might report to the directors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the trust.

NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Percentage of patient safety incidents resulting in severe harm or death

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and Ernst & Young LLP

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

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

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

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

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

- the Quality Account is not prepared in all material respects in accordance with section 8 of the Health Act 2009 and the criteria set out in the National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("the Regulations");
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 published on the NHS website in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the regulations and the six dimensions of data quality set out in the guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with the other information sources detailed in the 'NHS Quality Accounts Auditor Guidance 2014-15'. These are:

- Board minutes for the period April 2018 to June 2019;
- papers relating to quality reported to the Board over the period April 2018 to June 2019;
- feedback from the Commissioners dated 25/05/2019, 31/05/2019 and 10/06/2019;
- feedback from Local Healthwatch dated 21/05/2019 and 31/05/2019;
- the Trust's complaints report published under regulation 18 of the Local Authority,

Social Services and NHS Complaints (England) Regulations 2009, dated 23/05/2019;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 19/04/2019;
- the latest national staff survey dated 26/02/2019;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 14/05/2019;
- the annual governance statement dated 31/05/2019;
- the Care Quality Commission's Inspection report dated 21/03/2018.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included, but were not limited to:

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

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Account**.** The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

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

time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Princess Alexandra Hospital NHS Trust**.**

Basis for adverse conclusion

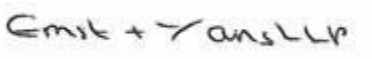
For the two indicators tested we found the following:

- The percentage of patients risk-assessed for venous thromboembolism (VTE) – we were unable to satisfy ourselves that the data was complete. We tested five patients excluded from the indicator and found that one had undergone a VTE assessment and they should have been included but had not been. We were also not able to satisfy ourselves as to the validity of the indicator. We tested 24 patients who had been included as having had an assessment. We could not find evidence that an assessment had been undertaken for one of these patients.

- The percentage of incidents resulting in severe harm or death – we were unable to satisfy ourselves that the data was complete. Testing of 18 incidents classified as 'moderate harm' found that two of these had been marked as requiring a review of the grading of the harm suffered by the patient which could have changed the assessment to 'severe'. We could not locate evidence that the review had been completed.

Adverse conclusion

Because of the significance of the matters described in the 'basis for adverse conclusion' section of our report, the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.



Ernst & Young
Luton
27 June 2019

Notes:

1. The maintenance and integrity of The Princess Alexandra Hospital NHS Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the web site.

2. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Glossary of terms

Acute Kidney Injury - is a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days.

Acute Bowel Obstruction - significant mechanical impairment of the passage of contents through the intestine (bowel) due to a blockage of the bowel.

Anticoagulation - are medicines that help prevent blood clots.

Antimicrobial – is a general term that refers to a group of drugs that includes antibiotics, antifungals used to treat a microbial infection.

Antimicrobial Resistance - is the ability of a bacteria to resist the effects of medication (antibiotics) that once could successfully treat the infection.

Antimicrobial stewardship - A coordinated intervention designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration.

Agents for Nutrition and Tissue Viability (ANTS) – ANTS are staff with specific training to identify skin issues patients may have and ensure that those at risk are getting all the right food that they need for their skin to remain healthy and thus avoid the danger of pressure sores developing.

Allied Health Practitioners - are healthcare professionals working in dietetics, occupational therapy, physiotherapy, operating department assistants, radiography and speech and language therapy. This is distinct from nursing, medicine, pharmacy and healthcare scientists.

Ambulatory Care - Medical care provided on an outpatient basis, includes diagnosis, observation, consultation, and treatment.

Ante-natal - is the care you get from health professionals during your pregnancy.

Audiology - the study of hearing and balance.

Avoidable - See unavoidable.

Cardiology - The branch of medicine that deals with diseases and abnormalities of the heart.

Care Quality Commission (CQC) - CQC is an executive non-departmental public body of the Department of Health United Kingdom. Established in 2009 to regulate and inspect health and social care services in England.

Chemotherapy - The treatment of disease by the use of chemical substances, especially the treatment of cancer by cytotoxic and other drugs.

Clostridium Difficile (C.Difficile) - Clostridium difficile, also known as C. difficile, or C. diff, is a type of bacterial infection that can affect the digestive system.

Clinical Audits - A process aimed to improve quality of patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Clinical Coding - The process by which patient diagnosis and treatment is translated into standard, recognised codes that reflect the activity that happens to patients.

Clinical Commissioning Group (CCG) - NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Clinical Nurse Specialist (CNS) - A nurse who has advanced knowledge and competence in a particular area of nursing practice.

