# Quality Accounts 2016-17

# Contents

# Introduction from the Acting Chief Executive Officer

Welcome to our annual review of the quality we believe that the Princess Alexandra Hospital NHS Trust (PAH) has delivered over the last year. 2016/17 was a difficult year for us; we were rated as Inadequate by the Care Quality Commission (CQC) and placed in Special Measures in October 2016. We are using this as a catalyst to further increase our focus on quality improvement.

In this review we also outline our ambitions for improving the care and achieving even better outcomes for patients. You will see the high level of both patient experience and excellent clinical outcomes that we have achieved and the pride we take in our staff, who are constantly living our values and despite all the pressures, giving their best every day.

Since being placed in special measures we have launched our Quality 1st programme. We are working with our staff, health and social care partners and other stakeholders to identify and deliver changes which will make a difference to patient care; to make the quality of our services sustainable for the future. We have reviewed the recommendations made by the CQC and consolidated the required actions identified by our staff into five work streams. These are:

i. Our People
ii. Getting the Basics Right
iii. Patient Focus
iv. Infrastructure
v. Governance, Risk Management and making informed decisions.

We are very proud of our track record of delivering planned care standards. Nationally we are one of a handful of organisations delivering consistently on Referral To Treatment (RTT), cancer and diagnostic standards; this is an outstanding achievement. Our RTT performance against the national standard has improved through 2016/17, seeing the Trust's performance increase from 86% (April 2016) to 94% (April 2017), with over 1,200 fewer patients waiting over 18 weeks. This dramatic improvement means that PAH is the organisation with the greatest level of improvement across the whole of England, which has been recognised by both the Secretary for State and our local commissioners.

The standards of care delivered by our maternity and gynaecology services are to be admired, with the CQC rating of "Outstanding". This is testament to the dedication of an exceptional team of staff. Listening to the feedback from women and their families is really important to us as we continually strive to provide the very best service that we can. All compliments are shared amongst the whole team and every single complaint or cause for concern is fully investigated and a response provided. The learning from investigations and any actions taken are shared with all staff.

Without doubt, our staff are our greatest asset, regardless of their role. In 2016 the CQC rated our staff as good for caring; they witnessed staff delivering care that was compassionate, involving patients in decision making and providing good emotional support to patients and those close to them.

We have a number of routes into employment with the Trust and in 2016/17 we continued to further explore new career pathways:

- Apprenticeships
- Foundation degrees
- Nurse Associate pilot
- Improving levels of maths and English

- Work experience

A vital priority for PAH is the safety of our services for patients, their families and our staff. We are continually striving to improve and to achieve this we actively encourage staff to report incidents without fear of reprisal or repercussions. Our aim is to increase the overall level of reporting as this helps us to identify where things are not working as they should. It provides us with the opportunity to investigate incidents to find root causes so that learning and improvements can take place the aim of which is to decrease the severity of reported incidents.

End of Life Care at the Trust received an 'inadequate' rating from the CQC and following that a lot of work has gone into joining up and streamlining processes in order to improve the delivery of end of life care at the hospital. The Trust has developed a strategy for End of Life Care for adults (2017 – 2020). Inspectors did recognise and report that 'all staff were seen to provide kind and compassionate care'. The inspectors also reported that pain relief was prescribed appropriately, that patients were encouraged to eat and drink as they wished and that their dignity was maintained at all times.

The Trust has made significant investment in technology in 2016/17 and we plan to continue to do so in 2017/18. The Trust completed full deployment of our electronic observation system to support the early detection of the deteriorating patient. The objective was to move away from paper documentation of the patient's vital signs to an electronic system that allows clinicians to enter the patient observations at the bed side using a mobile device. The system then undertakes a series of calculations that alerts the user to the patient's overall wellbeing.

This year we hope to introduce an electronic Doctor and Nurse Handover process using the same system. This will allow clinical teams to have live and up to date access to the most recent handover information and allows this information to be shared more readily to the whole clinical team. The plan is for this to commence in early July 2017 with a Trust wide deployment to all in-patient clinical areas completed by the end of September 2017.

Another key priority for this year is the development of the Strategic Outline Case for a new health, social care and science campus for the communities we serve. Our infrastructure is in a poor state of repair and requires significant investment, the community we serve is also growing at a rapid rate emphasising the case for change.

It is a joy and a privilege to serve this great organisation; the amazing staff, you the patients, families and service users and all future users of this fantastic hospital.

Trevor Smith

Acting CEO

# Statement on Quality from the Acting Chief Executive Officer

The development of this Quality Account gives staff the ability to look at and think about the quality of our services and how we can improve care for our patients

The Trust is very mindful of the CQC rating of Inadequate issued in 2016 following the previous rating of Requires Improvement from 2015. We are keenly focused on addressing these matters and making significant improvement to that rating going forward.

For the public, we aim for the Quality Account to offer a clear and honest overview of the work undertaken at The Princess Alexandra Hospital NHS Trust, demonstrating the progress made over the last year. Crucially it also provides everyone at the Trust with a good sign-post towards all we have to do over the coming year to further improve patient care.

I should like to thank all the staff and our volunteers for their input and support in helping us to progress against our objectives during the year.

I am very pleased that key stakeholders from our local community have had an input into this Quality Account, providing their ideas and comments. This additional perspective gives me assurance that we are concentrating on the things that really matter.

The information and data contained in this report has been subject to internal review and external verification. Therefore, to the best of my knowledge, the information contained within this document reflects a true and accurate picture of the performance of the Trust.

Trevor Smith

Interim Chief Executive

# Governance Arrangements

The Princess Alexandra Hospital NHS Trust Quality Account is prepared in line with the Quality Accounts toolkit guidance (2010-11). NHS England have advised that there are to be no changes to the reporting and recommended audit arrangements for 2016/17.

The Trust established a working group of staff representatives to identify the content including all aspects identified for inclusion by NHS England. A timetable for the production of quality account was presented and approved by the Executive Management Board in February 2017. The timetable for completion was shared with the Trust Audit Committee in March 2017. The drafted quality account was circulated to the Executive Management Board members for peer review and to the Quality and Safety Committee in April 2017. The amended draft was shared with external stakeholders (clinical commissioning groups and Healthwatch committees for both Hertfordshire and Essex and also external auditors on 28 April 2017.

The final draft document was presented to the Trust Audit Committee for approval on 30 May 2017 and was recommended for Trust Board sign off.

# Priorities for Quality Improvement 2017-2018

Each year we assess our performance against previous quality priorities and patient outcomes; taking account of national reports, feedback from regulators and emerging themes from incidents as well as patient and staff feedback. This year the outcomes from the Care Quality Commission (CQC) inspection report (October 2016) has afforded us an opportunity to create and launch our Quality Improvement Strategy which is underpinned by **Quality 1st** ; the Trust's plan for improvement. Essential to the achievement of Quality 1st is the removal of "Special Measures". To achieve this 2017/18 will focus on the themes from the CQC inspection report.

The following work streams in the table below have been developed with the staff and patients of the Princess Alexandra Hospital NHS Trust and have been approved by the Board. The Quality First Improvement plan forms the basis of all Trust-wide improvements throughout the year ahead.

| **Priorities for Quality Improvement 2017/2018** | | | | |
|---|---|---|---|---|
| **Ref:** | **Quality Improvement Area** | **What we are trying to improve** | **What success will look like** | **How we will monitor progress** |
| **1. Safety Culture** | | | | |
| **SC 1.1** | Getting the basics right | Compliance with essential safety standards i.e. emergency equipment, controlled drugs and drug fridge temperature monitoring | Equipment will be fit and ready for patient use.<br>Essential resources will be available for use | Compliance checks reported through Quality dashboards and presented in line with the Governance reporting framework |
| **SC 1.2** | Improving the identification and treatment of patients with Acute Kidney Injury (AKI) | To build on the progress made in 2016/17 so that early recognition and treatment of AKI is fully embedded across the whole Trust | Patients leave hospital with knowledge of their diagnosis of AKI which facilitates monitoring under primary care | Quarterly reports highlighting compliance through audit of AKI patient blood profiles submitted in discharge summaries. |
| **SC 1.3** | Timely identification and treatment of sepsis in ED and acute inpatient settings<br>Antibiotic prescribing and review. | Early recognition and treatment with improved antibiotic prescribing and review; leading to reduced consumption per 1000 admissions | Patients with sepsis receive appropriate treatment within 60 minutes of diagnosis of sepsis.<br>Reduced antibiotic consumption per 1000 admissions. | Quarterly reports of compliance with national sepsis guidance through audit of patient records. |
| **SC 1.4** | Continue to enhance the care people receive at end of life while in hospital. | Provision of an appropriate care plan agreed with the patient and their appropriate next of kin when approaching the end of their life.<br><br>Early transfer to the patients preferred place of care. | Patients will agree their preferred place of care to optimise end of life care.<br>Delays associated with hospital discharge at the end of life will be eliminated.<br>All patients at the end of life will have an individual care plan to meet their needs. | Data on average length of delays for Hertfordshire and Essex patients. Barriers to discharge will inform whole health economy priorities for action.<br>Compliance with End of Life documentation will be audited and presented through Health Economy wide meetings |

| | | | | |
|---|---|---|---|---|
| **SC 1.5** | To embed a Learning culture | Improved process to capture learning from all feedback.<br>Improve the process for raising concerns, celebrating success, identifying root causes and demonstrate improvement and solutions.<br><br>Implement process to support learning from every death | Robust governance systems that are standardised and consistently used.<br><br>Production and implementation of Learning From Every Death Policy which identifies key metrics to monitor compliance | Monitoring compliance and use of systems.<br>Audits<br>Risk assessments and mitigation.<br>In your shoes events.<br>Records of issues and root cause analysis and development of solutions and mitigation.<br>Capture all methods of sharing feedback with consistent approach to dissemination.<br>Compliance with Learning from Every Death metrics. |
| **SC1.6** | Embed and sustain Safeguarding processes for children and adults | To improve safeguarding for all our patients through training of staff.<br><br>Evidence based and consistent processes in place.<br><br>Timeliness of safeguarding investigations with shared learning. | Accessible range of training methods including face to face and e learning.<br><br>Evidence of Sharing good practice and enhanced network of support for staff involved in safeguarding issues.<br><br>Compliance with Education and training requirements | Improved compliance for adult and child safeguarding training.<br><br>Evidence of timely and improved feedback from our regulators and commissioners of services. |
| **2. Patient Focus** | | | | |
| **PF 2.1** | Transforming our care (In and through and out) | Establishing a high performing Frailty Unit, ambulatory care, assessment and short stay.<br><br>Sustain SAFER Patient Flow Bundle, Red2Green and internal professional standards (IPS) | Patients are assessed and treated in a safe and timely manner Improving patient safety, quality and experience.<br><br>Reduced in-patient length of stay (LOS) and bed occupancy.<br><br>Improvement in patient flow with timely and earlier in the day discharges.<br>Increased short stay admissions.<br>ED attendances reduced leading to less crowding in the ED.<br>Improved ambulance handover, improving safety and release of ambulance crews.<br>Patients are treated in the right place by the right team at the right time. | Improvement in access standards.<br><br>Reduction in hospital length of stay.<br><br>Reduction in clinical outliers.<br><br>Improved ambulance handover times. |

| | | | | |
|---|---|---|---|---|
| **PF 2.2** | Co-design/personalised care | Develop and implement the discharge to assess model | Patients time in hospital adds value and there are no delays in their treatment or discharge/transfer | Reduction in delayed transfers of care |
| **3. Our People** | | | | |
| **OP 3.1** | Recruitment and retention | Develop and improve our ability to recruit and retain staff | Improved and timely recruitment process where non-value added steps are reduced or eliminated.<br>Staff are retained working in the Trust for longer periods. | Monitor agreed workforce quality indicators through the Trust Performance meetings |
| **OP 3.2** | Staff engagement | A workforce who are committed to their roles, to the organisation and take positive action to further the hospital's reputation and interests through our Quality First Programme | Development and implementation of staff engagement plans that are developed in collaboration with staff groups. | Improved Staff survey, Staff FFT and GMC Trainee Survey results and feedback. |
| **OP 3.3** | Communication | Achieve good quality, effective and clear communication throughout the hospital | Development and implementation of Trust communication Improvement plan. | Improved Staff survey, Staff FFT and GMC Trainee Survey results and feedback. |
| **OP 3.4** | Fit and proper persons regulations | Ensure compliance with all aspects of the fit and proper person's policy. | All Executives and Directors are assessed as of good character with the necessary qualifications, competence, skills and experience for their role. | Workforce Compliance records |
| **OP 3.5** | CQC preparation | Ensure PAH is regulation ready and there is also a focus beyond getting out of special measures with a clear understanding (plan) for what is takes to achieve 'good' or 'outstanding'. | Implement and deliver supporting plan, which addresses underlying causes and root causes | Quality Improvement Plan (QIP) milestones and output tracker.<br><br>Oversight Committee feedback<br><br>CQC inspection report |
| **4. Governance and Risk management** | | | | |
| **G&RM 4.1** | Medical engagement and MDT working | Strengthening capability and competence.<br>Strengthening team working | Clinical teams increasingly taking responsibility and ownership for quality improvements. This will be evidenced through agreeing and establishing best | Medical Engagement Tool completed to provide current baseline.<br>Improved GMC Survey results and feedback.<br>Increased involvement, delivery and ownership of quality improvements, |

| | | | | |
|---|---|---|---|---|
| | | | practice with colleagues. | evidenced by minutes of meetings. |
| **G&RM 4.2** | Risk management | Robust risk identification and management | We are able to identify, forecast and evaluate risks together with the identification of mitigation to avoid or minimise their impact. | Reporting from risk management system (Risk Assure) and QIP dashboard<br>Staff survey feedback on risks and understanding |
| **5. Infrastructure** | | | | |
| **Inf 5.1** | Strategic Estates issues | Agree strategic intention and develop plans to ensure sustainability and service viability | Development of Strategic Outline Case (SOC) for new hospital | SOC<br>Outline business case<br>Full business case for new hospital |
| **Inf 5.2** | Operational estate issues | A clear risk assessed and prioritised list of Estates works fully costed. | Plan for implementation approved by the Board of Directors | Compliance with agreed milestones and outputs. |
| **Inf 5.3** | IT Infrastructure | Full review of our IT needs, capability and capacity | Review and recommendations to the Board of Directors.<br>Plan developed and approved for implementation. | Compliance with milestones and outputs from IT Improvement plan |

Monitoring of performance will be scrutinised through each sub-committee of the Board and reported at monthly Trust Board meetings over the course of the year.

# 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 too.

The Trust has 420 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).

The current service portfolio is outlined below:

| Directory of services | | | |
|---|---|---|---|
| Adult Critical Care | Dermatology | Gynaecology Ambulatory Service | Pathology |
| Ambulatory Care | Diabetic Medicine | Gynaecology | Patient Appliances |
| Audiology | Dietetics | High Dependency Unit | Physiotherapy Occupational Therapy |
| Breast Screening | Early Pregnancy Unit | Intensive Care unit | Pre Op Assessments |
| Breast Surgery | Emergency Department | Interventional Radiology | Radiology |
| Cardiology | Endoscopy Services | Maternity | Respiratory Medicine |
| Chemotherapy | Endocrinology | Medical Oncology | Rheumatology |
| | ENT | Neonatal Critical Care | Special Care Baby Unit |
| Clinical Decision Unit | Frailty service | Neurology | Specialist Palliative Care |
| Clinical Haematology | Gastroenterology | Obstetrics | Speech & Language Therapy |
| Clinical Oncology | General Medicine | Ophthalmology | Transfusion services |
| Colposcopy and hysteroscopy services | General Surgery | Oral Surgery | Trauma and Orthopaedics |
| Community Midwifery | Genito-Urinary Medicine | Paediatric Diabetic Medicine | Urology |
| Day Surgery | Geriatric Medicine | Paediatrics | |

The Trust has a service level agreement in place with subcontract providers for the provision of services and has regular contact with them to agree levels, type and timescales for patient treatment.

The review of services and all associated data is undertaken through the Trust Governance structure. This includes monthly Patient Quality and Safety Group, then through to the monthly Quality and Safety Committee which reports to the Trust Board. External review within the Trust is through the Performance and Finance Committee and external review outside the Trust is by both Essex and Hertfordshire commissioners at the monthly Service Performance and Quality Review Group (SPQRG).

# Prescribed Indicators

Below are the core indicators which NHS England has requested are included in the 2016 - 2017 Quality Accounts by all NHS Trusts.

The Princess Alexandra Hospital NHS Trust considers that this data is as described having been provided by NHS Digital and Dr Foster.

| 12 | Standardised Hospital Mortality Indicator | October 2015 – September | National average | Improvement action plan |
|---|---|---|---|---|
| **12a** | (a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and | 102.71 | 100.0 | The Trust's mortality falls into the 'as expected' range. 22 Trusts had higher than expected. 16 Trusts had 'lower than expected'<br><br>Continuation of Trust Morbidity and Mortality Strategy, which includes the implementation of learning from all deaths.<br><br>Continued Reporting and Performance process with monthly Patient Quality and Safety review Panel chaired by the Chief Nurse, the Medical Director or the Chief Executive to hold individual health groups accountable for performance in their area. |
| | HSMR | January – December 2016<br><br>105.0 | 99.63 | PAH is 1 of 6 Trusts within the peer group of 17 that sit within the 'as expected range' |
| **12b** | The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | January – December 2016<br><br>2.5 % | 3.53 % | No difference between weekday and weekend deaths.<br><br>Further training for staff to understand and implement more robust clinical coding – improved from 1.88% in 2015/2016.<br><br>Better communication between coders and doctors and Advanced Practitioners.<br><br>Continuation of escalation process for coding difficulties. |

The Princess Alexandra Hospital NHS Trust considers that this data is as described having been published by the NHS Digital.

**Patient Reported Outcome Measures (PROMs)**
PROMs measure health outcomes in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.

Data available – April 2016 to September 2016 - where the health gain could not be calculated as there were fewer than 30 modelled records the period April 2015-March 2016 has been used. Figures in brackets represent the national average.