COSMIC - The Electronic Patient Record system we have in place at PAHT. See Electronic Patient Record.

Colorectal care - treatments for patients with symptoms of the gastrointestinal tract including colorectal cancer and inflammatory bowel disease.

Colposcopy and hysteroscopy services - a procedure used to examine the cervix and inside of the womb (uterus).

Chronic obstructive pulmonary disease (COPD) - is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.

Continuing Professional Development (CPD) - is defined as the education of physicians following completion of formal training.

CPR - Cardiopulmonary arrest means that a person's heart and breathing has stopped. When this happens it is sometimes possible to restart their heart and breathing with this emergency treatment.

CQC - The Care Quality Commission is the independent regulator of all health and social care services in England

CQUIN - Commissioning for Quality and Innovation is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Cryoprecipitate - is given to patients with bleeding disorders.

CTG - Cardiotocography is a recording of babies heartbeat used during pregnancy prior to birth.

DAISY project - A hospital based advocacy service offering advice and support for both staff and patients, male and female, who are victims of domestic abuse.

Datix - Softwere used in healthcare to collect patient safety incidents and for reporting adverse events.

Delirium - is a state of mental confusion that can happen if you become unwell. It is also known as an acute confusion.

Dementia Champions - a group of staff who have had specific training in dementia care. Their aim is to make other colleagues more understanding of why a patient may be more challenging and encourages them to tailor therapies accordingly.

Dermatology - The branch of medicine concerned with the diagnosis and treatment of skin disorders.

Diagnostics - Tools used to help identify disease and illness.

Diagnostic overshadowing - making an assumption that what is wrong with a patient is their Learning Disability (LD) not their medical condition.

Dietetics – a branch of healthcare concerned with the diet and its effects on health, especially with the practical application of a scientific understanding of nutrition.

DNACPR - Do not attempt cardio-pulmonary resuscitation - this is an order telling medical professionals not to perform CPR. This means that doctors, nurses and emergency medical personnel will not attempt emergency CPR if the patient's breathing or heartbeat stops.

Door to Needle Time – a national target used to measure the time from a patients arrival in the hospital until the drugs required to commence their treatment is administered.

Dr Foster – a provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service.

Duty of Candour/Being Open - A process of apologising to patients and/or their carers when things go wrong, and communicating with them in an open and honest manner.

Endocrinology - The branch of physiology and medicine concerned with endocrine glands and hormones.

Endoscopy - is a procedure that allows a view the inside of a person's body; An endoscope is a long, thin, flexible tube that has a light source and camera at one end. Images of the inside of your body are relayed to a television screen to be viewed by the doctor.

Escherichia Coli (E.coli) bacteraemia - Type of bacterial infection and a blood stream infection.

Fractured Neck of Femur – a broken hip.

Frailty service – reviews *frail* older people using a holistic assessment of physical, mental and social needs.

Friends and Family Test (FFT) - Test aimed at providing a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and galvanise improved patient experience. It asks “How likely are you to recommend our services to friends and family if they needed similar care or treatment?” with answers on a scale of extremely likely to extremely unlikely.

FY1 - First year junior doctor

Gastroenterology - The branch of medicine which deals with disorders of the stomach and intestines.

Genito-Urinary - The branch of medicine relating to the genital and urinary organs.

Geriatric - relating to older people, especially with regard to their healthcare.

Governance - Establishment of policies, and continuous monitoring of their proper implementation, by the members of the governing body of an organisation.

Gram negative blood stream infections (GNBSIs) - Type of bacterial infection and a blood stream infection.

Gynaecology - The branch of physiology and medicine which deals with the functions and diseases specific to women and girls, especially those affecting the reproductive system.

Haematology - The branch of medicine involving study and treatment of the blood.

Healthcare Associated Infections (HCAI) - Infections that are acquired as a result of health care. The burden of healthcare-associated infections has mainly been in hospitals where more serious infections are seen.

Health Education England - is the new national leadership organisation for education, training and workforce development in the health sector.

Hospital Standardised Mortality Ratio (HSMR) - Calculation used to monitor death rates in a trust.

Interventional Radiology - is a sub-specialty of radiology which utilises image-guided procedures in order to diagnose and/or treat diseases using the least invasive techniques.

Klebsiella bacteraemia - Type of bacterial infection and a blood stream infection.

Laparotomy - a surgical incision into the abdominal cavity, used for diagnosis or in preparation for major surgery.

Learning Disability Mortality Review Programme (LeDeR) - a review into the deaths of people with learning disabilities aged 4 years and over, irrespective of whether the death was expected or not, the cause of death or the place of death. This will enable trusts to identify good practice and what has worked well, as well as where improvements to the provision of care could be made.

Maternal and Fetal Assessment Unit - Outpatient Antenatal Unit offering planned appointments for assessment of the mother and unborn baby in pregnancy.

Maxillofacial department – an area where diagnosis and treatment is provided to conditions of the mouth, face and adjacent structures.

MBRACE - confidential enquiry into maternal deaths.

Mealtime Buddies - A group of volunteers who help feed patients during mealtimes at PAHT

MCA - The Mental Capacity Act is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so.

Medicines Reconciliation - Is the process of creating the most accurate list possible of all medications a patient is taking.

Meticillin-Resistant Staphylococcus Aureus (MRSA) / Meticillin-Sensitive Staphylococcus Aureus (MSSA) – A specific bacterial infection**.**

Mitigation - The action of reducing the severity, seriousness, or painfulness of something.

Morbidity and Mortality - meetings established to review *deaths* as part of professional learning.

Musculoskeletal - conditions affecting the joints, bones and muscles.

Myocardial Ischaemia - when blood flow to your heart is reduced, preventing the heart muscle from receiving enough oxygen.

Myocardial Infarction - Commonly known as a heart attack.

Early Warning Score (NEWS) and Vital Signs - A simple system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

a) respiratory rate
b) oxygen saturations
c) temperature
d) systolic blood pressure
e) pulse rate
f) level of consciousness

National Confidential Enquiries (NCEPOD) - National Confidential Enquiry into patient Outcome and Death.

Neonatal - New born children.

Neurology - The branch of medicine or biology that deals with the anatomy, functions, and organic disorders of nerves and the nervous system.

Neutropenic Sepsis Policy - guidance surrounding the development of neutropenia which is an abnormally low number of neutrophil granulocytes (a type of white blood cell) in the blood.

Never Events - Serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented.

NHSI - NHS Improvement is responsible for overseeing trusts and NHS services, as well as Independent providers that provide NHS-funded care. They offer providers support to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NICE - The National Institute for Health and Care Excellence provides guidance which supports healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for money.

Norovirus - A type of viral infection that can affect the digestive system.

National Reporting and Learning System **(NRLS) -** a central database of patient safety incident reports.

Obstetrics - The branch of medicine that deals with the care of women during pregnancy, childbirth, and the recuperative period following delivery.

Oesophago-gastric care – treating patients with problems of the gullet (oesphogus) and stomach.

Oncology - The study and treatment of cancer and tumours.

Operating Department Practitioners – members of the theatre team that provide care to patients at every stage of their operation.

Ophthalmology - The study of the structure, functions, and diseases of the eye.

Orthopaedic - The branch of medicine that deals with the prevention and correction of injuries or disorders of the skeletal system and associated muscles, joints, and ligaments.

Objective structured clinical examination (OSCE) - modern type of examination used in health sciences.

Patient Advice and Liaison Service (PALs) - offers confidential advice, support and information on health-related matters. Provides a point of contact for patients, their families and their carers.

Paediatrics - The specialty of medical science concerned with the physical, mental and social health of children from birth to young adulthood.

Palliative Care - An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Pathology - The scientific study of the nature of disease and its causes, processes, development, and consequences.

Patient Panel - A group of volunteers who represent patients, families and carers of PAHT

Patient Safety Alerts - issued by NHS Improvement to rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death.

Patient Safety Thermometer – a monthly hospital audit to measures the quanity of patients who have incurred harm through their long term care at home or whilst in hospital. The data is submitted monthly to NHS England and looks at harm from falls, tissue injuries, urinary tract infections if patient has a catheter or developing a deep vein blood clot following hospital care.

Perioperative care - occurring or performed at or around the time of an operation.

Public Health England (PHE) - an executive agency sponsored by the Department of Health with the aim of protecting and improving health, wellbeing, and to reduce health inequalities.

Physicians Associates – staff who support doctors in the diagnosis and management of patients.

Patient Led Assessments of the Care Environment (PLACE) – Annual quality assessments looking at hospital environment, information for patients and the food provided. The assessment is conducted jointly by patients, hospital staff and external partners

Post Anaesthetic Care Unit (PACU) – an area in theatre where patients are taken directly after surgery so they can wake up from their anaesthetic and will remain until well enough to go to a ward for ongoing care.