**EQ-5D Index** (a combination of five key criteria concerning general health) Percentage increase in the EQ-5D Index score following their operation:

**Groin respondents recorded**
April 2015 – March 2016 72% (88%)
April 2016 – September 2016 not enough records (89%)

**Hip replacement respondents recorded**
April 2015 – March 2016 42% (43.8%)
April 2016 – September 2016 not enough records (44.9%)

**Knee replacement respondents recorded**
April 2015 – March 2016 30.2% (32%)
April 2016 – September 2016 not enough records (33.7%)

**EQ VAS** (current state of the patients general health marked on a visual analogue scale)
**Groin respondents recorded**
April 2015 – March 2016 -1.361(-0.8)
April 2016 – September 2016 not enough records (-0.1)

**Hip replacement respondents recorded**
April 2015 – March 2016 10.5 (12.4)
April 2016 – September 2016 not enough records (13.7)

**Knee replacement respondents recorded**
April 2015 – March 2016 4.2 (6.2)
April 2016 – September 2016 not enough records (8.1)

**Condition Specific Measures** (a series of questions specific to the patients' condition)

**Oxford Hip Score**
April 2015 – March 2016 20.7 (21.6)
April 2016 – September 2016 not enough records (22)

**Oxford Knee Score**
April 2015 – March 2016 16.4 (16.4)
April 2016 – September 2016 18.9 (16.9)

**Participation and Coverage**
April 2015 – March 2016

| | Pre-operative questionnaires completed | Post-operative questionnaires sent out | Issue Rate | Post-operative questionnaires returned | Response Rate |
|---|---|---|---|---|---|
| **All Procedures** | 605 | 598 | 98.8% | 424 | 70.9% |
| **Groin Hernia** | 81 | 81 | 100.0% | 51 | 63.0% |
| **Hip Replacement** | 225 | 221 | 98.2% | 167 | 75.6% |
| **Knee Replacement** | 250 | 247 | 98.8% | 180 | 72.9% |
| **Varicose Vein** | 49 | 49 | 100.0% | 26 | 53.1% |

April 2016 – September 2017

| | Pre-operative questionnaires completed | Post-operative questionnaires sent out | Issue Rate | Post-operative questionnaires returned | Response Rate |
|---|---|---|---|---|---|
| **All Procedures** | 370 | 143 | 38.6% | 64 | 44.8% |
| **Groin Hernia** | 47 | 25 | 53.2% | 19 | 76.0% |
| **Hip Replacement** | 140 | 40 | 28.6% | 14 | 35.0% |
| **Knee Replacement** | 139 | 48 | 34.5% | 19 | 39.6% |
| **Varicose Vein** | 44 | 30 | 68.2% | 12 | 40.0% |

19. The Princess Alexandra Hospital NHS Trust 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**<br><br>**October 2015 – September 2016** | **National Average** | **Improvement action Plan** |
|---|---|---|---|
| Re-admitted 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<br>. | PAH All ages 7.3% observed<br><br>PAH 0-14 5.8% observed<br><br>PAH 15 or over 7.4% observed | National Acute (Non Specialist) 8.1% observed Lowest 5.8% Highest 10.5%<br><br>National Acute (Non Specialist ) Aged 0-14 9% Observed Lowest 4.1% Highest 14.4%<br><br>National Acute (Non Specialist 15 or over 8.0% observed Lowest 5.8% Highest 10.8% | Flagging of patients on re-admission<br><br>Priority referral to home team (who are familiar with patient and are able to make the best plan for the patient<br><br>Internal Professional Standard that patient should be seen within 30 minutes of referral by **decision maker** to review if admission is needed or if alternative method of care is appropriate |

Source: Dr Foster

20. The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

| 20 | Trust's responsiveness to the personal needs of its patients during the reporting period. Ensuring that people have a positive | 2015 -2016 | 2016-17 | Improvement action plan |
|---|---|---|---|---|
| | Number of PALS cases resolved | 89.9% (n=1906) of 2121 cases resolved on review within 48 hours | 79% (n=2119) of 2683 cases resolved within 48 hours<br><br>No national comparison available therefore<br>Highest Month 250 (August)<br>Lowest Month 164 (December) | Implement the findings of the two patient experience workshops run in 2015-16 |

21. The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

| **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 2016 | Trust's nationally set target for this question | Our grading | Improvement action plan |
|---|---|---|---|---|---|
| | *Friends and Family Test - staff* | 76%<br>Trust Recommended as provider of care highest 76% and lowest 68% | 80%<br>England percentage Recommend Care National Lowest 44%<br><br>Highest 98% | Amber | Better communications with all staff around survey to ensure more respondents |

21.1 The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

| **21.1** | The percentage of patients who would recommend the trust as a provider of care to their family or friends. | Average for 2016-17 | National Average | Improvement action plan |
|---|---|---|---|---|
| | **Friends and Family Test – patients** | 93.4% | 93%<br>Lowest average across four data sets 72%<br>Lowest for any data set (A&E) 48%<br><br>Highest across three data sets 100% apart from A&E 99 % | Continue communications working group within minimum standards for compliance with 'Values, Standards and Behaviours Framework' being set across all Health Groups |

23. The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

| **23** | March 2016 | March 2017 | 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 p5eriod | 97.51% | 98.7% | 95.64% England Average<br><br>October – December 2016<br><br>Lowest 76.48%<br>Highest 99.43% | Continue failsafe check lists at ward level.<br><br>Continue updated VTE risk assessment proformas. Patient leaflets available in clinical areas.<br><br>Patient Safety Thermometer includes whether prophylaxis given.<br><br>Process for poor compliance shared with all ward and departments.<br>Continue Anticoagulation Nurses undertaking teaching at ward level and for all new doctors. |

24. The Princess Alexandra Hospital NHS Trust considers that this data is as it is part of the Integrated Performance Report and audited Trust data.

| **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. | No. of cases<br><br>April – March 2017 | PAHT Target * | Improvement action plan |
|---|---|---|---|---|
| | C-Diff - cases on national surveillance database<br><br>C-Diff - cases attributable to PAH (total less successful appeals)<br><br>Therefore rate per 100,000 bed days for PAH = 12.98 | 18<br><br>7 | 10<br>Latest National Figures April 2015 – March 2016:<br><br>England C Diff rate per 100,000 bed days 40.8 (14139 reports)<br><br>Lowest rate 0% (0 reports) | Continue responsible use of antibiotics<br>Continue thorough cleaning and monthly cleaning and hygiene code audits<br>Continue hydrogen peroxide decontamination<br>Continue excellent standards of hand hygiene |

* Latest benchmark data available from NHS Choices

25. The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

The Trust has taken action to improve its scores and the quality of its services, by continuing to train all clinical staff in Root Cause Analysis and holding regular workshops and events around Being Open and Duty of Candour.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **25** | 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. | *Number of Severe harm/ Serious Incidents and incidents resulting in death<br><br>1 April - 30 Sep 2016 | *Severe Incident National<br><br>Average<br><br>1 April - 30 Sep 2016 | Severe harm Incident Trust<br><br>Average<br><br>Serious Incident Trust Average | Incidents resulting in death.<br><br>National average<br><br>1 April - 30 Sep 2016 | Incidents resulting in death.<br><br>PAH average<br><br>1 April - 30 Sep 2016 | Incident reporting rate<br><br>1 April - 30 Sep 2016 |
| | The total number of incidents as reported to the NRLS during this period was 3580 incidents. | 10 Severe harm at time of data submission to NRLS.<br><br>15 Serious Incidents (StEIS).<br><br>1 Death on NRLS at time of data submission. | 0.3% | 0.3% at time of data submission<br><br>SI Trust Average is 2.5 SI's/month | 0.1% | 0% | 42.59 incidents per 1,000 bed days<br><br>Median rate for organisations within Trust cluster (Acute non specialist) is 40.02 incidents per 1000 bed days. |

*Reference for National Data is as provided for Acute (non-specialist) organisation in the NRLS organisation patient safety report 1/4/2016 to 30/09/2016 - data is only provided on severe harm levels not serious incident numbers.

## Statement on Relevance of Data Quality

The Princess Alexandra Hospital NHS Trust continues to progress improvements in data quality:

- Regular reporting on data quality issues to the Information Governance Steering Group via the Trust's weekly Operational EPR Group, the Performance and Finance Committee and Board of Directors.
- Continue clinical validation of medical records coding to ensure 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 issues
- NHS Data Quality Maturity Index overall the Trust scored 96.9% (July-September 2016) and the Trust compares favourably with other local acute trusts.

## Data quality, metrics and processes

### NHS Number and General Medical Practice Code Validity

The Princess Alexandra Hospital NHS Trust submitted records during 2016/17 as at February 2017 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 (2015/2016 in brackets):

Which included the patient's valid NHS number was:

- 99.7% (99.5%) for admitted care
- 99.7% (99.6%) for outpatient care
- 98.1% (97.9%) for accident and emergency care

Which included the patient's valid General Medical Practice Code was:

- 100% (99.7%) for admitted patient care
- 100% (99.8%) for outpatient care
- 99.9% (99.7%) for accident and emergency care

## Information Governance (IG) Position Statement

The Trust's Information Governance Assessment Report overall score for 2016-17 (V14) was 78%, with no requirements showing below level 2. The Trust remains satisfactory and continues to be rated green.

## Clinical Coding Audit

PAH was subject to a Clinical Coding audit undertaken by an NHAS approved Clinical coding auditor. The audit was based on the methodology detailed in the NHS Connecting for Health publication *Clinical Coding Audit Methodology version 10.0*.

A total of 200 finished consultant episodes across a range of specialities were audited.
The accuracy rates reported at the time for diagnosis and procedure coding were:

| **PAH Attainment Level for Information Governance Purposes** | | |
|---|---|---|
| **Subject Area:** | **(%)** | **Level** |
| **Primary diagnosis** | 92.5 | Level 2 |
| **Secondary diagnosis** | 95.3 | Level 3 |
| **Primary procedure** | 93.2 | Level 2 |
| **Secondary procedure** | 93.6 | Level 3 |

Clinical coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes that reflect the activity that happens to 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.
The audit found good progress towards previous audit recommendations with further work required regarding case note improvements.
The Princess Alexandra Hospital will be focusing on addressing the recommendations from the audit.

# Achievements and challenges in 2016-2017

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

| Priorities for quality improvement 2016-2017 | | | | | |
|---|---|---|---|---|---|
| **1** | **Patient Safety Priorities** | What we are trying to improve | What success will look like | How we will monitor progress | How we did |
| **1.1** | Improving the identification and treatment of patients with Acute Kidney Injury | To improve early recognition of Acute Kidney Injury to allow intervention and treatment | Patient have a diagnosis of AKI which facilitates monitoring under primary care | Audit of patient records to ensure that discharge summary contains the blood profile to alert primary care of AKI. This will be reported quarterly | Introduced training to improve early recognition.<br>Created patient information and advice leaflet<br>Automated alert system for doctors is expected to go live in Q1 2017/18 |
| **1.2** | Improving the identification and treatment of patients with Sepsis | Standardisation and early recognition of sepsis and treatment with first dose antibiotics for both inpatient and those presenting in the emergency department | Patients with sepsis receive timely appropriate treatment in line with the national sepsis guidance | Audit patient records to ensure that treatment concurs with the national sepsis guidance and that first dose antibiotics are delivered in 60 minutes of a formal diagnosis of sepsis. This will be reported quarterly | Quarter 1 90%<br>Quarter 2 80%<br>Quarter 3 70%<br>Quarter 4 80% |
| **1.3** | To improve Trust wide antibiotic stewardship | To improve antibiotic prescribing, to ensure rationale and duration are in accordance with best practice | To reduce antibiotic consumption per 1000 inpatient admissions | To reduce antibiotic consumption per 1000 inpatient admissions | 6.7% reduction in all antibiotic consumption per 1000 inpatient admissions |
| **2** | **Clinical Outcome Priorities** | What we are trying to improve | What success will look like | How we will monitor progress | How we did |
| **2.1** | Continue to enhance the care people receive at end of life while in hospital and patients and appropriate next of kin are involved in end of life discussions | The discussion and completion of appropriate Do Not Attempt Cardiopulmonary Resuscitation orders<br><br>End of Life plans of care in partnership with patients and their appropriate next of kin<br><br>Early discharge to preferred place of care | Eliminate inappropriate resuscitation and demonstrate that patient return to their preferred place of care | CQUIN milestones and other key performance indicators include: Improvements in the National Care of the Dying Audit<br><br>Monthly audit of all cardiac arrest and mortality to ensure that patients has received appropriate end of life discussions and plans | E-learning package for DNACPR developed and in Place by April 2017. National Resuscitation Form launched in April 2017.<br><br>Individualised plans of care for those patients in their anticipated last days of live implemented.<br><br>100% patients who were asked were able to discuss a preferred place of care (PCC). Preferred Place of |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Death (PDD) achieved in >65%.<br><br>Improvements in care delivery for specialist palliative care services to 6 days per week and bank holidays. |
| **2.2** | Continue to improve the care received in hospital by people living with dementia in accordance with the Alzheimer Society 2015 Annual Report | Early detection of dementia and onward referral to appropriate agencies<br><br>Improvements in ward environment in accordance with recommendations from the Alzheimer Society<br><br>Implementation the Dementia Champions and dementia volunteers for every patient facing area | Screening of all admitted patients aged over 65 (for their potential dementia risk) in line with the local and national CQUIN schemes<br><br>Improved environment for dementia patients<br><br>Continuation of dementia champions programme as part of the dementia training programme as required for the local and national dementia CQUIN<br><br>Implementation of dementia volunteers national programme | Compliance with >90% patients screened and referred. Monthly submission to UNIFY<br><br>Compliance with agreed standards for the environment for dementia patients<br><br>At least one dementia champion in each clinical area | Over 90% compliance consistently achieved with the Find, Assess and Refer process for early detection of dementia and onward referral for patients over age 65 years.<br><br>Appointed Dementia Support practitioner in July 2016.<br><br>As of March 2017 the Trust has 4 dementia volunteers.<br><br>28 staff members have successfully completed the Dementia champion programme<br>Ward refurbishment includes a focus on dementia; Lister ward completed in 2016/17<br><br>Gibberd ward has been completely redesigned with a focus on dementia care; the layout, décor and furniture have all been chosen to best meet the needs of people living with dementia. |

| | | | | | |
|---|---|---|---|---|---|
| **2.3** | Successful introduction of Hospital at Night to facilitate seamless and equitable care 24 hours a day for acutely unwell patients | This is a two year scheme to introduce and sustain a Hospital at Night team<br><br>It will consist of a group of multi-professional individuals with an agreed range of skills and competencies to meet the immediate needs of patients and facilitate effective operational management of the Hospital at Night, optimising patient safety and minimising risk | Reduce avoidable cardiac arrests<br><br>Reduction in the number of unplanned admission and readmission to ITU<br><br>Reduce avoidable patient harm incidents occurring after 8pm and at weekends<br><br>Reduction in the number of 'failure to rescue'/suboptimal care' incidents | Hospital at Night project team to monitor progress<br><br>Compliance with local CQUIN milestones | Critical Care Outreach services extended to 24/7 in September 2016.<br>Referrals have increased.<br>Recordable cardiac arrests have fallen by 35% since 2015<br><br>Cardiac arrests associated with failure to rescue the deteriorating patient have fallen by 60% since 2015 |
| **3** | **Patient Experience Priorities** | What we are trying to improve | What success will look like | How we will monitor progress | How we did |
| **3.1** | Improvements in transfers of care as detailed by 7 areas for improvement in the National Inpatient Survey | Increased involvement in transfers of care of families, patients and carers<br>Clearer contact information if you are unwell again and on key items such as medication side effects | The National Inpatient Survey 2016 and locally audited metrics supported by Clinical Friday and volunteers running surveys at ward level | Board and committee reports<br><br>Process Improvement workshops<br><br>Clinical Friday audit programme | During 2016/17 we launched a new integrated discharge team. The team combines Trust, community - SEPT, mental health, Essex Social and Hertfordshire locating and working together to improve the discharge process of our patients. |
| **3.2** | Achieve at least 3 areas in the top 20% for ED and Inpatient Surveys for 2016 | Improve Patient Experience survey results against 2015-16 and national comparison | Ensure all 77 Inpatient Survey indicators are at least in the middle 60% or above with at least three indicators in the top 20% of Trusts in England and Wales | Monthly Integrated Performance Review<br><br>Real-time PALS/ patient feedback<br><br>National survey results | 78% of patients felt treated with respect and dignity<br>Dr/nurses always had confidence and trust 74%<br>The ED was clean/ very clean 94%<br>Received test results before leaving 75%<br>Always enough Privacy when being examined or treated 78% |
| **3.3** | Implement an effective electronic feedback system for patients with sampling rate of at least 20% | Pace of acknowledgement of complaints<br>Quality of communication with complainants | 99% of complaints are acknowledged within 3 working days<br><br>At least 80% of complaints are responded to within a timeframe agreed | Complaints process monitoring at committee level and via the Patient led Complaints Reference group<br><br>Annual and quarterly reporting. | Sampling rate of >30% achieved through the Friends and Family test.<br>Procurement process completed for electronic feedback system; yet to identify |

| | | | | | |
|---|---|---|---|---|---|
| | | | with the complainant<br><br>At least 80% of complainants who provide a phone number and request a call, get a call within 3 working days of making a complaint | Satisfactions levels shown through survey | a preferred provider. Plan to appoint by July 2017. |
| **4** | **Staff Experience Priorities** | What we are trying to improve | What success will look like | How we will monitor progress | How we did |
| 4.1 | Create a better working environment where staff morale is improved and all staff have received appropriate workplace training | Score the national average or above through staff survey | Progress will be monitored through monthly surveys | National and local surveys | We conducted 4 staff surveys asking the Friends and Family questions which focus on recommending the hospital as a pale to work or receive treatment.<br>We introduced a range of Staff Engagement groups accessible to all staff groups. |
| 4.2 | Ensure that the Trust's Vision and Values are embedded among the workforce | Increase number of staff being trained in Trust's Vision and Values | A rise in the number of staff receiving training from the current level of 61% to a minimum of 70% | Regular reports to the Board | Achieved consistently above 80% throughout the whole year. |
| 4.3 | To provide an improved working environment and career progression that will encourage staff to stay at the Trust long term | Staff retention | Reduce voluntary turnover to 10% or lower | Regular workforce reports to Performance and Finance Committee | Voluntary turnover has reduced from 16.2% to 14.9% for all staff. In nursing there has been a 2% reduction from 21% to 19%<br>A number of actions are being taken to further improve the position. |

# Care Quality Commission rating

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

In June 2016, the CQC carried out a full and comprehensive inspection of the Trust services. This was a follow-up to assess if improvements had been made in all core services since the last inspection which took place in July 2015.

The outcome of the inspection was an overall rating of ***Inadequate*** due to significant concerns related to safety, responsiveness and leadership. The Trust did receive a rating of ***Good*** for Caring in all areas and Maternity and Gynaecology services were rated ***Outstanding***. Following receipt of verbal feedback directly after the inspection, the Trust took decisive action to make immediate changes, which included:

- Increase of staff numbers in the Emergency Department,
- A review and refresh of the ambulance queue management system; clear responsibility written on the allocation board for a named nurse and doctor for the management of the patient queue in the Emergency Department,
- Implementation of a Consultant Dashboard in Critical Care to demonstrate that emergency equipment was being checked regularly,
- Decommissioning of a small number of mortuary fridges which had been deemed unfit, with a temporary solution put in place by the following day.

Following receipt of the inspection report, the Trust went into **'Special Measures'** in October 2016. A Quality Summit was held on the 19 October 2016 to share the findings with the Trust's regulators, local commissioners and partners.

**CQC ratings grid 2016**

| Overall | Safe | Effective | Caring | Responsive | Well led |
|---|---|---|---|---|---|
| **Urgent & Emergency Services** | Inadequate | Requires improvement | Good | Inadequate | Requires improvement |
| **Medical Care** | Requires improvement | Good | Good | Requires improvement | Good |
| **Surgery** | Inadequate | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| **Critical care** | Inadequate | Requires improvement | Good | Inadequate | Inadequate |
| **Maternity & Gynaecology** | Good | Good | **Outstanding** | Good | **Outstanding** |
| **Services for children and young people** | Inadequate | Good | Good | Good | Requires improvement |
| **End of Life care** | Requires improvement | Requires improvement | Good | Inadequate | Inadequate |
| **Out Patient and diagnostic imaging** | Good | **Inspected but not rated** | Requires improvement | Requires improvement | Good |

Since then, the Trust now has an Improvement Director in place. Appointed by NHS Improvement, this individual is working alongside the Trust Board to support, advise and challenge the outcomes from actions taken. We are working with our staff, health and social care partners and other stakeholders to identify and deliver changes which will make a difference to patient care. We have reviewed the 38 recommendations made by the CQC and consolidated the required actions identified by our staff into five work streams. These are:

i. Our People
ii. Getting the basics right
iii. Patient Focus
iv. Infrastructure
v. Governance, Risk Management and making informed decisions.