Preceptorship - A period of practical training for a newly registered nurse or mdwife or novice under the supervision of an expert.

Preferred Priorities of Care (PPC) - Document used to plan an individual's future end of life care. Includes thoughts and feelings about the patient's illness, what is happening, preferences and priorities for future care and where the individual would like to be cared for in the future.

PROMPT – training for staff working in maternity care, utalising clinical issues that have occurred where all the members of different professionsls who work together attending the training together and so learning and resolving issues together

Pseudomonas aeruginosa - A specific bacterial infection.

Public Health England - A government body with the role to protect and improve the nation's health and wellbeing and reduce health inequalities.

Pulmonary Embolism (PE) - A sudden blockage in a lung artery.

Radiology - The branch of medicine that deals with the use of radioactive substances used in diagnosis and treatment of disease.

Rapid Assessment and Treatment (RAT) - A treatment model used in emergency care to provide an early senior assessment and early treatment.

Reasonable adjustments - is a change that has been made to a service so that people with learning disabilities can use them like anyone else.

Referral to Treatment (RTT) – a constitutional standard that trusts are measured against in which a person's waiting time starts on the day the hospital receives the referral letter from a GP to the time of first appointment or treatment.

Respiratory - The act of breathing.

Resuscitation - is the process of correcting physiological disorders (such as lack of breathing or heartbeat) in an acutely unwell patient. Well known examples are mouth-to-mouth resuscitation.

Rheumatology - The study and treatment of arthritis, autoimmune diseases, pain disorders affecting joints, and osteoporosis.

Root Cause Analysis (RCA) - The method of problem solving that tries to identify the root causes of faults or problems with the goal of preventing a recurrence.

Safeguarding - Protection or defence that ensures safety.

Sepsis and Septicaemia - Sepsis is a serious blood stream infection. A serious complication is septicaemia which is when inflammation occurs throughout the body which can be life threatening.

Serious Incident Group (SIG) - A formal review of serious incidents which may need external reporting.

Serious Incidents (SIs) - An unexpected or unplanned event that caused harm or had the potential to cause harm to a patient, member of staff, student, visitor or contractor.

Stakeholders - A stakeholder is anyone with an interest in a business. Stakeholders are individuals, groups or organisations that are affected by the activity of the business. They include: Owners who are interested in how much profit the business makes

- Strategic Executive Information System (**STEIS**) – National data base to report incidents where harm is identiried. This system can be accessed by trusts, commissioners and all regulators.

Standardised Mortality ratio (SMR) and Summary Hospital-level Mortality Indicator (SHMI) - Ratio between the actual number of patients who die following treatment 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.

Sustainability and Transformation Partnerships (STP) - bringing together local health and care leaders to plan the long-term needs of local communities and how care will be delivered.

Suboptimal care – care that is dissatisfactory or substandard resulting in a poor patient outcome.

Tachycardia – a heart rate that is higher than normal.

Trauma Audit and Research Network (TARN) – an audit where information is collected and analysed for patients who are moderately or severely injured after an injury. Data is submitted by trusts and a comparison can be undertaken.

Transitional Care - Refers to the coordinated and continuity of health care during a movement from one healthcare setting to another or to home.

Triage - A process for sorting injured people into groups based on their need for or likely benefit from immediate medical treatment.

To Take Away (TTA) – Medication given to patients to take after their discharge from hospital.

Trial Without Catheter (TWOC) – a trial to remove a catheter (tube draining urine from the bladder) which can be completed in the outpatient or in patient areas of a trust.

Unavoidable - Used when an individual has been affected even though the:

- condition and risk has been evaluated
- goals and recognised standards of practice that are consistent with individual needs had been implemented
- impact of these interventions had been monitored, evaluated and recorded
- approached had been revised as appropriate

Term usually used in relation to cases of hospital acquired infections, pressure ulcers and falls.

Urology - The study of urinary organs in females and the urinary and sex organs in males.

Vancomycin resistant enterococci (VRE) - A specific bacterial infection.

Vascular surgery – specialists that treat people with diseases of the circulation which can be conditions affecting arteries, veins and where there are blockages to the flow of blood.

Venous Thromboembolism (VTE) - A condition where a blood clot forms in a vein. Most commonly in a leg where known as a DVT, a blood clot in the lungs is called a pulmonary embolism (PE).

VTE Prophylaxis - The giving of a medicine or treatment to prevent a VTE.

6 Facet Survey – an assessment of the estate which reviews backlog maintenance, condition and compliance of the environment.

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