Related actions from the 2015 inspection have also been incorporated into the five work streams to create one overarching Quality Improvement Plan; ***Quality 1st.***

## Monitoring our progress

There are a number of ways in which we are working with staff, service users, health and social care partners as well as our commissioners, regulators and NHS Improvement to monitor our progress:

- We participate in monthly multi-agency oversight meetings, chaired by NHS Improvement; the purpose is to oversee the delivery of our quality improvement plan across the health economy. Each month one of the services presents on their achievements.
- Twice a month the Trust hosts quality inspections to review compliance with the fundamental standards of quality; immediate feedback is provided to the area inspected. The inspectorate includes members of the Patient Panel and colleagues from both commissioning groups.
- Each service is invited to monthly progress meetings with executive board members and the NHSI Improvement Director. 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.
- Progress against the Quality Improvement plan is also discussed at every Health Group board meeting, the Executive Management Board and Trust Quality and Safety Committee before updating the Trust Board.
- Monthly progress is shared on the Trust website for staff and service users.

# CQUIN achievement 2016/17

The Commissioning for Quality and Innovation (CQUINs) payment framework encourages care providers to share and continually improve how care is delivered. The aim is to achieve transparency and overall improvements in healthcare. For patients this means greater involvement, a better experience and improved outcomes.

The national CQUIN schemes for 2016/17 undertaken by the Trust were:

| National CQUIN Schemes | Income potential | Projected Year-end percentage achievement | Final confirmation |
|---|---|---|---|
| NHS staff health and wellbeing | **£1,158,996** | **73%** | **66.66%** |
| Timely identification and treatment of Sepsis | **£386,332** | **78%** | **80.18%** |
| Antimicrobial Resistance and Antimicrobial Stewardship | **£386,332** | **15%** | **50%** |

The following locally developed CQUIN schemes were also undertaken in 2016/17

| Local CQUIN Schemes | Income potential | Projected Year-end percentage achievement | Final confirmation |
|---|---|---|---|
| Integrated workforce across the local healthcare system | **£482,915** | **100%** | **98.48%** |
| Introduction of system wide "virtual" MDT meetings for care homes in Essex | **£482,915** | **92%** | **TBC** |
| Introduction of Ask 3 Questions to support patients with informed decision making about the care and treatment options | **£347,699** | **100%** | **TBC** |
| Cancer pathway linked to 2 week and 32 day standards in line with national cancer strategy | **£309,066** | **100%** | **TBC** |
| Recognition of stroke symptoms and timely intervention for patients in ED and inpatient wards | **£309,066** | **100%** | **TBC** |

:

Specialist commissioning CQUINS undertaken in 2016/17 were:

| Specialist CQUIN Schemes | Income potential | Confirmed Year-end percentage achievement |
|---|---|---|
| Pre-term babies hypothermia prevention | **£18,599** | 100% |
| 2 year follow-up for very pre-term babies | **£37,198.80** | 75% |
| Nationally standardised dose banding adult intravenous SACT | **£37,198.80** | 50% |
| **NHS E non specialist CQUIN scheme** | **Income potential** | **Year-end Achievement** |
| Oral health | **£66,501** | 100% |

**CQUIN plans for 2017 - 2019**

For the first time NHS England have published a 2 year scheme which is aimed at providing greater certainly and stability on the CQUIN goals, leaving more time for health communities to focus on improvement initiatives. The CQUIN schemes are:

- Improving staff health and wellbeing
- Reducing the impact of serious infections (antimicrobial usage and sepsis)
- Improving services for people with mental health needs who present to A&E
- Offering advice and guidance (hospital clinicians to GP's)
- NHSe referrals
- Supporting proactive and safe discharge
- Preventing ill health by risky behaviours – alcohol and tobacco (2018/19)

# Enhancing recognition and treatment of the deteriorating patient

In September 2016 the Critical Care Outreach team (CCOT) extended their hours to provide a service 24 hours a day, 7 days per week. The Outreach service was initially created in 2001 in response to a national report highlighting the need to improve the care provided to deteriorating patients outside of critical care, on the wards.

The team consists of 11 registered nurses who each have extensive intensive care experience and advanced clinical assessment skills. Utilising the track and trigger system, all patients whose condition deteriorates are alerted to the CCOT. The team will assess and initiate treatment in the ward as well as supporting the ward team with advice and guidance on the best care for the patient.

By rapidly responding to escalation from the wards, the CCOT are able to optimise the care that patients are receiving and this prevents avoidable admissions to the Intensive Care Unit or High Dependency unit.

The team provide education and training for staff as well as telephone advice when a member of staff is concerned about a patient but the patient hasn't yet triggered for escalation.

Activity for the team continues to grow; in 2016/17 the CCOT received 2057 patient referrals and undertook 4700 clinical assessments. Recordable cardiac arrests in the hospital have reduced by 35% since 2015. Extending the hours of work means that there is now a seamless service for all of our patients.

| Activity | 2014/2015 | 2015/2016 | 2016/2017 |
|---|---|---|---|
| Referrals made to CCOT | 1953 | 1977 | 2057 |
| Patient assessments completed | 4008 | 4200 | 4700 |
| Recordable cardiac arrests (total) | 99 | 77 | 66 |
| Cardiac arrests where previous DNACPR not considered | 34 | 19 | 19 |
| Cardiac arrests where evidence of delay in recognising the deteriorating patient | 15 | 8 | 6 |

The introduction of electronic observations in 2016/17 has further enhanced the timeliness of escalation to the CCOT as there is an automatic alert for patients triggering the National Early Warning Score (NEWS).

When a nurse at the bed side enters the patient's observations in to a mobile device the Nervecentre app automatically applies the National Early Warning score to the observation recorded. This builds a picture of the overall patient condition. Once completed the full score appears at the top of the screen and allows the user to submit this record.

When the user submits a high score the system automatically sends an alert to the CCOT clinical team. This alert notifies of the NEWS outcome, where the patient is located and the details of the observations that have triggered the alert. This allows immediate notification and enables the CCOT clinician to provide advice prior to attending the patient.

**Members of the Critical Care Outreach team**

## Improving End of Life Care: Our story so far

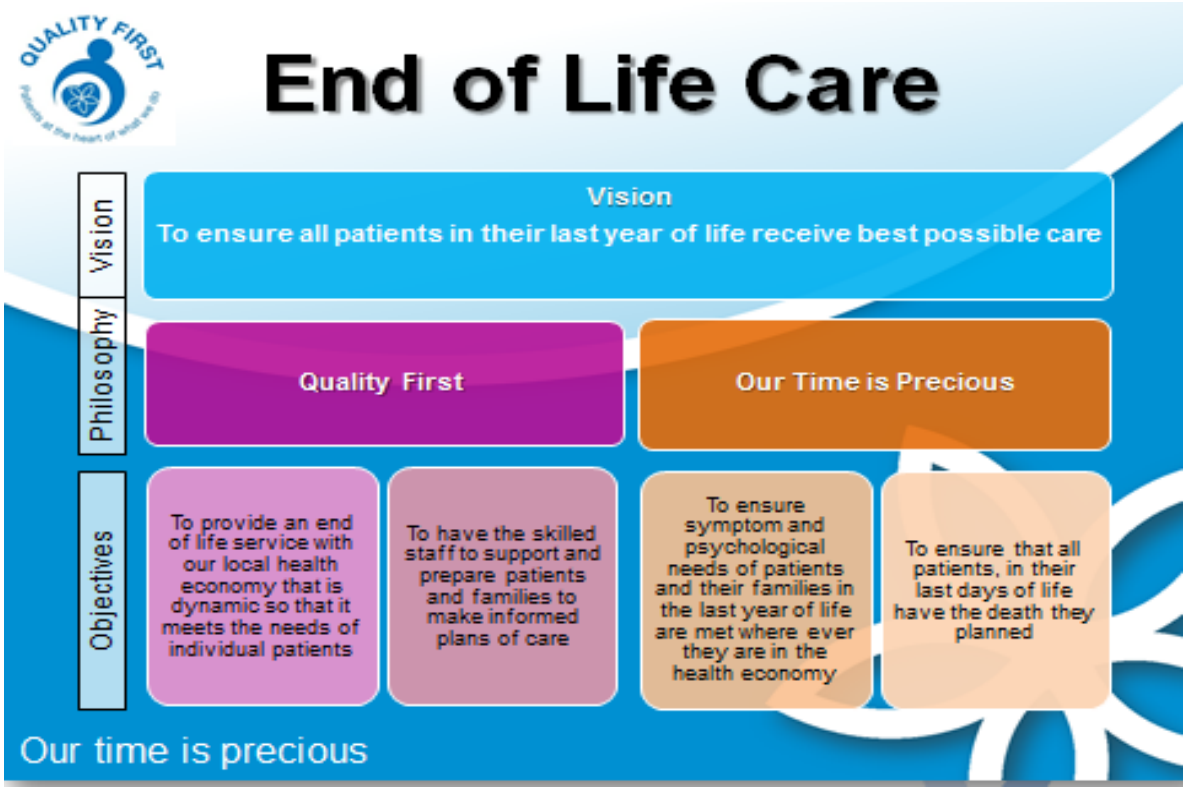
End of Life Care is a true quality barometer for the organisation on how we prioritise care. Although End of Life Care received an "Inadequate" rating from the CQC, inspectors recognised and reported that *"all staff were seen to provide kind and compassionate care".* The inspectors also reported that pain relief was prescribed appropriately, that patients were encouraged to eat and drink as they wished and that their dignity was maintained at all times.

Whilst The Trust has always prioritised the delivery of individualised End of Life Care, we acknowledge that not all processes were joined up with other healthcare organisations; this is now being addressed. An Improvement Steering Group has been invigorated and includes representation from a number of other healthcare organisations from both West Essex and North and East Hertfordshire to ensure all of our patients' needs are taken into account when planning improvements. This group reports directly to Trust Board via the Trust Patient Safety and Quality Group, with executive and non-executive representatives from the board taking a lead in the improvement of End of Life Care. Quarterly reports on progress are provided to the Trust Quality and Safety Committee which in turn reports to the Board of Directors.

The Trust has developed a strategy for End of Life Care for adults (2017 – 2020). The strategy is in line with the six ambitions for Palliative and End of Life Care: A national framework for local action 2015 to 2020 (National Palliative and End of Life Care Partnership 2015).

We have created a vision with four objectives that encompass all six ambitions for end of life care. We will measure our achievements through continuous monitoring of improvements, bench marked against the six ambitions. The vision for the hospital is

***"To ensure all patients in their last year of life receive the best possible care"***



While addressing the key concerns raised by the CQC, the Trust is also striving to continually improve End of Life services. One area of focus has been to introduce a mechanism for ensuring that we share the learning from our patients, their family's and carer's experience.

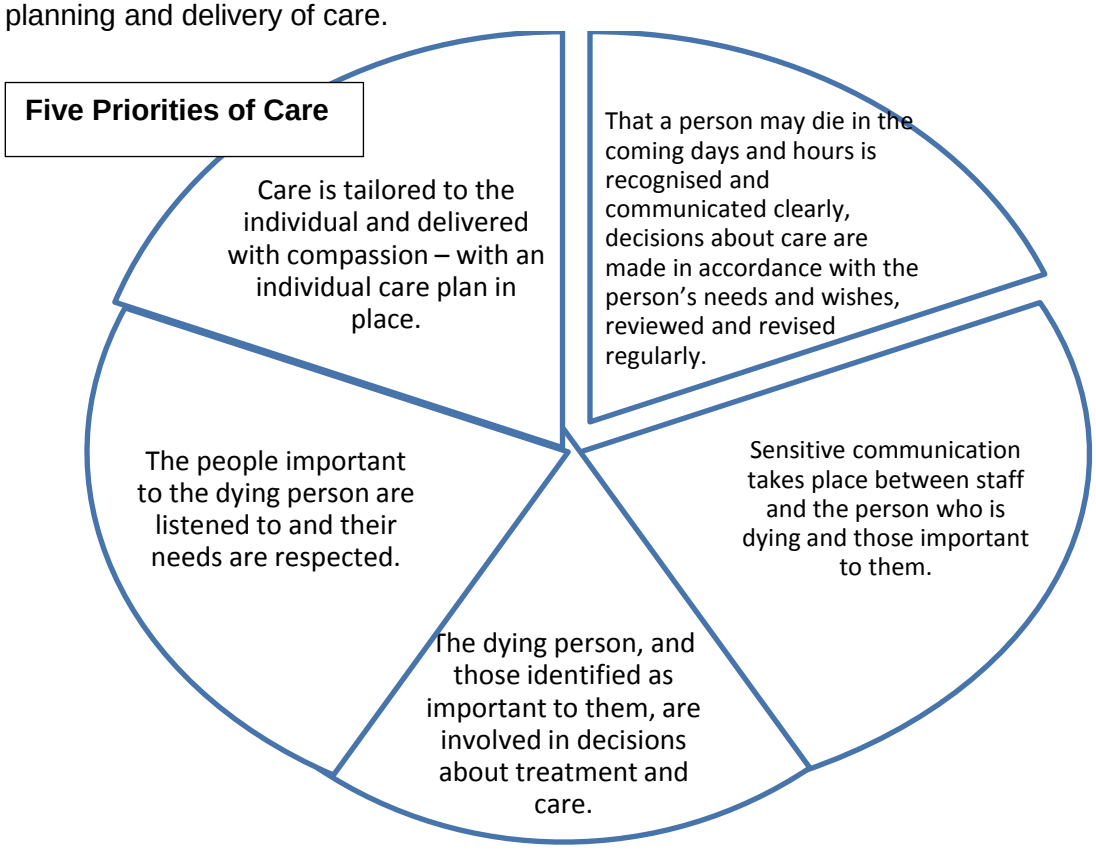
The Trust has developed a new process to supplement the learning that is already achieved through complaints, the patient advice and liaison service (PALS) and reported incidents. Working with the Bereavement team, Patient Panel and Clinicians, we will be ensuring that every death is reviewed. "Learning from every death" will also make sure that all relatives and carers have an opportunity to share their experience.

Other areas of focus include:
**End of Life Care Champions:** These key individuals based on every ward and department will be responsible for sharing best practice within their areas, developing their own skill sets to support patients and relatives at the End of Life and to support the development of other members of their team.

**Training**: in all aspects of End of Life Care is provided to all new clinical staff across the organisation. We have developed an innovative approach to training; using simulation with real scenarios; including End of Life care supporting dementia patients and sharing of patient and relatives stories.

**Individualised care plans for the anticipated last days of life**: To ensure patients, their families and carers receive the best possible care, our Specialist Palliative Care Team (SPCT) have developed new documentation.

Available on every adult ward in hard copy and electronic folders, our aim is to support caring for the dying person in line with the Leadership Alliance for the Care of Dying People (2015). The care plan is based on the five priorities for care; touchstones for every point of care for those in the last days and hours of life and their families. The documentation focuses on the needs and wishes of the dying person and those closest to them, in both the planning and delivery of care.



**Building the team:** The SPCT successfully recruited a third Macmillan clinical nurse specialist who joined the team in February 2016. The nursing team is supported four half days a week by a consultant in palliative medicine. The vision for the Trust is to have a full time end of life consultant. However the trust has been unsuccessful in recruiting to this post. To mitigate this risk to patient experience, expertise from colleagues from local hospices is available and consultants with a special interest in end of life care within the Trust are offering support to patients and clinical staff.

In recognition of the importance of early discussions with patients to allow them the opportunity to make choices about their care, we are piloting a new role. The post holder is working with our medical teams to help them to have discussions with individuals where quality of life may be more relevant to them and their family and carers.

The SPCT have experienced an increase in the number of referrals during 2016/17. An average of 55 new patient referrals were recorded per month; compared to 43 per month in 2015/16. Since May 2016 the service has been available six days per week including bank holidays; this has undoubtedly helped the team to respond to 100% of all referrals within 24 hours.

The Trust has worked closely with local providers to reduce delays in transferring patients who do not wish to die in hospital to their preferred place of death. The Fast Track and Rapid Discharge Home to Die Process and Escalation Pathway was launched in April 2017 and will be monitored to ensure that it meets the needs of patients and their families.

**Mortuary improvements**

The deceased are cared for by highly trained and qualified Anatomical Pathology Technicians. The department and all staff are licenced to practice in compliance with the Human Tissue Authority (HTA) 2004. Technical staff are qualified in compliance with the Royal College of Pathologists and Royal Society of Public Health requirements. The mortuary has full Clinical Pathology Accreditation (CPA) and is working towards UKAS (CPA &ISO 15189) accreditation.

In June 2016 the CQC raised concerns about the mortuary environment which included the use of a temporary, non-secure refrigeration trailer and rust on doors and hinges of some refrigeration units. Although there had been no incidents associated with the concerns raised, immediate actions were taken to address them and all improvements were completed by April 2017. Improvements included repair and refurbishment of all doors and refrigeration units, decoration and refurbishment of the viewing room and the relative area. An additional secure permanent refrigeration trailer was purchased; improving security, privacy and dignity. A full inspection of the mortuary department by the Human Tissue Authority took place in December 2016 and the summary of their inspection

***"found the Designated Individual, the Licence Holder and the premises and practices to be suitable in accordance with the requirements of the legislation"***

The Bereavement Services at PAH deal with approximately 1300 patient deaths per year; the support and guidance provided to bereaved families has received positive feedback and was commended by the CQC inspection in June 2016.

## NHS Staff Survey results and Staff Family and Friend Test

The annual NHS Staff Survey and the quarterly Staff Family and Friend Test are crucial barometers of how our staff view their workplace. The feedback is useful in helping us highlight improvements that will make the hospital a better place to both work and be treated. Some of the key weaker areas identified in the 2016 Staff Survey compared with other NHS Trusts were:

- Some staff had not had an appraisal in the last 12 months
- Staff do not have adequate material, supplies and equipment to do their work
- Not enough staff in the organisation to do the job properly
- Organisation definitely takes positive action on health and wellbeing
- Organisation treats staff involved in errors fairly

However staff did report an improvement in the quality of staff appraisals in that the Trust values were definitely discussed.

We have looked at the results and have developed some key action points to address the weaker issues. Each Health Care Group has received their own staff survey report and will develop their own action plans to address their key areas of weakness.

On the Staff Family and Friends Test in Quarter 4 (Jan-Mar 2017) 68% of staff said they would recommend the Trust to family and friends if they needed care or treatment here. This is 1% above the target of 67% set by the Department of Health, and gives PAHT a 'green' rating. 55% of staff said they would recommend PAHT as a place to work, which is below our Department of Health target of 61%, and gives PAHT an 'amber' rating.

**Workforce Race Equality Standard (WRES) - KF26 and KF21**

| | | | Your Trust in 2016 | Average (median) for acute trusts | Your Trust in 2015 |
|---|---|---|---|---|---|
| KF26 | Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | White | 27% | 24% | 30% |
| | | BME | 35% | 27% | 30% |
| KF21 | Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion | White | 82% | 88% | 90% |
| | | BME | 68% | 76% | 61% |

We recognises that our results are above (worse than) the average for acute Trusts, and we have established an Equality and Diversity Steering Group. This group is currently collating our available equality and diversity data to understand our key issues. As part of this, the Workforce Race Equality Standard (WRES) will be reviewed alongside our Trust policy, to develop an initial work plan.

Initiatives introduced during 2016-17 include a new career development section as part of the appraisal paperwork for all non-medical staff. This ensures that every staff member is prompted to discuss their career aims and receive support from their manager to identify their possible next steps. The Trust also has a nominated executive Freedom to Speak Up Guardian; staff are encouraged to raise any concerns via this route if they don't feel able to discuss this with their line manager.

# Our Staff

In 2016 the Care Quality Commission rated our staff as **good** for caring; they witnessed staff delivering care that was compassionate, involving patients in decision making and providing good emotional support to patents and those close to them. The care observed in the maternity services was rated **outstanding** with staff going beyond the call of duty to deliver the best experience possible for women.

Without doubt, our staff are our greatest asset, regardless of their role. We have a number of routes into employment with the Trust and in 2016/17 we continued to further explore new career pathways:

**Apprenticeships**: 31 new apprenticeships started in 2016/2017; these included Health, Business Administration and Plumbing Apprenticeships for substantive staff and employees on an apprenticeship.

**Apprenticeship Levy:** Contributions to the Levy commenced in April 2017. Plans are underway to ensure that we can support our substantive staff and new employees to the Trust.

**Foundation Degree:** 17 Trust employees from a range of different services started year 1 of 2 in September 2016 and 19 other employees continued into year 2 and will qualify in September 2017.

**Nursing Associate Pilot:** We are part of the "fast follower" national pilot of this new role with 4 of our Healthcare Support Workers commencing the 2 year university programme in April 2017.

**Improving level of Maths and English:** We are committed to supporting our staff to grow and develop their careers in healthcare; working with Harlow College, more than 20 of our employees are at various stages of improving their Maths and English. This is a fundamental stepping stone towards further career progression.

**Work Experience/Ambassador/Schools and College:** As an organisation we recognise the value of work experience as a means of helping young people to make the transition from education into working life and we have a well-established programme which, since its inception 12 years ago, has facilitated more than 2000 work experience placements for young people in the local area. In 2016/17 we facilitated 155 successful work experience placements in the Trust, in both clinical and non-clinical areas, for students aged 14 and over.

We also work with local schools, colleges and other education providers to promote Princess Alexandra Hospital and the wider NHS as an employer and to support them in the delivery of the curriculum. There are currently 9 of our staff who are registered STEM Ambassadors. STEM ambassadors aim to inspire young people to enjoy STEM (Science, Technology, Engineering and Maths) subjects at school and to go on to pursue careers in related areas.

The STEM ambassadors, along with a range of other Trust staff, attended 24 careers events at schools and colleges in the local area. These events were attended by an estimated 2000+ young people and their parents. Future planned events include a careers pathway workshop at the Trust for the local Further Education Institutes and a Scenario Day for 100 students at local secondary schools organised in conjunction with the Britten Partnership and us.

We have also initiated a steering group to bring together all stakeholders to discuss partnership working with the aim of recruiting more local people to nursing degrees at the local Universities and to explore how we, with the Higher Education Institutes (HEIs) can provide curriculum to promote the wide range of careers available in the NHS through a range of different entry routes.

**HEE Quality Performance Review non-medical feedback/student activity:** A multi-professional learner's handbook which is e-mailed to all learners prior to their commencement in placement areas and provides them with concise but detailed information about The Princess Alexandra NHS Trust has been extremely well received. In addition, a standardised ward information booklet template has been designed for nursing and midwifery placement areas to complete, so that each student has an outline of the specific learning opportunities available to them. Students have access to a newsletter to keep them up to date on the extensive educational opportunities available to them within The Princess Alexandra NHS Trust. The bespoke three day Trust Induction programme is detailed by Health Education England as being *"of a high standard".*

To further support students in placement, we have successfully put in place monthly student forums; anecdotal evaluation has been good. Going forward we plan to enhance the monthly event further by including an hours forum and an hours teaching session.

**Health Education England (HEE) three-yearly multi-professional inspection:** This took place at The Princess Alexandra NHS Trust in December 2016. Issues raised at the visits included staffing levels and student supervision on 2 particular wards. A full investigation into the issues raised was undertaken, providing HEE with reassurance. However, HEE requested a return visit to The Trust in February 2017 to meet with students and their mentors on Ray and Harvey wards. The February meetings established that:

***"Overall students were happy with their placement and were getting a good learning experience, although they acknowledged the heavy workload demands on staff and nurse staffing shortage. No students had experienced bullying or harassment and reported a very supportive ward culture on both wards. All students evidenced timely completion of both formative and summative assessments and reflective accounts in their assessment documentation had been signed off by mentors. These were completed to a high standard. All students identified that they spent much more than 40% of time with their mentor – two students reported 100% and the third student 100% wherever possible. This was validated by mentors, ward managers and matron who had put in measures to support this such as the allocation of mentors and co-mentors to all students."***

An outcome of **"Met with Conditions"** was awarded. An action plan has been devised the actions from this aim to provide HEE with assurance that the level of educational support provided to all non-medical learners is of a high standard and is constantly monitored.

**Staff Appraisals**

A new approach to Staff Appraisal launched in October 2016, based on staff feedback and suggestions for ensuring appraisals are meaningful and effective conversations. Since then the following has been achieved

Over 300 staff trained in the new process (including local briefings)

- Appraisal compliance has seen an increase of 12% up to the end of March 2017.
- Feedback received from managers after the training has been extremely positive.
- The individual is sent an appraisal quality monitoring survey within one month of having their appraisal - 77 staff have completed this so far. This data is being shared with senior leadership teams to support them in identifying areas of best practice and areas for improvement.

Feedback from the CQC inspection in June highlighted staff appraisal as an area for improvement. The new and simplified appraisal process has supported the Emergency Department and adult critical care to achieve 100% compliance for both medical and non-medical staff. These two areas, rated inadequate by the CQC in the June 2016 inspection, continue to achieve their appraisal improvement trajectory and have robust processes in place to maintain this performance.

**Staff Engagement**

Staff Engagement work during 2016-17 at PAH has been predominantly led by local departments. Examples of this include;

- Local staff interviews run by the Medicine Health Care Group to identify how staff experience can be improved (followed up with action plans and 'you said, we did' messages)
- EFQM – The Medicine Health Care Group have been using a model which supports collaborative working between staff to create a continuous cycle of improvement which is aligned to the Trusts objectives. As a result of the successes achieved in Medicine there is a plan to adopt this model across the wider organisation.
- Local staff survey action plans (based on the 2015 NHS Staff Survey)
- Local staff celebration event run by the Cancer, Cardiology and Clinical Supports Services (CCCSS) Health Care Group.
- Local Staff Experience Group run by CCCSS

Other initiatives and events led corporately and impacting Trust-wide include:

**The 2016 Staff Awards**

The Princess Alexandra Hospital annual Staff Awards took place on Wednesday 20 July 2016 and were a great success!

There were a total of 14 awards, four of which were **'Living the Values'** awards which were nominated by staff and acknowledged those who uphold and champion the Trust's values: Responsible, Respectful, Committed and Caring.

The Trust also ran an award ceremony to mark the long service and commitment to the hospital of 20 members of staff, all of whom have worked at PAH for over 26 years. This took place on 20 September 2016 at the Water Ball, a charity event to raise funds for drinking water for staff in the hospital.


Also in 2016 the Trust launched a staff recognition scheme called the Daisy Chain. Recipients of the Daisy Chain Badge are those colleagues who go the extra mile for patients or colleagues, so far there have been 47 Daisy Chain winning staff.

Anyone can nominate a colleague as part of the Daisy Chain; nominees will be someone who has demonstrated the Trust's values - through an act of kindness or help to a patient or colleague.

Our annual Celebration of Nursing and Midwifery was held in May 2016 and a Celebration of Achievements event for bands 1-4 staff in September 2016.

A new Staff Development and Engagement Steering Group commenced in October 2016, bringing together key stakeholders to enable a clear strategy and plan of work for 2017-18. So far work has begun on the development of a Staff Engagement Dashboard, a new 'Cultural Barometer' and a new "Engaging our People" workshop for managers. The appointment to a new Head of Staff Engagement in March 2016 will enable progression of this vital work at pace and scale.

# Training and Safety checks

Following our inspection in June 2016, the CQC recommended improvement in mandatory training rates; in particular they referred to hospital life support. Another recommendation advised that we must *"ensure that resuscitation trolleys and difficult airway trolleys are routinely checked, stocked and kept in safe condition for emergency use"*

In September 2016 we appointed a lead resuscitation practitioner and since then we have seen the team grow; there are now 3 full-time members who are visible in the clinical settings supporting staff in the early recognition of deteriorating patients as well as attending cardiac arrests to ensure that staff are confident in applying the learning from training.

**Resuscitation Training**
Following a review and analysis of our staff training needs, we have fully aligned ourselves to Skills for Health recommendations in terms of resuscitation education and the curriculum that we provide. We now offer level 2, 3 and 4 adult and children resuscitation courses.

We have redesigned our curriculum to be focused more on the recognition and prevention of acute physiological deterioration, in line with both the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and National Institute for Health and Care Excellence (NICE) guidance. This has been supplemented with the creation of a bespoke e-learning package to support mandatory resuscitation training.

**Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)**
In direct response to feedback from the CQC and our commissioners of services, we have implemented a brand new DNACPR form, in line with national guidance from the Resuscitation Council (UK). To support the change and to optimise the knowledge and skills or our staff, we have created a bespoke e-learning package. This package explores the DNACPR decision, communication and documentation required, using the new form. The forms will also be quality checked by a senior member of the nursing team to ensure that each one is completed appropriately including the documentation of communications with the patient and appropriate members of their family who have been involved.

**Safety Checks (Resuscitation Trolleys, Drug Fridges and CD checks)**
To support improvements to the checking and maintenance of resuscitation trolleys, we reviewed the content of the trolleys and the process for checking. A complete overhaul of the process has been completed and in January 2017 we implemented new pre-packed and sealed resuscitation trolley trays and revised checking procedures across all areas (65 trolleys). This has driven a significant improvement in the overall safety of resuscitation trolleys and availability of equipment in an emergency.

Prior to the change, there was a protracted checking system for 256 items within the resuscitation trolley. The review identified excessive and unnecessary stock, making the checking process cumbersome and time consuming. The number of items to be checked has been reduced from 256 to 64 and is contained within a one page checklist. An initial audit of the new pre packed trays and the one page simplified checklist shows a marked improvement in overall safety.

All areas continue to monitor compliance with all safety checks. Where an area falls below 100%, safety huddles are undertaken to understand the reasons for variable practice. Sub optimal performance is challenged at the face to face Executive Challenge meetings with every service.

# Research Development and Innovation

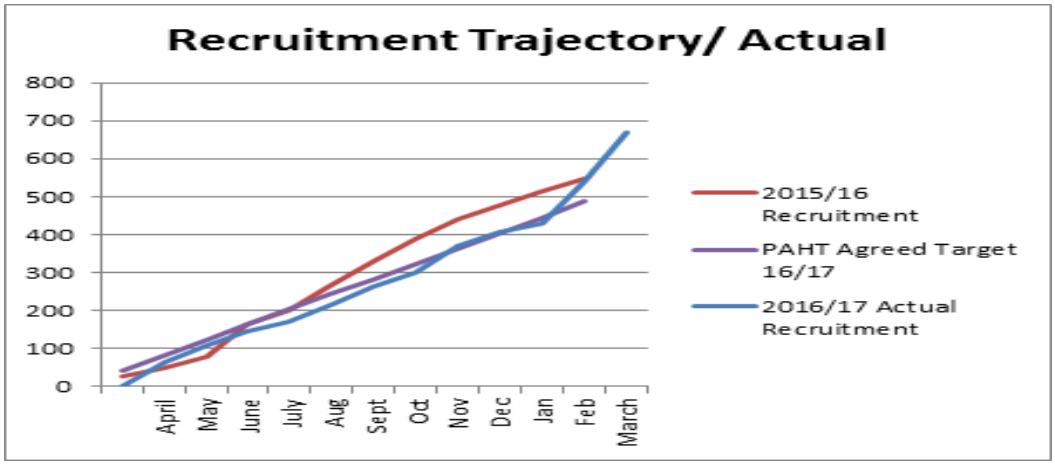
Every year we participate in a wide range of research studies. The studies vary in their purpose and may be academic or commercial in nature. A commercial study is one that is developed by the pharmaceutical/device company, whereas an academic study is developed in a university teaching hospital environment.

The aim of participating is to support the development or evaluation of treatments and interventions provided to patients.

| Active Studies 2016/17 | |
|---|---|
| **Commercial** | **Academic** |
| **14** | **45** |

**Recruitment Target 2016/17**

At the beginning of 2016/17 it was agreed with North Thames Clinical Research Network that The Princess Alexandra Hospital NHS Trust would recruit a target of **487** patients into National Institute for Health Research (NIHR) portfolio adopted trials. The final number of patients recruited into research for this financial year is **671**.




| Recruitment | Speciality | Health Care Group | Commercial/non commercial |
|---|---|---|---|
| **Portfolio Activity** | | | |
| 104 | Cancer | C,C & CSS | Non – Commercial |
| 3 | Cardiology | C,C & CSS | Non – Commercial |
| 15 | Dermatology | Medical | Non – Commercial |
| 5 | Diabetes | Medical | Non – Commercial |
| 27 | Emergency | Medical | Non – Commercial |
| 15 | Ophthalmology | Medical | Non – Commercial |
| 165 | Respiratory | Medical | Non – Commercial |
| 35 | Rheumatology | Medical | Non – Commercial |
| 143 | Surgical | Surgery | Non – Commercial |
| 9 | Gastroenterology | Medical | Non – Commercial |
| 57 | Staff Survey | Medical | Non – Commercial |
| 1 | Maternity | F & WS | Non – Commercial |
| 22 | Sexual Health | F & WS | Non – Commercial |
| 5 | Cancer | C,C & CSS | Commercial |
| 20 | Surgery | Surgery | Commercial |
| 15 | Diabetes | Medical | Commercial |
| 18 | Rheumatology | Medical | Commercial |
| 11 | Ophthalmology | Medical | Commercial |
| 1 | Dermatology | Medical | Commercial |

**Good News Stories**

- Women's Health became active in Research with two studies opening – one involving patents presenting with ectopic pregnancies, and one to prevent pre-term birth.
- Hollie Robinson-Perry joined the team as a Research Midwife. This is a shared role with Mid Essex Hospitals NHS Trust.
- The Emergency Department became active in Research with two Studies opening, both involving the use of Penthrox, a new pain relief drug.
- Carol Muir joined the team in April, 2017 as a Research Nurse. Carol has previously worked in the Early Pregnancy Unit.
- Positive Voices is a national survey of people living with HIV and is a formal research study led by Dr Gail Crowe as the Principal Investigator. The March, 2017 newsletter, recently received, headlined that The Princess Alexandra Hospital NHS Trust is the highest recruiting site having recruited 25 patients; more than twice the minimum target.

- Two commercial studies are now open in Cardiology where previously studies have been academic.

- Successful International Clinical Trials Day on 21st May 2016, where stands and presentations were;
    1. First Clinical Trial/GCP/Research Governance/Approval process
    2. Research Nurse Stand – with demonstrations of equipment used in various studies across all specialties from around the Trust
    3. Quintiles/Anglia Ruskin University Clinical Trials Unit
    4. North Thames Clinical Research Network
    5. Recruitment data and successes of trials at PAHT

- The Trust met the qualifying criteria to receive Research Capability Funding of £20,000. This has been awarded due to the Trust achieving the national high level objectives for clinical trials and is allocated to research active organisations to enable them to maintain research capacity and capability.

- Confirmation from the NIHR that all contracts can be renewed for the next financial year. The Trust are working with the North Thames Network to make all posts substantive later in this financial year.

- Finance for NHS Innovations: The Medtech Accelerator has been set up to facilitate the early stage development of medical technology and software innovations from within the NHS. It will support and finance projects through early stage proof of principle to maximise the chances of success further down the development pipeline. The next application deadline is Friday 12th May, 2017 for the Medtech Accelerator Awards Committee who meet on a quarterly basis to review all applications. Shortlisted applicants will have the opportunity to pitch to the Awards Committee on Friday 16th June at Milton Hall, Cambridge. Awards of between £15K and £125K are available to all HEE Member Trusts in the East of England, with a total of £1.5 million on offer for innovations that show the potential to create new company opportunities. Two projects are currently being worked into bids for this funding stream.

- Lister Ward achieved the Quality Mark for Elder-Friendly Hospital Wards which demonstrated the commitment by Lister Ward Team and Medicine Health Care Group to achieve a consistent quality of care delivery to older people. This success is being followed by Locke, Henry Moore and Ray Wards who are also participating in this programme in the final phase of this programme.

**Lister Ward manager Caroline Ashton**


**R&D Approvals (Masters/Doctorate)**

In 2016 members of staff have also sought and successfully attained approval to undertake research studies as part of their academic professional development.

| Study Name | Brief Description | Commercial or Academic |
|---|---|---|
| Patients accounts of pressure ulcer prevention following fractured NOF | Dawn Royall - CNS - Doctorate | Non- Portfolio Non-Commercial |
| What factors contribute to the delay in discharge of end of life patients in hospital who wish to die in their own homes? | Christian Nweke - OT- Masters | Non- Portfolio Non-Commercial |
| Does a never event for a retained instrument foster learning in band 5 theatre | Maxine Priest - Matron - Masters | Non- Portfolio Non-Commercial |

## Incident management, sharing the learning and safety improvement

At The Princess Alexandra Hospital NHS Trust, 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.

For the reporting period 1 April 2016 and 31 March 2017 we planned and delivered **5** *Sharing the Learning* events. We continued to develop the knowledge and skills of our Staff; providing **80** places for *Being open*/Duty of Candour Training and **40** places for Root Cause Analysis (RCA) investigation training. In addition, the Trust has strengthened Risk Management arrangements and has begun to strengthen our Mortality review process.

**Incident Management**

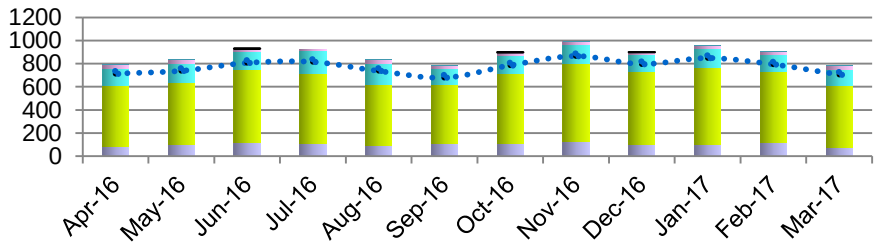
In 2016/17 a total of **9287** incidents were reported on the Trust's Datix incident management system as having occurred in PAH. This a slight decrease in incident reporting compared with 9360 in 2015/16.

The majority of incidents reported were assessed as causing no harm **(7044)** representing **75.8%** of the total incidents for this period. Approximately **96.4%** of reported incidents during this period were a combination of resulting in no harm **(7044)** or minor harm **(1913).** The severe harm incidents comprise 0.2% of reported incidents whilst the combined severe harm and death incidents equate to 0.25%.

All of the incidents are reported to the National Reporting and Learning System (NRLS); enabling comparison with similar sized organisations as well as opportunities to learn from others.

We actively encourage staff to report incidents without fear of reprisal or repercussions. Our aim is to increase the overall level of reporting as this helps us to identify where things are not working as they should. It provides us with the opportunity to investigate incidents to find root causes so that learning and improvements can take place thereby decreasing the severity of reported incidents.

**Figure - Monthly Reported Incidents By Severity – 1 April 2016 – 31st March 2017**




| | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Death ** | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 |
| Severe Harm ** | 2 | 1 | 1 | 0 | 1 | 1 | 0 | 4 | 1 | 2 | 6 | 1 |
| Moderate Harm | 32 | 34 | 23 | 12 | 28 | 28 | 24 | 23 | 17 | 23 | 27 | 35 |
| Minor Harm | 149 | 167 | 158 | 193 | 189 | 139 | 157 | 169 | 150 | 165 | 143 | 134 |
| No Harm (inc near miss) | 531 | 536 | 624 | 610 | 519 | 511 | 604 | 670 | 628 | 659 | 618 | 535 |
| Near Miss | 82 | 102 | 123 | 107 | 97 | 108 | 112 | 130 | 102 | 105 | 117 | 78 |
| Total number of reported incidents | 714 | 738 | 807 | 815 | 737 | 679 | 786 | 866 | 797 | 849 | 794 | 705 |

**** These incidents are subject to change following review**

## Serious Incident Themes and Trends

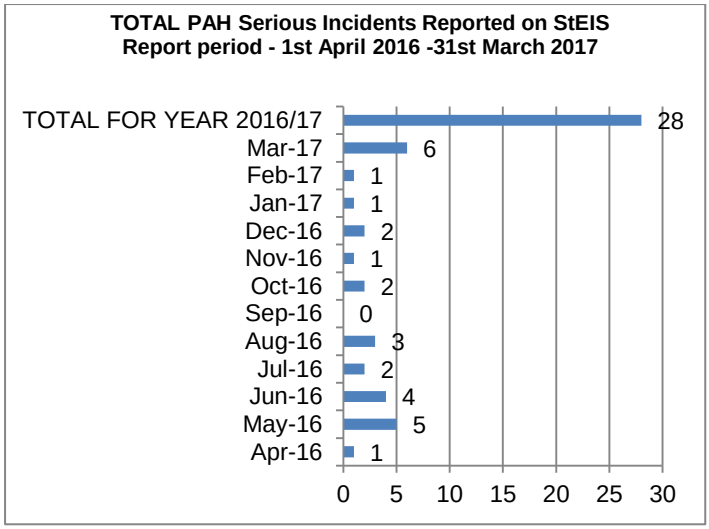
There have been **28** PAH serious incidents (SIs) for the reporting period 1 April 2016 to 31 March 2017. This figure has been drawn from the external Strategic Executive Information System (StEIS).This excludes SIs that have been de-escalated as either there were no care or service delivery problems identified or they did not meet the SI threshold when scrutinised for further information.

This is a reduction in numbers compared with **61** SIs in 2015/2016. It is important to note that national reporting requirements and SI categories changed in March 2015 and the changes were implemented locally in May 2015. The changes eliminated the use of a pre-determined list of incidents that must be reported. The SI framework encourages discussion and review of incidents on a case by case basis leading to decisions on the level or degree of harm caused.

The process used by the Trust to ensure open and honest review and discussion takes place is known as the Serious Incident Group (SIG). The group is chaired by either the Chief Medical Officer or Chief Nurse and time is scheduled Monday to Friday to ensure that there is no delay. All potential SI's are presented and discussed to identify whether they meet the national SI framework requirements.

The most frequently reported SIs during this reporting period are in the category 'Treatment delay meeting SI criteria'. These incidents will be subjected to a thematic review once all investigations are completed.

**Figure – SI's by Month reported – Reporting period 1 April 2016 31 March 2017** (search date 8 May 2017):




## Never Events

There were no never events in 2016-17. The table below shows the number of never events reported in the last five years.

**Never Event data from 2012/13 to 2016/17**

| Year | Total nos | Type |
|---|---|---|
| 2012/13 | 1 | Retained Foreign Object |
| 2013/14 | 2 | Retained Foreign object |
| 2014/15 | 2 | Retained Foreign Object |
| 2015/16 | 2 | Wrong site surgery and Use of Wrong Implant |
| 2016/17 | 0 | |

**Sharing the Learning (STL) Events**
The Trust's central Patient Safety and Quality Team, working with relevant experts have organised and facilitated five events during 2016-2017.

1. April 2016: A *Focus on the Trust's three* ***Sign up to Safety*** *(SUS) priorities* – Improvements in Acute Kidney Injury, Sepsis and End of Life (EOL). These are known as the Three Big Dot items and are endorsed by the Trust Board with each priority being led by a senior doctor. A summary of progress on these items is shared elsewhere in part of this report.
   The Trust committed to the ***Sign up to Safety*** national campaign in December 2014. The output from the work undertaken so far has been shared with staff to raise awareness.

2. June 2016: ***Sign up to Safety*** celebrated its second birthday. We celebrated with information stands, balloons, badges, goody bags, games and a competition held outside the restaurant on Friday lunchtime facilitated by the central Governance and Quality team (PSQ). The central team were on hand to remind staff about the national campaign, its vision, and the Trust's priorities for improvement (Acute Kidney Injury, End of Life and Sepsis).
   Our staff were encouraged to sign up to support the campaign, the Trusts priorities for improvement and to make their own personal safety pledge(s). 86 staff members Signed up to Safety during the lunch event, bringing the total number of staff signed up to 324. As we move forward with our Quality Improvement strategy, the Big Dot items will be fully embedded in work streams.

3. July 2016: ***Focus on Learning from Claims and Litigation.*** The Trust was very fortunate to welcome our Panel Solicitor firms of Kennedys and BLM and also the NHS Litigation Authority (NHSLA) to participate in the week-long event.

   There was a formal launch on Monday 4 July 2016 in the Trust Board Room with an excellent presentation from Kennedys on the Inquest process which was very informative, interesting and helpful. Information boards from the central Governance and Quality team (PSQ) and the legal annual report was available for perusal throughout the day.

   There was a session on Public and Employee Liability in the morning of Wednesday 6 July 2016 delivered by Kennedys and followed by the Trust view on Reporting on Injuries, Diseases and Dangerous Occurrences Regulation (RIDDOR) incidents delivered by the Trusts Health and Safety Officer.

   The Wednesday afternoon session focused on a mock Inquest with actors facilitated by BLM our other panel solicitors. A scenario was acted out in front of the Coroner (BLM Partner) on how not to attend and give evidence at an Inquest followed by a more appropriate presentation of how witnesses should give evidence. It was interesting to have the different newspaper reports on the conclusion from the Coroner depending on how the witnesses gave evidence.

   The last day of the Sharing The Learning week was divided into two sessions with morning session dedicated to the Trust Board. The Trust was very fortunate to welcome the Director of Safety and Learning from the NHSLA, Denise Chaffer, who provided a presentation on how the Trust can learn from its claims and how to improve safety for our patients. BLM also delivered a session on claims as well as facilitated a claims quiz.

4. October 2016: ***Focus on National Standards Safety for Interventional Procedures (NatSSIPS).*** The central PSQ team invited Dr Annie Hunningher, Consultant Anaesthetist and NatSSIPs lead for the Royal Free Hospital NHS Trust, who have successfully launched and is implementing the NatSSIPS programme, to deliver a talk on how this was achieved including the challenges.

Human Factors experts, *Attrainability* were also on hand to deliver a very compelling and engaging human factors perspective on the topic. The key message is that clinical engagement is central to success and implementation and embedding has to be driven by clinicians themselves. The Trust has scoped its procedures and implementation will be part of the Trusts Quality First Improvement programme.

5. November 2016: ***Focus on Duty of Candour***, the last STL for the year was held at the Trust's Multidisciplinary Team meeting (MDT). The central team, working closely with our Panel solicitors Kennedys, designed the day around a case presentation that had been to the coroner's court and the Trust was highly commended for its openness and candour. The team also delivered a talk, reminding Trust staff of the principles and requirements for Duty of Candour, shared the Duty of Candour checklist which acts a prompt to help clinicians through the process and were also advised on the legal requirements of *Being open.* This was a very well attended session by clinicians.

   The central PSQ Team have recently launched a working group to audit compliance with the requirements of Duty of Candour, with a view to strengthening the process and required documentation.

   Duty of Candour has remained a consistent feature in the Trusts STL activities. Posters designed and printed by the central PSQ Team can be seen placed in different areas across the Trust, reinforcing the Trust's commitment to transparency and candour.

**Being Open and Root Cause Analysis (RCA) Investigation Skills Training**

The Trust has continued to invest in Root Cause Analysis (RCA) investigation training, ensuring that staff are supported in having *Being open/ Duty of Candour* conversations with patients and families when things go wrong.

*Being open/ Duty of Candour* training: In 2016/17 The Trust held four sessions (80 places) in December 2016 and March 2017.

*Root Cause Analysis (RCA)* training: Two sessions providing 40 places for staff took place in December 2016 and February 2017 and a further session is planned for May 2017.

**Risk Management Improvement**

Feedback from the 2016 CQC inspection identified a perceived disconnect between the management of risk at ward and Board level. As a direct response to the feedback in the report, the Trust introduced a new Risk Management Group (RMG). Chaired by the Chief Medical Officer, the inaugural meeting took place on 16 December 2016 and now meets monthly every month.
Achievements so far include:

- Revision and update of the Trust Risk Management Strategy (including policy & procedure); ratified by the Trust Board in January 2017.
- Implementation of RiskAssure, the new Risk Management electronic information system for Risk Registers. Data migration was completed by 31 March 2017. All migrated data is now being reviewed by Risk Register owners. All new risks are being recorded directly onto RiskAssure.
- Approval and launch of a work plan for the review of risks and risk registers has been introduced through the Risk Management Group with good challenge and engagement in the process.

The Trust plans to conduct a survey to assess staff knowledge of the risk management process during the 2017/18 year.

**Mortality Reviews**
In December 2016, the CQC published a report titled "Learning, candour and accountability". This was a review of the way NHS Trusts review and investigate deaths. In response to this the Trust is developing a framework to ensure there is robust review, escalation, reporting and learning from all deaths and that families and carers are integral to that process.

The Trust has introduced a Mortality Surveillance Group and Mortality data will be reported to the Trust Board from July 2017. To support this process, a Mortality dashboard with evidence of detailed analysis of a minimum of 25% of all deaths, including all Learning Disability patient deaths, any death that has raised a concern and any patient who died with a DOLs in place will be shared with the Trust Board. Learning will also be disseminated across the Trust. An annual summary of the review and findings will be reported through the Trust's Governance processes and published in the June 2018 Quality Accounts.

**Clinical Effectiveness:**
The Trust is required to participate in National audits to ensure that we are taking every opportunity to learn and improve. In 2016/2017 we participated in 92% of all national clinical audits (37) to which we were eligible. We also participated in 6 (75%) national confidential enquiries. These are listed in Tables 1, 2 and Table 3 below

**Table 1 National Clinical Audits and Clinical Outcome Review programmes which the Trust participated in.**

| Name | Participation | % Cases submitted |
|---|---|---|
| Acute Coronary syndrome or Acute Myocardial Infarctions (MINAP) | Yes | 100% |
| Adult Asthma | Yes | 100% |
| Adult Cardiac Surgery | Not applicable to PAHT | |
| Asthma (paediatric and adult) care in emergency departments | Yes | 100% |
| Bowel Cancer (NBOCAP) | Yes | 79% |
| Cardiac Rhythm Management (CRM) | Yes | 100% |
| Case Mix Programme (CMP) | Yes | 100% |
| Child Health Clinical Outcome Review Programme | Yes | 100% |
| Chronic Kidney Disease in Primary care | Not applicable to PAHT | |
| Congenital Heart Disease (CHD) | Not applicable to PAHT | |
| Coronary Angioplasty / NATIONAL Audit of Percutaneous Coronary Interventions (PCI) | Not applicable to PAHT | |
| Diabetes (Paediatric) (NPDA) | Yes | Data collection period not elapsed |
| Elective Surgery (National PROMs Programme) | Yes | Full year data not available until August 2017 |
| Endocrine and Thyroid National Audit | No | |
| Falls and Fragility Fractures Audit programme (FFAP) | Yes | Falls – 100%<br>National Hip Fracture – Full year data not yet available |
| Head and Neck Cancer Audit | Not applicable to PAHT | |
| Inflammatory Bowel Disease (IBD) programme | No | |
| Learning Disability Mortality Review Programme | No data collection 2016/17 | |
| Major Trauma Audit | Yes | Data completion period not elapsed |
| Maternal, Newborn and Infant Clinical Outcome Review Programme | Yes | 100% 2016<br>Data completion period for 2017 not elapsed |
| Medical & Surgical Clinical Outcome Review Programme | Yes | 80% |
| Mental Health Clinical Outcome Review Programme | Yes | 100% |
| National Audit of Dementia | Yes | 100% |

| | | |
|---|---|---|
| National Audit of Pulmonary Hypertension | Not applicable to PAHT | |
| National Cardiac Arrest Audit (NCAA) | Yes | 100% |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit programme | Not applicable to PAHT | |
| National Comparative Audit of Blood Transfusion | Yes | 100% |
| National Diabetes Audit – Adults | Yes | 66% |
| National Emergency Laparotomy Audit (NELA) | Yes | 72% |
| National Heart Failure Audit | Yes | Minimum 100 achieved. Data completion period not elapsed |
| National Joint registry (NJR) | Yes | 100% |
| National Lung Cancer Audit (NLCA) | Yes | 100% |
| National Neurosurgery Audit Programme | Not applicable to PAHT | |
| National Ophthalmology Audit | Yes | Data completion period not elapsed |
| National Prostate Cancer Audit | Yes | Data completion period not elapsed |
| National Vascular Registry | Yes | Data completion period not elapsed |
| Neonatal Intensive and Special Care (NNAP) | Yes | 100% |
| Nephrectomy audit | Yes | 96% |
| Oesophago-gastric Cancer (NAOGC) | Yes | Data completion period not elapsed |
| Paediatric Pneumonia | Yes | Data completion period not elapsed |
| Percutaneous Nephrolithotomy (PCNL) | Yes | 66%<br>(2 out of 3) |
| Prescribing Observatory for Mental Health (PHMH-UK) | Not applicable to PAHT | |
| Radical Prostatectomy Audit | Not applicable to PAHT | |
| Renal Replacement therapy (Renal Registry) | Not applicable to PAHT | |
| Rheumatoid and Early Inflammatory Arthritis | Data not collected 2016/17 | |
| Sentinel Stroke National Audit programme (SSNAP) | Not applicable to PAHT | |
| Serious Hazards of Transfusion | Yes | 100% |
| Severe Sepsis and Septic Shock – care in emergency departments | Yes | 100% |
| Smoking Cessation Audit | Yes | n/a |
| Specialist rehabilitation for patients with complex needs | Data not collected 2016/17 | |
| Stress Urinary Incontinence Audit | Yes | 20% (1 out of 5) |
| UK Cystic Fibrosis Registry | Not applicable to PAHT | |

**Table 2 Summary of NCEPOD studies that the Trust was eligible to enter data into**

| NCEPOD Study Title | Participation | % Cases Submitted |
|---|---|---|
| Mental Health | Yes | 100% |
| Acute Pancreatitis | Yes | 0 |
| Chronic Neuro disability | Yes | 100% |
| Young People's Mental Health | Yes | 100% |
| Cancer in Children, Teens and Young Adults | No cases at PAH | |

The reports of a number of national clinical audits were reviewed by PAH during 2016/17. Some of the actions taken to improve the quality of healthcare provided in response to the audits can be found in Table 3 below.

**Table 3 Examples of actions taken following review of national clinical audit reports**

| Name of national audit | Actions completed |
|---|---|
| Adult Asthma | Two respiratory nurses have been employed and a specialty doctor has been appointed to review all respiratory patients including COPD/Asthma in Emergency Assessment Unit (EAU). |
| National COPD Audit Programme | Two respiratory nurses have been employed and a specialty doctor has been appointed to review all respiratory patients including COPD/Asthma in EAU. |

| | |
|---|---|
| National Diabetes Audit - Adults | To improve recording of care processes, in particular ensuring that all patients have urine microalbumin level recorded, further training in diabetes outpatient clinics has been delivered. A new electronic medical record form has been introduced which auto-calculates BMI for ease of recording. |
| Elective Surgery (National PROMs Programme) | The Trust has reviewed its Enhanced Recovery Programme, standardising the anaesthetic techniques and analgesia regimes, and introduced physiotherapy follow-up classes to take ownership of patients' rehabilitation post hip replacement. |
| Falls and Fragility Fractures Audit Programme (FFFAP) | A dedicated escalation bed has been assigned. |
| Procedural sedation in the emergency department (ED) | A new procedural sedation proforma for adults in ED has been locally produced and introduced. |

The reports of 27 local clinical audits were reviewed by PAHT during 2016/17. Examples of action planned / taken to improve the quality of healthcare provided in response to the audits are in Table 4 below. The reports were scrutinised, to understand the actions taken or planned as a result of the audit outcomes.

**Examples of actions taken following review of national clinical audit reports**

| Name of national audit | Actions completed |
|---|---|
| Adult Asthma | Two respiratory nurses have been employed and a specialty doctor has been appointed to review all respiratory patients including COPD/Asthma in Emergency Assessment Unit (EAU). |
| National COPD Audit Programme | Two respiratory nurses have been employed and a specialty doctor has been appointed to review all respiratory patients including COPD/Asthma in EAU. |
| National Diabetes Audit - Adults | To improve recording of care processes, in particular ensuring that all patients have urine microalbumin level recorded, further training in diabetes outpatient clinics has been delivered. A new electronic medical record form has been introduced which auto-calculates BMI for ease of recording. |
| Elective Surgery (National PROMs Programme) | The Trust has reviewed its Enhanced Recovery Programme, standardising the anaesthetic techniques and analgesia regimes, and introduced physiotherapy follow-up classes to take ownership of patients' rehabilitation post hip replacement. |
| Falls and Fragility Fractures Audit Programme (FFFAP) | A dedicated escalation bed has been assigned. |
| Procedural sedation in the emergency department (ED) | A new procedural sedation proforma for adults in ED has been locally produced and introduced. |

The Trust introduced software (Allocate NICEAssure) in 2016 to further strengthen the recording and monitoring of activity against National Institute for health and Care Excellence (NICE) and Quality Standards as part of an on-going programme of review.

**Next Steps across Governance**

As a direct response to the feedback received from the CQC inspection in June 2016, The Trust has commissioned a review of our current Governance arrangements. The review will be undertaken by a buddy Trust and Terms of Reference have been agreed. Once completed, the Trust will respond as appropriate to the review report.

## Information and Technology achievements

**Deployment of Electronic Observations**

In 2016-17 the Trust began its deployment of a clinical information technology application to support the early detection of the deteriorating patient. The Trust has worked with Nervecentre; a Software Company with a track record of successfully delivering this type of technology to a number of Acute NHS Trusts. The funding of this was achieved following a successful bid to NHS England for Nurse Technology monies with the Trust receiving the maximum award of £1m.

The objective was to move away from paper documentation of the patient's vital signs to an electronic system that allows clinicians to enter the patient observations at the bed side using a mobile device. The system then undertakes a series of calculations that alerts the user to the patient's overall wellbeing. The system then alerts the clinical teams that the patient may be at risk of deterioration; electronically notifying them that support and actions are required, this allows the treating team to respond more readily to the needs of the patient when they are not in attendance at ward level.

In addition, the nursing teams receive a notification of when the next set of observations is due through a message alert to their mobile device. This ensures that observations are taken at the correct time and reduces risk to patient safety due to delays in taking patient vital signs.

**Healthcare Support worker – Kingsmoor Ward**
*"It's great that I can be alerted when observations are due, also the fact that I have to get a qualified nurse to sign off high observations scores means I know that they are aware of the patient's condition immediately*"

All of the observations are accessible away from the patient bedside and clinicians can also see the full history and trend of the patient's vital signs. This assists in the auditing of patient care and supports the completion of timely investigations due to easier access to patient records.

The deployment began with 3 adult wards in June 2016 and completes with the final wards in maternity going live in April 2017. This will mean that all acute in-patient wards will have access to the system and all patients in these wards will be having their clinical observations entered into the system.

**Registered nurse - Harold Ward:**
*"Now I can see every patient's observation and NEWS score even before I to go to their bedside. I can also see which patient's need to have their observations done so that I can allocate staff to undertake them"*

**Introducing an electronic handover system**

In 2017 the Trust plans to introduce an electronic Doctor and Nurse Handover process using the same system. This will allow clinical teams to have live and up to date access to the most recent handover information and allows this information to be shared more readily to the whole clinical team. The plan is for this to commence in early July 2017 with a Trust wide deployment to all in-patient clinical areas completed by the end of September 2017.

The handover tool will also support whiteboard information sharing to all clinical teams and help reduce delays in patients receiving treatment thereby supporting their journey to an effective and timely discharge from hospital.

**My Care Record Clinical Portal**

In October 2016 the Emergency Department (ED) started to use the My Care Record Clinical Portal. Whilst Doctors are using the electronic patient record (COSMIC) in the ED, they can now access the patient's record that is stored in their GP practice system, with their explicit consent. Initially access was constrained to GP practices in West Essex CCG but we have been working to extend access with GP Practices in East & North Hertfordshire CCG. In early March 2017 East and North Hertfordshire GP practices began to appear in the portal.

The portal enables our clinicians to check a patient's medication history and to view any alerts in respect of known allergies. This saves clinical time and also increases patient safety and improves their experience whilst in the ED. A monthly audit is undertaken by a clinician to ensure that access is appropriate.

**Chemotherapy Prescribing and Medicines Management systems**

During 2016/17 we configured and tested our Chemotherapy Prescribing and Medicines Management systems ahead of their deployment across the Trust in 2017/18.

**Laboratory Information System (LIMS)**

We have been testing our upgraded Laboratory Information System (LIMS) and training staff in preparation for planned go live in April 2017.

With so many clinical electronic information systems coming on stream, we have invested in a single sign-on solution to support our clinicians. This enables a user to sign onto a workstation once and be presented with access to all the systems that they need to use to

save them time. With this in mind we have also invested in improving our wireless network to ensure that it is widely available across the hospital site to support the use of mobile technology i.e. new drugs trolleys to support electronic prescribing, Apple devices to support electronic observations and also employee bring your own devices to access email and calendars on the go.

## Recruitment and Retention

**Medical staff:** We have made a number of changes within the Medical Recruitment team over the past 12 months; with an emphasis on recruiting Consultants, 12 additional Consultants have been recruited.

## Nursing and Midwifery recruitment and retention

A recognised national shortage of registered nurses makes recruitment to nursing vacancies an on-going challenge. A wide range of recruitment initiatives have been undertaken across the last 12 months including international, national and local campaigns. At the end of the 2016/17 year the Trust had 32 more registered nurses in post than the same time last year. Particular areas of success have been in the operating theatres and also in maternity. The midwife vacancy rate has consistently fallen, meaning that we are now achieving a midwife to birth ratio of 1:30 and have single figure vacancies.

We have established a Recruitment and Retention Group, chaired by the Chief Nurse. One of the areas identified related to staff leaving the Trust within the first 12 months of employment. Our recruitment team now make contact with new starters 2, 5 and 9 months into their employment to check in and see how they are progressing

There has been progress on reducing the staff turnover percentage for nursing and midwifery from 21% in 2015 to 19% in 2017. Undoubtedly the turnover reflects the relentless challenge of working in a busy hospital striving to deliver safe and effective care to patients. This can become overwhelming and for some staff who become fatigued with the challenges that we face, an alternative employer is often the only solution that they can see.

In our continued pursuit of a reduction in staff turnover, we have been working hard to create a number of opportunities within the Trust and across the local health economy to encourage staff to continue their employment with us:

**Preceptorship:** we have a well-established development programme for band 5 registered nurses, the feedback is excellent. Listening to our staff and their requests for further professional development to support career progression, we have extended the programme from 6 months to 12 months. During the second half of the programme individuals will be able to access a range of development opportunities to meet their individual needs and all candidates are allocated a long arm mentor senior nurse/midwife, who they meet with at least 3 times per year.

**Secondment:** We initially piloted this development opportunity within our Tissue viability Service as a 4 month secondment opportunity. The role has been so successful that we are continuing with it and have just appointed the next secondee. We will now be extending the secondment opportunity to Safeguarding Children's services and Infection Prevention and Control. Early indications point to enhanced skills that can be applied back in the substantive role, as well as strengthening self-confidence and clinical leadership which will support career progression. Additionally this opportunity for registered practitioners to work in a specialist field may support succession planning as they may identify a wish to pursue further career development within the chosen speciality.

**Champion roles:** We have created a range of speciality specific champion roles to make available additional expertise in our wards. Roles include Agents for Nutrition and Tissue Viability (ANT), Dementia Champions, Learning Disability and autism champions, Falls prevention champions and End of Life champions.

**Supplementary ways of working**

Over the last year, to support our wards whilst we recruit to the outstanding registered nurse vacancies, we have implemented a range of additional roles to strengthen the team. This gives registered practitioners more time to deliver patient care at the bedside. Roles that have been introduced support the completion of a range of clerical duties previously

competed by the ward nursing team. There are also individuals focusing on the planning the safe discharge from hospital for our patients.

All necessary training is provided to ensure that the individuals have the skills that they require and importantly, the registered nurse remains accountable for identifying the delegated tasks to the right people.

# Planned Care Standards

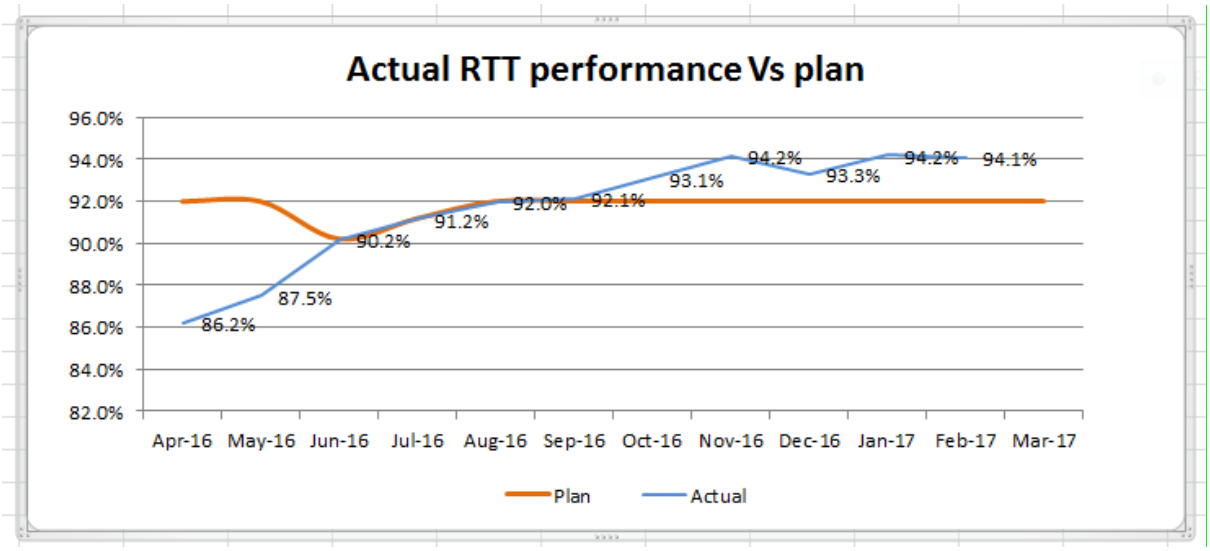
Nationally, The Princess Alexandra Hospital NHS Trust is one of very few organisations delivering consistently on all planned care constitutional standards (RTT, Cancer and Diagnostics); this is an outstanding achievement.

**Referral to Treatment (RTT)**

Performance against this standard has improved steadily since Jan 2016, seeing the Trust's performance increase from 85.1% (Jan 2016) to 94.2% (Jan 2017), with 1,286 fewer patients waiting over 18 weeks.

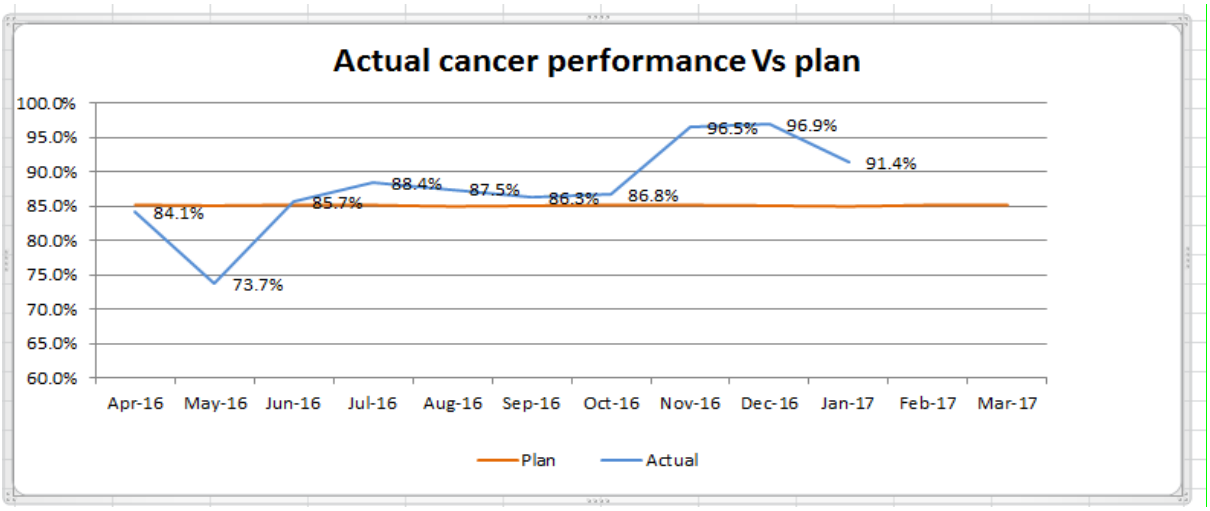
At the end of January 2017, the national RTT performance was at 89.9%, with a median waiting time of 7.2 weeks. PAH achieved 94.2% for RTT with a median wait time of 6 weeks.

This dramatic improvement means that PAH is the organisation with the greatest level of improvement across the whole of England, which has been recognised by both the Secretary for State and our local commissioners.

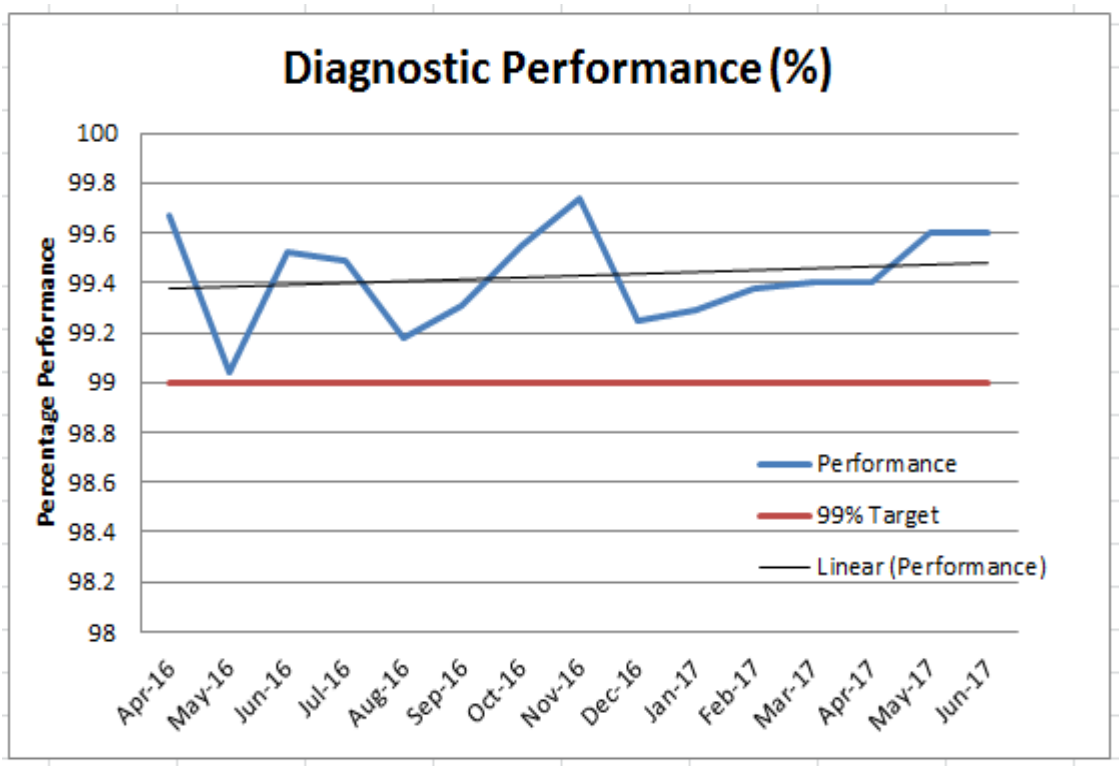



**Cancer**

Performance against the Cancer 62 day standard has been achieved consistently since June 2016, which means that we are amongst the top 20% of all Trusts.



**Diagnostics**
The Trust delivered 99.38% against the standard of 99% in February 2017.
Performance remains consistent with progress across all areas of diagnostics.




## Emergency Care standards

The Trust has been working hard to mitigate the increased pressures on our Emergency services, particularly over the past winter. Our own situation is a reflection of the national picture which has seen emergency admissions increase by 47% in the last 15 years. In the past year we have seen 1001152 Emergency Departemtn (ED) attendances.

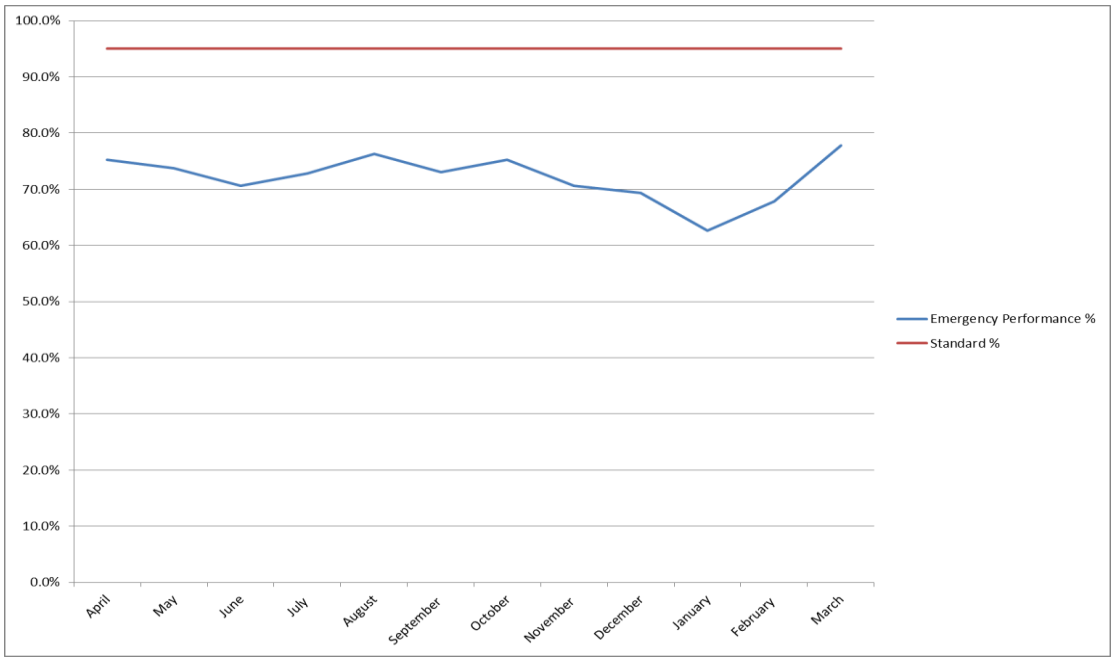
The National Emergency Access Target (NEAT) requires the ED to treat, admit or discharge 95% of attending patients within four hours. The Trusts performance fell below this standard, and also our agreed recovery trajectory in 2016/17.

The key reasons are best understood when separated into external pressures and internal pressures:

**External pressures**
- Primary care services in the local area have struggled to deal with the increase in demand and ambulance conveyances have increased.
- Out-of-area ambulance conveyances (where we are not considered to be the nearest hospital) have increased. 15% of the Trusts adult ED attendances are over the age of 75. This patient group have a higher rate of admission due to their complex care needs and exacerbation of longer term medical conditions.
- Delays in transferring patients for care outside the hospital remained above the 3.5% threshold.

**Internal pressures**
- Overcrowding in the A&E department.
- Physical capacity in terms of the Emergency Department and wider Hospital.

- Mismatch of ED demand and capacity specifically relating to patients brought in by ambulance which result in delayed handovers.
- Increase in patient clinical acuity as demonstrated through recent audits completed at PAH.
- Delays in patient discharges.
- Increased patient admissions to hospital.
- Continued use of escalation capacity to maintain patient safety.
- Staffing levels affecting ability to open extra areas when demand is very high.




In response to the recommendations from the CQC inspection (June 2016) The ED team have introduced an ambulance assessment checklist for staff to demonstrate that patients in the ambulance queue have been assessed and are being monitored regularly. The compliance with the checklist is continually audited.

In addition, the team now hold daily standardised communication huddles which include a review of safety check and staffing allocation.

To support staff development, all non-medical ED staff have been aligned to one of six mentor groups from January 2017. Each mentor group has one allocated administrative day every six months to complete appraisals, training & mortality meetings.

Bespoke recruitment for ED Nurses & Doctors was initiated in 2016/17; to date 8 middle grade doctors have been recruited. The department have put together a Nurse Orientation pack to provide information regarding the department, expectations and procedures to all nurses , there are plans to extend this to all non-nursing staff.

Another area of concern raised by the CQC was the allocation of nurses to the resuscitation area in the department. In response, we have implemented an escalation Standard Operation Procedure (SOP) for a second nurse in resus. This is monitored where this has not been achieved; there is a robust process in place to move staff across the department to ensure the presence of two Registered nurses in resus. Staff are aware of how to escalate concerns to the shift leader/senior clinician.

Thrice daily safety huddles continues, ensuring a pro-active review of staffing levels to ensure patient care is delivered based on clinical acuity.

**Safer Bundle and Red to Green**

The Trust launched the SAFER bundle including the Red 2 Green element to all wards during 2016/17. The SAFER bundle is aimed at ensuring our patients receive timely senior clinical review so that all treatment and interventions can be planned in a way that ensures the person spends only the absolutely necessary time in hospital.

A green day is when a patient receives an intervention that supports their pathway of care through to discharge from hospital.

A red day is when a patient is waiting for an action to progress their care.

Red 2 Green is described as a social movement and visual management system to assist in the identification of wasted time in the patient's journey through hospital to discharge.

Picture – the daily board round on Ray Ward

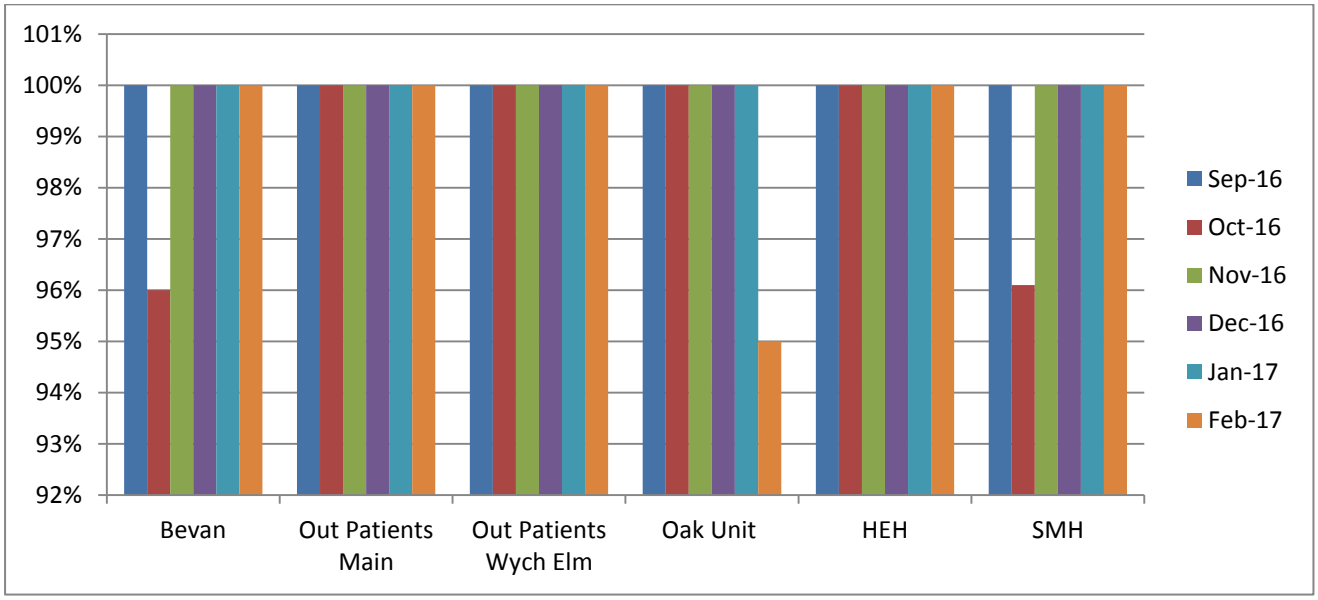
During 2016/17 we launched a new integrated discharge team. The team combines hospital, community, mental health, social services staff from Essex and Hertfordshire localities; working together to improve the discharge process for our patients. The integrated hospital discharge team is part of the SAFER and Red 2 Green initiatives.

# Outpatient Services

Following a 2015 'Requires Improvement' rating; our Outpatient services received an overall rating of 'Good' from the CQC in the 2016 inspection and are aiming for 'Outstanding'. A range of initiatives has been put in place to enable this to be possible; the previous year rating was "requires improvement".

**Collaborative working** –The nursing and reception staff meet each morning in each of the outpatient departments. The senior nurse on duty provides an update for staff; alerting them to any complaints or incidents and sharing any learning from these. The meeting ensures that all staff on duty are aware of who the senior person is for escalation purposes and who the nominated first aider is for the day. Further to this, there is a monthly meeting with representatives from medical records, appointments staff, the outpatients nursing team and representatives from the Patient panel, working together to improve the service that is being delivered.

**Quality improvements** – Each month compliance is monitored with regards to the daily checking of the resuscitation equipment and the daily temperature checks for the drug fridge. Where there is less than 100% compliance, the department are asked to speak to all staff to remind of the importance of carrying out the daily checks. The table below shows three occasions since September 2016 where the daily checking of the resuscitation equipment is less than 100% compliance - each episode relates to just one day where there is the omission.




**Learning from complaints** – following a concern raised to the Care Quality Commission by a patient in February 2016, we arranged for the patient to receive treatment in another part of the building that negated the need for the patient to use the lift. As a result of talking to both the patient and the relative, the concern was that staff had not understood what it was like for a person with a phobia not to be listened to.

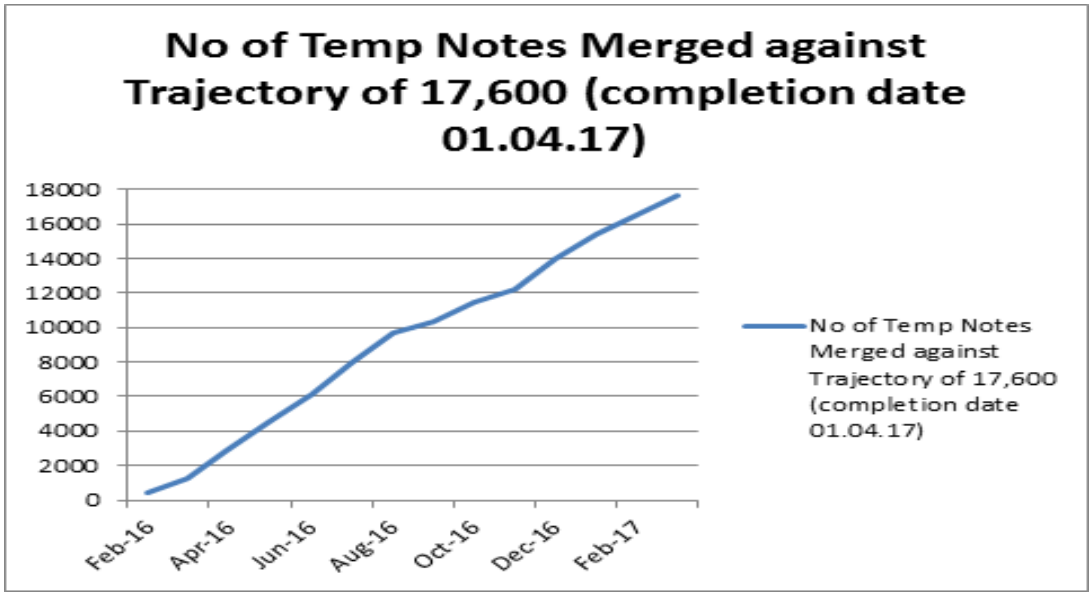
A charity, Triumph Over Phobia, came to the hospital and spoke with our staff about the issues that people face on a daily basis when they suffer from a phobia. The session included a great deal of interaction between the staff, as some opened up to how they themselves have phobias. At the end of the session, the staff were much more aware of the need to be sensitive to the needs of people attending Outpatients who may have a phobia.

*The CQC stated, in the 2016 inspection report related to Outpatients: "Staff provided compassionate and respectful care to patients. We observed that staff were understanding and maintained patient dignity. The majority of patient feedback that we received during our inspection was positive, and the latest Friends and Family Test (FFT) results demonstrated 96% of patients would*

In April 2016 the Medical Records Department embarked on a project to address a specific aspect of medical records management. It had become clear that the number of temporary duplicate patient files had been increasing and this was creating a risk that vital clinical information might not be available when needed should the permanent and temporary file become separated from each other.

A project commenced to merge every temporary record with its corresponding permanent record stored in the Trusts off site library. A calculation of numbers involved revealed there were an estimated 18,000 (actual number 17,600) temporary duplicate records. A trajectory was set to spread the task over a period over 12 months – this would mean a target of 1500 record merges per month by the small Medical Records team.

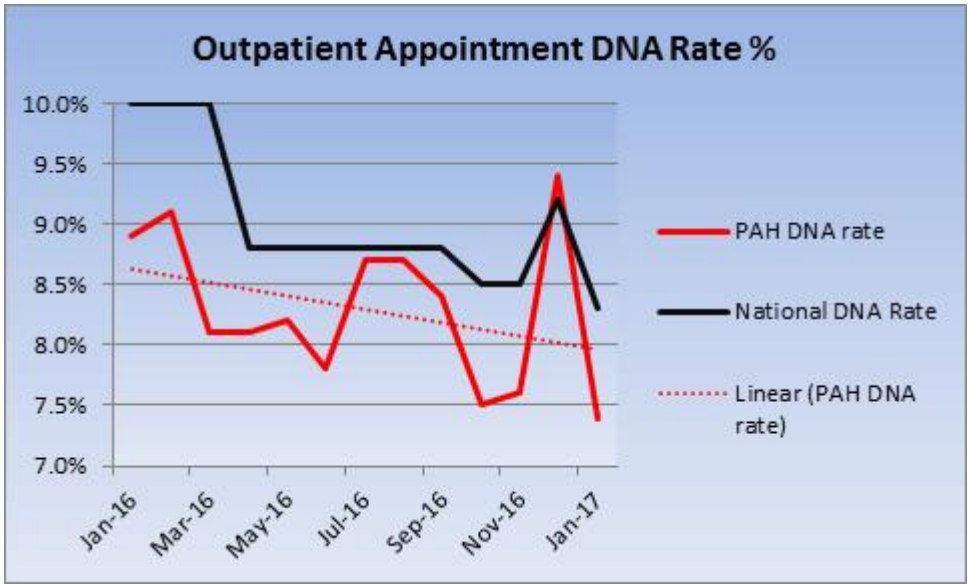
The graph below shows the incredible journey toward project completion with 17,600 records merged ahead of schedule at the end of March 2017.



Until the Trust is able to provide a fully electronic, non-paper patient record, there will be a necessity for temporary records. This in the main is due to physical location of records across a multi-sited Trust. As part of the recovery project and to ensure that the problem of increasing temporary records does not happen again, a new process dealing with incoming temporary medical records has been introduced in April 2017. The merger process ensures that no temporary record is ever filed within the records department as all temporary records are merged with the main patient file at the point of entry.

**Improving Patient 'Did not Attends' DNA's**

An analysis of our 'Did not Attend' (DNA) data in late 2015 revealed scope for reducing the number of patients that failed to attend their Outpatient Appointment thereby increasing the number of available appointments for other patients waiting to be seen. A project was launched to scope potential opportunities to reduce patient DNA's and changes to the way appointments were booked were introduced in January 2016. Patient Focussed Booking ensured that patients were given the opportunity to be involved in the booking of their appointment at a date, time and where possible a location of their choice.




Our aim is to continue to improve on the number of Outpatient DNA's and although rates are consistently below the National average, we endeavour to maximize on our ability to provide an efficient, patient focussed service.

In 2017/18 we will be working closely with our Commissioners and GP colleagues to move towards a single, non-paper based Electronic Booking Service (EBS) which will further enhance patient choice and efficiency, thus improving further still attendance and clinic utilisation.

# Diagnostics Performance

The Trust has achieved the 99% Diagnostic Wait target every month for the last 12 months. 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.

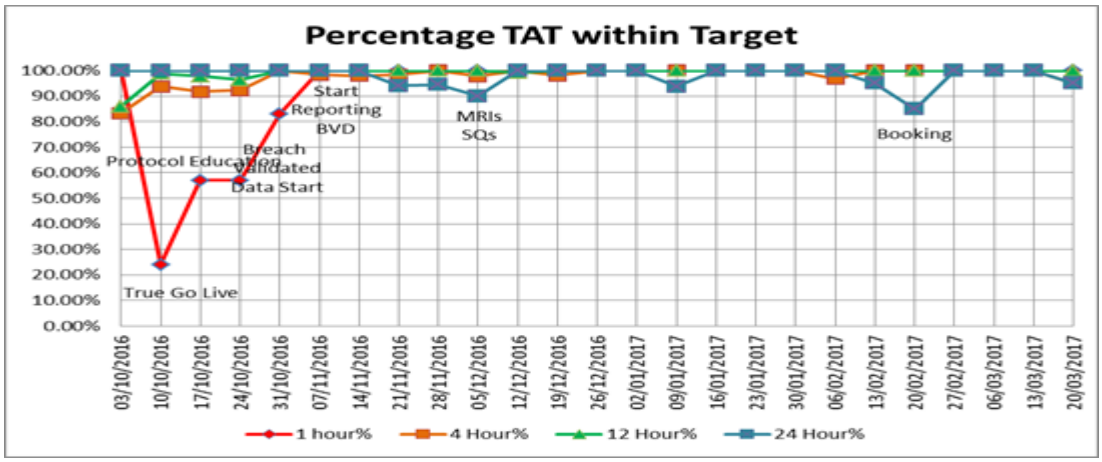
**Diagnostic Performance**

| Test | Target | PAH Average Performance 2016/17 | National Average Performance 2016/17 |
|---|---|---|---|
| Magnetic Resonance Imaging (MRI) | 99% | 99.98% | 99.30% |
| Computed Tomography (CT) | 99% | 99.82% | 99.00% |
| Non-Obstetric Ultrasound (Non-Obs US) | 99% | 99.96% | 99.70% |
| DEXA | 99% | 100.00% | 99.90% |
| Audiology - Audiology Assessments | 99% | 100.00% | 98.80% |
| Cardiology - Echocardiography | 99% | 100.00% | 97.50% |
| Neurophysiology | 99% | 96.99% | 99.20% |
| Urodynamics | 99% | 91.01% | 91.40% |
| Colonoscopy | 99% | 92.51% | 96.90% |
| Flexi Sigmoidoscopy | 99% | 91.68% | 97.20% |
| Cystoscopy | 99% | 75.42% | 95.50% |
| Gastroscopy | 99% | 92.89% | 97.80% |
| **OVERALL PERFORMANCE** | 99% | **99.40%** | **98.90%** |

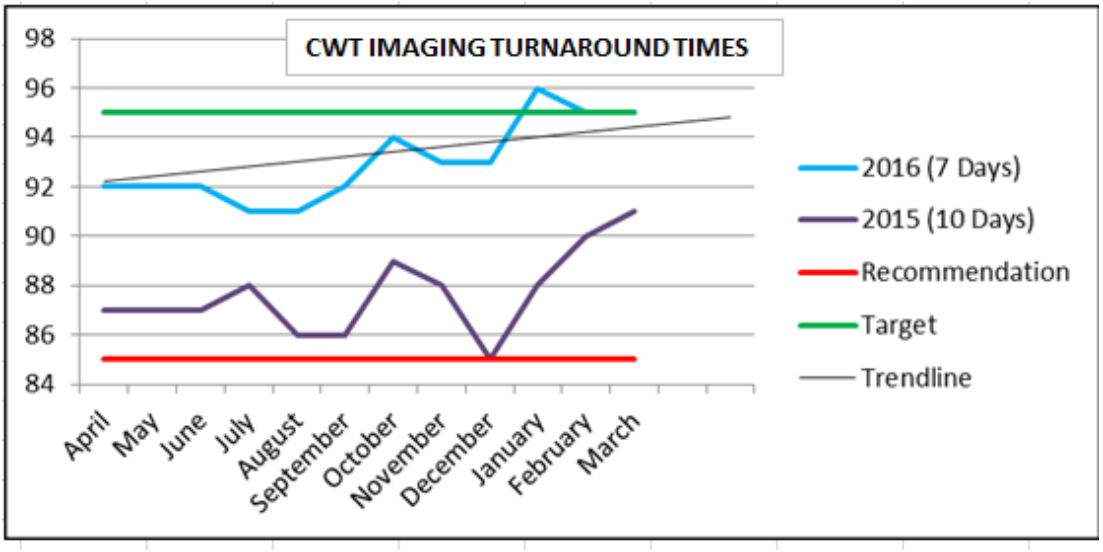
Performance around diagnostic tests for Cancer patients is something the Trust is equally excelling at with turnaround times that are better than the nationally set guidance. We currently turnaround more than 90% of cancer diagnostic tests inside 7 days from referral as opposed to the national guidance of 10 days.

Our Radiology and Pathology Services have recently implemented new standard operating procedures in order to adhere to the new Internal Professional standards set out under the Transforming Our Care Program. This has enabled patients from the Emergency department or Short Stay Assessment Units to be receive their tests and results more quickly than ever before and this in turn is aiding faster discharges.

This graph demonstrates an improvement in our front door imaging Turnaround times since the introduction of the Internal Professional Standard.




The below graph demonstrates the improvement in Cancer Waiting Time performance in Radiology (as a percentage). The national turnaround times are still 10 days, however at the start of 2016, we decided to push for our diagnostic tests to be performed in 7 days.




Our ability to continually achieve these targets is due to our main diagnostic providers (i.e. Radiology) being a full seven day service offering patients appointments late into the evening and over the entire weekend. This has been hugely popular with patients as results from our patient feedback surveys showed that the ability to attend for a scan without the need to take time off work was hugely beneficial.

**Areas for Improvement**

The main area for improvement around diagnostics is centred around the monitoring and performance of examinations that cannot be done at our hospital and are sent externally to other providers. It is very difficult for us to control the performance of other providers, yet we are still accountable for any breaches in this respect. We believe that work could be done around improving service level agreements with external providers and holding them to account for performance related to our patients. A second area for improvement is around capacity for consultant reporting of scans. With technology improving all the time, scans are being done more quickly, leading to more scans being completed each day. We are reaching a point where scanning capacity is outstripping reporting capacity. Consultant Workforce reviews are on-going to try and address this issue.

**Cardiology Services**

Since Cardiology was transferred from the Medicine HCG to CCCS, we have seen significant improvements in Referral to Treatment performance. In December 2015, Cardiology had a total waiting list of over 2,500 patients and only 75% of patients were treated inside the 18 weeks against a target of 92%. As of February 2017, the waiting list has halved to just over 1,100 patients and 93% of patients were treated inside 18 weeks. In addition to this, the median wait for a Cardiology Diagnostic procedure has dropped from 6 weeks to 4 weeks.

The Cardiology Specialist Nursing Team has grown significantly over the course of 2016/2017. The heart failure team has seen significant growth following a successful authority to invest application approved at Trust Board level proving the Trust's commitment to improving the quality of care provision. There is now a second full time heart failure nurse specialist and administration assistance in the heart failure team. This has resulted in increased capacity to clinically engage with patients and their carers to offer expert assessment and guidance irrespective of a patient's location within the hospital. The administration assistant ensures that the nurse specialists are utilised predominantly in direct clinical activity and has been paramount in releasing time to care.

The growth of the team has ensured that there is robust service provision and this has been appreciated by the patients cared for with a zero complaint rate and numerous examples of positive feedback, even including staff members being nominated for clinical excellence awards. Despite the success of 2016/17 the team is not resting on its laurels; a key performance indicator for the heart failure service is the national heart failure audit which benchmarks this hospitals performance against nationally agreed best practice. The team is set to achieve its highest data completion statistics for this financial year and plans to utilise this data to identify areas which can be further developed and improved ensuring the patient remains at the centre of all we do and receives the best possible care.

The team have successfully implemented a nurse led rapid access chest pain service run by our new Advanced Nurse Practitioner (ANP) in cardiology. The ANP independently assesses and decides on treatment plans for patients attending clinic and then reviews results and decides on further cardiology management. The ANP also supports the assessment of in patients referred to cardiology services and reviews patients in ED, EAU and other outlying wards.

The ANP role has created a more cohesive and a seamless cardiac pathway for the patient in the hospital by ensuring patients are referred for all cardiac diagnostics on the day of review. This has resulted in a significant reduction in length of stay on Fleming Ward. The next area for consideration includes a nurse led atrial fibrillation clinic.

The cardiac specialist nursing team are committed to improving the care of cardiology patients They are developing a teaching program for staff and preparation is underway for Heart Failure awareness Day on 5th May 2017.

The Princess Alexandra Hospital NHS
NHS Trust

# Heart Failure Service

## Suspecting or treating your patient with heart failure (congestive cardiac failure)

**Refer to us:**

**Bleep 216 (Monday to Friday, 9am to 5pm)**
**Email: heartfailure@pah.nhs.uk**

Find the referral form via link on ALEX intranet:
**http://intranet/index.php?mode=download&document_id=703**

Respectful | Caring | Responsible | Committed | From Values to Standards

**Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Accreditation**
In March the Medicine Health Care Group were awarded JAG Accreditation for the Endoscopy Unit. This scheme is regarded as one of the most innovative and effective in the health sector. The assessment standards focus on four main domains which are

- Clinical Quality
- Quality of the Patient Experience
- Workforce
- Training

Achievement of the accreditation demonstrates the high quality safe and effective care delivered to patients in Endoscopy. The accreditation is cyclical, however due to the increased demand and the requirement to expand services there will be a further review next year. We are currently progressing with a business plan to support the continued improvements so that we are able to meet the standards required over the next 12 months.

**Non Invasive Ventilation Services (NIV)**
NIV services are currently being delivered within the Critical Care unit. The Medicine Health Care Group have successful initiated a business plan to repatriate this service to the care of the Respiratory Team on Locke Ward. The plan includes the refurbishment and creation of a high dependency area where patients will receive NIV. Successful recruitment of Clinical Nurse Specialists and staff has been completed and it is anticipated that the service will move in 2017.

# Cancer and haematology Services

We are committed to supporting 'Achieving World-Class Cancer Outcomes, A Strategy for England 2015-2020. As part of this strategy, a new metric is being developed nationally that will support patients receiving a cancer diagnosis or being given the all clear within 28 days. As a result, a number of initiatives have been introduced to support reducing waiting times for diagnostic tests to ensure prompt treatment and improve patient outcomes.

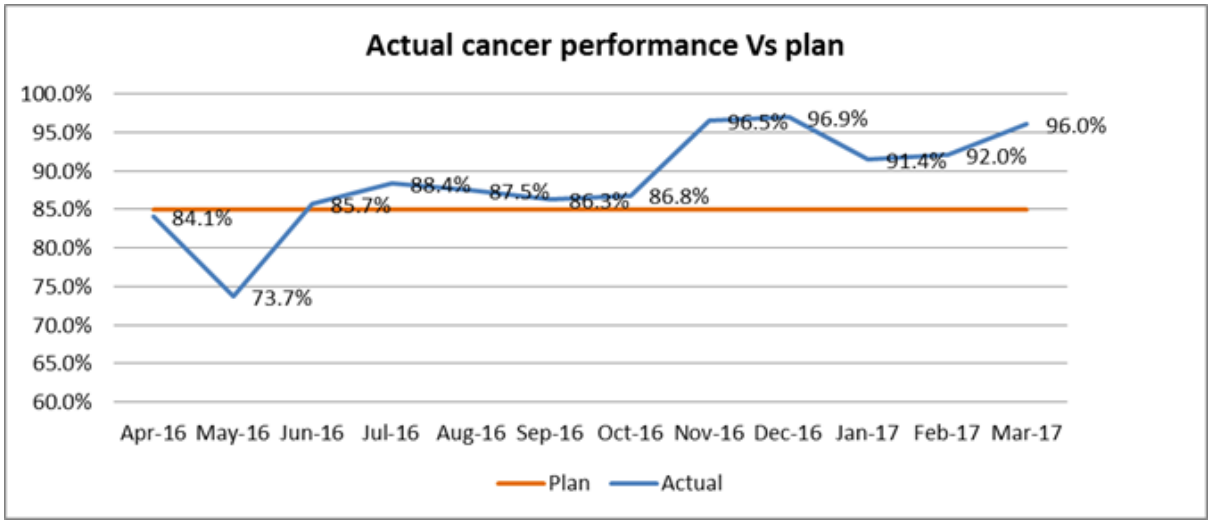
We aim to deliver:-

- 7 Days from an urgent GP referral for suspected cancer to date first seen for all suspected cancers, the National Standard is set at 2 weeks.
- 7 Days for diagnostics or follow up appointments

These initiatives are delivering a marked improvement in the achievement of Cancer Waiting Times at the Trust in comparison to National performance. The National Cancer Waiting time's standard for patients referred into the Trust is 85%, this means that a minimum of 85% of all patients referred on a 2 week wait pathway should be treated within 62 days.

| 2016/17 Month | Actual No of patients treated at PAH | % meeting Standard | National performance % |
|---|---|---|---|
| APR | 60 | 84.1% | 82.7% |
| MAY | 44 | 73.7% | 81.3% |
| JUN | 57 | 85.7% | 82.5% |
| JUL | 61 | 88.4% | 82.0% |
| AUG | 60 | 87.5% | 82.6% |
| SEP | 56 | 86.3% | 81.3% |
| OCT | 51 | 86.8% | 80.9% |
| NOV | 62 | 96.5% | 82.1% |
| DEC | 72 | 96.9% | 82.9% |
| JAN | 59 | 91.4% | 79.5% |
| FEB | 62 | 92.0% | 79.6% |
| MAR | 59 | 96.0% | 82.9% |

The table below sets out the improvements made in the quarterly performance since 2014. Our aim is to continue to drive down waiting times for all our patients.



**National Cancer Patient Experience Survey:**

A total of 148 Trusts took part in the 2015 National Cancer Patient Experience Survey which involved adults over the age of 16 *with* a confirmed primary diagnosis of cancer who was treated as an inpatient/day case in the months of April, May and June 2015. The survey is designed to monitor national progress on cancer care and to provide information to drive local quality improvements. The survey has now officially closed and all the data has been verified and integrity checked. The overall national response rate ended at 66% and the final response rate for Princess Alexandra Hospital is 68% which is an increase of 6% from the previous survey.

The survey results were published in July 201*6* and a detailed presentation of the results and action plan was presented at Cancer Board.

**What is being done well?**

- Respondents were asked to rate their care on a scale of 0 -10. Respondents gave an average rating of 8.5, the national average was 8.7
- 88% of respondents felt that the length of time waiting for tests was about right
- 91% said they were given a name of a Clinical Nurse Specialist who could support them
- 88% reported that they know who to contact following discharge
- 87% said that overall administration of their care was good/very good

**Areas of concern:**

- Only 64% reported being offered practical advices and support in dealing with side effects
- 49% of respondents reported being given information on getting financial help
- Only 61% reported that those close to them had an opportunity to speak with their doctor

These 3 areas of concern were added to our local Trust survey so that we can have early indication of improvements.

**Respondent comments:**

**Was there anything particularly good about your NHS Care?**

- The NHS moved very quickly; I was diagnosed with cancer within 10 days of my first GP visit
- Nurse in the Williams Day Unit were very supportive
- My surgeon was wonderful in all respects
- Staff was always helpful and caring

**Was there anything that could have been improved?**

- Waiting times for the outpatient clinic were often quite lengthy
- Parking at the Hospital
- Would like to have been offered copies of blood results so I could monitor my illness and feel more in control
- Nurses did not give enough information of self-help group's or what to expect whilst on treatment

**Other comments:**

- The hospital discharge procedure needs speeding up as I waited anything from 1-3 days for paper work and discharge papers
- More aftercare perhaps someone to talk to following discharge, better access to community nurses

Following publication of the results we created an action plan which forms part of the work plans for all cancer tumour sites:

- Review of timeliness of information given to patients
- Clinical Nurse Specialists to have a greater presence on the wards
- The development of End of Treatment Summaries for patients and GPs
- An increase in patients receiving an Holistic Needs Assessment at key points of their cancer pathway
- Access to Health and Wellbeing Events which support patients living with and beyond cancer

**Actions:**

- Patients are given information at multiple stages within their pathway and this is now revisited at key points of their care to better support patients in dealing with possible side effects. The implementation of Treatment Summaries will also support this practice (see below).
- Patients are given an information pack which contains advice on how to access financial support both locally and nationally. The newly introduced electronic Holistic Needs Assessment will provide an opportunity for the patient to raise any concerns they have, which can then be addressed.
- The cancer nurse specialists are now having a greater presence on the wards to help facilitate patient / doctor conversations
- Outpatient waiting area has seen the addition of a hot drink vending machine to make waiting times less arduous.
- There are plans to review outpatient clinic templates in the Spring of 2017, to ensure outpatient appointments times are adequately spaced.
- The introduction of Stratified Care Pathways will give patients greater control to manage their care with a supportive self-management focus.
- Patients now have greater access to “Health and Wellbeing Events”, with 4 events planned each year funded by Macmillan Cancer Support.

**Annual Local Survey**

An annual local cancer survey was completed in all tumour sites for 2015/16. The results continue to demonstrate that the majority of patients feel that they were treated with dignity, respect and privacy. Patients felt supported and involved in their decisions about their care and knew how to contact their keyworker. However, following the results of the national survey some questions have been changed for the coming year to enable us to compare.

**PICC LINE SERVICE**

2016/17 saw the development of a nurse led service for ‘PICC line’ insertion. Peripherally inserted central venous catheters (PICC) are an invaluable tool in gaining short to intermediate term vascular access for the delivery of treatments such as chemotherapy, total parental nutrition, medications and blood sampling without the need for multiple venepunctures. At the Princess Alexandra Hospital (PAH) PICC lines have been routinely inserted by interventional radiologists. However, with the growing demand for such requests and an ever increasing workload, a 6 month pilot for a nurse-led PICC line service was commenced in February 2016, which successfully resulted in outpatients and inpatients receiving vascular access more quickly.

The range of conditions and specialities where patients are currently benefiting are:

- Oncology and Haematology, particularly chemotherapy patients
- Medical - cellulitis
- Trauma and orthopaedics
- Cardiology
- Respiratory conditions

This nurse led service has improved the patient experience and the safety of patient care, and enabled patients to have drug treatments at home. It has enabled numerous early

discharges, freeing up hospital beds to allow more patients to use the hospital for other treatments.

**Specialist nurse Jodie Johnson leading the PICC line service**

**Recovery Package**

The Trust is committed to the delivery of the "Recovery Package" which is recognised in the NHS England Five Year Forward View and the Cancer Taskforce Strategy which outlines a commitment to ensuring that '*every person with cancer has access to the elements of the Recovery Package by 2020*'. The Recovery Package has five main interventions:

- Holistic Needs Assessment (HNA)
- Treatment Summary
- Stratified Care Pathways
- Health and Wellbeing Events
- Cancer Care Review (Community driven)

These elements form part of an overall support and self-management package for people affected by cancer – physical activity as part of a healthy lifestyle, managing consequences of treatment, and information, financial and work support. The roll out of these interventions will better support and improve the quality of life of people living with and beyond cancer.

To support implementation the Trust have partnered with Macmillan to recruit a project manager for 2 years, to date the following has been implemented:

- Recovery package steering group established
- 2 Health and Wellbeing events – well attended with over 60 patients.
- Increased number of holistic needs assessments being completed.
- Templates for Treatment summaries have been developed for Colorectal, Breast and Prostate
- IPADS purchased through Macmillan grant to support electronic HNA's

The Trust continues to work jointly with West Essex Living with and Beyond Cancer group and London Cancer Living with and Beyond Cancer Expert Reference Group.

**Specialist Nurse Led Clinics**
The Cancer Nurse Specialists now hold daily telephone clinics to support patients who do not require an outpatient appointment but that may benefit from additional support or symptom control advice.

**Clinical Harm Reviews**
Patients that are treated outside of the National Cancer Standard are reviewed by a clinical team where consideration is given to any physical or psychological harm that may have been caused as a result of the delay. The outcomes of these reviews are analysed to establish whether care pathways can be improved or further investigation is required. Any case requiring further investigation is reviewed by an executive chaired panel, and findings shared with both the patient and the Clinical Commissioning Group.

**Chemotherapy**
The Williams Day Unit is where all patients receive their treatment; there are 22 chairs in the chemotherapy suite that can be utilised to administer chemotherapy and a variety of other treatments. The unit receives approximately 250 patient visits per week, as well as providing a full outpatient service.

# Pharmacy – Improving medicine management

Medicines are the most common intervention in medical care. The costs of medicines amount to around 10% of NHS expenditure. There is evidence to demonstrate that interventions for enhancing medication adherence improve patient outcomes.

In support of this, Lord Carter's review of English NHS acute hospitals recommends that NHS trusts use at least 80% of their pharmacist's resource for direct medicine optimisation activities, medicine governance and safety remits.

To improve compliance with medicines optimisation and safety, the Pharmacy Department at PAH is now collaborating with the Lister Hospital under a memorandum of understanding to review the pharmacy infrastructure between the two organisations. In addition the Trust is liaising with West Hertfordshire Hospitals NHS Trust on how this work can be extended across the whole local health economy.

Some of the key achievements within the last 12 months are as follows: -

- The timeliness of prescribing To Take Away (TTA) drugs and their supply is monitored and shared with teams to reduce delays for patients and screening is enhanced at ward level
- A pharmacist is now based on Kingsmoor ward and Saunders ward to support medicine management
- An enhanced pharmacy service is provided to adult critical care
- Consolidation of a Trust Medicine Management and Incident Committee (MMIC) to support medicine management across the Trust
- Consolidation of the West Essex Medicines Optimisation Programme Board (WEMOPB) to ensure a joint formulary across the whole health economy
- Following implementation of phase one of the pharmacy workforce plan a number of pharmacists, pharmacy technicians and pharmacy assistant posts have now been recruited to.
- Following comprehensive drug use reviews patient safety and cost effective prescribing have continued for total parenteral nutrition.
- All medical and non-medical prescriber staff that prescribe medication receive prescribing training and competency assessment.
- Funding secured for replacement of existing medicine cupboards with British Standard approved medicine cabinets for most wards and departments.
- The Pharmacy Department received a 'good' score from the internal staff survey about the services it provides.

**Medication safety**

Following the introduction of the Medication Safety Officer role, a number of initiatives have commenced to improve medication safety. Some of these include:

- Training
- Prescribing assessments for junior and new non-medical prescribers
- Review of management of medication incidents
- Review and updating of drug security arrangements
- Review of drug stocks to avoid wastage and delays
- Robust review and documentation of patient allergy statuses
- Drug storage and safety audits
- Improvements in timeliness of drug availability including out of hours
- Improvement in the number of medication incidents reported within the Trust, compared to the same period the previous year, in order to demonstrate that we are an organisation with a 'learning culture'.
- Medication tips and medication safety awareness bulletins

**Areas for pharmacy development in 2017/18**

- Investigation into the most effective way to ensure that learning from medication incidents occurring locally, and those highlighted via national alerts, reaches all clinical staff.
- Continue to work closely with clinical staff in the development and review of an audit tool to assess: the quality of medicines storage and security, quality and extent of drug allergy recording, rate of drug omissions, knowledge of staff regarding Trust medicines policies, use of drug transfer paperwork and the discharge checklist for medication.
- Ensure that medication incidents involving controlled drugs are investigated to completion without delay.
- Simulation training films will be produced with the aim of optimising the supply of discharge medication to patients leaving the hospital and the supply of urgently needed medication to inpatients.
- Ensure that all medication safety issues are considered and risks assessed during the development of the electronic prescribing and medicines administration.

**Antibiotic stewardship**

Each year, around 4,000,000 operations are carried out in England and for most of these, antibiotics are key to preventing infections both pre- and post-operatively. One in four births in England is by caesarean section, where antibiotics are used to protect mother and baby. Half of women in the UK will suffer a urinary tract infection at some point in their lives and most of these will need antibiotics to treat the infection.

Most cancer treatments suppress the body's ability to respond to infections, so antibiotics, antifungals and antivirals help to keep people alive while they receive routine cancer care. Meanwhile, anyone who has had a transplant knows that their life depends on antibiotics to treat and prevent life-threatening infections.

Resistance is something that develops in bacteria themselves, through spontaneous genetic mutation. Once it has occurred, resistant bacteria will survive treatment with antibiotics and will go on to reproduce, passing the resistant genes on to their off-spring. While resistance is a process of natural selection, and thus something we cannot ultimately avoid, there are many instances where we use antibiotics inappropriately and therefore 'drive' the development of resistance.

Antimicrobial stewardship is a coordinated program that promotes the appropriate use of antimicrobials, improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.

Misuse and overuse of antimicrobials is one of the world's most pressing public health problems. People infected with antimicrobial-resistant organisms are more likely to have longer, more expensive hospital stays, and may be more likely to die as a result of an infection.

The solution to tackling antimicrobial resistance is complex, and needs action by everyone across the hospital. The following has been achieved as part of our antibiotic stewardship program at The Princess Alexandra Hospital NHS Trust:

- Use of Prescribing and Intravenous Antibiotic Review Stickers.
- Improvements in fulfilling NICE requirements and quality standards for antimicrobial stewardship.
- Introduction of Antimicrobial ward rounds by the Consultant Microbiologist and the Antimicrobial Pharmacist with the aim to promote appropriate, safe and cost-effective antibiotic prescribing and optimal infection control practices.
- A collaborative Trust wide point prevalence audit of antimicrobial prescribing is undertaken at ward level twice a year to monitor adherence to the Trust's prescribing guidelines. Report findings have been shared with the Infection Control Committee

(ICC), Medicines Management and Incidents Committee (MMIC) and Quality and Safety Committee (QSC).

**Electronic prescribing and medication administration (EPMA) and chemotherapy management system (CMS)**

The Trust has a Clinically Led Electronic Prescribing team who are working to implement new electronic medicine management, prescribing and administration systems to promote patient safety in line with the Carter report.

- The Chemotherapy Management System (CMS) is a web-based solution for prescribing, scheduling and managing therapies for chemotherapy patients. The system's specialist functionality focuses on reducing errors, streamlining patient management and optimising efficiency. The chemotherapy electronic prescribing CMS went live in a User Assessment setting on the 3rd of February 2017 for the GI tumour group. Further roll-out to the other tumour groups will follow.

- JAC Electronic Prescribing and Medicines Administration (EPMA) provides pharmacy stock control, e-prescribing and medicines administration. The configuration for the electronic prescribing and medicines administration (EPMA) system is in its final stages with a roll-out planned to the early adopter areas in the next few months. New purpose built drug carts with PCs have been purchased to support the implementation of this system and are being allocated out to the inpatient areas.

**Plan for the next 12-36 months**

Medicines Management at Princess Alexandra Hospital has made progress in the last year but there is still much to do to improve compliance with medicine management standards. The priorities requiring immediate action over the next 12-36 months are:

- Medicine optimisation
- Implementation of National Pharmacy Transformation CQUIN
- Implement phase 2 of pharmacy workforce plan
- Develop integrated pharmacy services

**Medication Safety to Improve Patient Experience and Reduce Patient harm**

The most recent NRLS report showed that we remain in the top 25% of Trusts for reporting incidents, with a reporting rate of 46.79 incidents per 1000 bed days. However, of the incidents reported only 7.5% were medication incidents. This is much lower than the average for other Trusts at 10.5%. This indicates that whilst the Trust is generally good at reporting incidents, it is not good at reporting medication incidents or sharing lesson learnt locally and outside the organisation. We have improved since 2015/16 when we reported 6.5%. but there is still a risk that the Trust will not learn and improve medication practice if problems are not known about.

The Trust has a medication safety officer (MSO) and this post is integral to improving medication error incident reporting and learning within the Trust. One of the key roles of the MSO is to promote the safe use of medicines across the organisation and be the main expert in this area to understand the impact of medication errors on patient care and involvement of staff. In addition to improving the quality of reporting, the MSO will serve as the essential link between the identification and implementation of (local and national) medication safety initiatives and the daily operations to improve patient safety with the use of medicines.

**Pharmacy Capital, Equipment and IT**

The external pharmacy review and chief pharmacist of NHSE identified that the pharmacy estate and IT would benefit from modernisation as many of the fixtures and fittings, particularly the aseptic preparation area, are nearing the end of their useful life.

The STP has set up a working group between the Lister Hospital, Watford Hospital and ourselves to explore options for collaborative working for aseptic pharmacy services.

# Infection prevention and control

The safety of patients, their families, visitors and our staff is a top priority for us and we are fully committed to this. We are proud of the robust infection prevention and control (IP&C) measures that we have in place to effectively control healthcare associated infections (HCAIs) including outbreaks of infection. The prevention and control of infection is pivotal to the Trust's overall risk management strategy and fundamental to the provision of the best clinical care.

In 2016/17 our pursuit of excellent control of healthcare acquired infection and antimicrobial resistance has continued and PAH remain in the top 1/3 nationally. Our success is reflected in our position nationally; demonstrating low rates of infection in four key alert organisms, two of which have annual trajectories which if not met incur financial penalties for the Trust; Meticillin Resistant *Staphylococcus aureus* bacteraemia (MRSA) and *Clostridium difficile* (*C difficile*).

IP&C is a Board to ward priority; staff across the organisation are trained, audited and engaged in measures for the control of infection, and the IP&C team are well supported by the Executive Team in ensuring this remains 'Everybody's business'. Staff are focused on the prevention and control of HCAIs, and preventing the emergence and spread of antimicrobial resistance, the latter being a national and global threat to the modern day practice of medicine.

The Trust IP&C indicators and standards are benchmarked and monitored via the national Public Health England (PHE) mandatory surveillance system and local Clinical Commissioning Groups (CCG).

**Trust Performance**

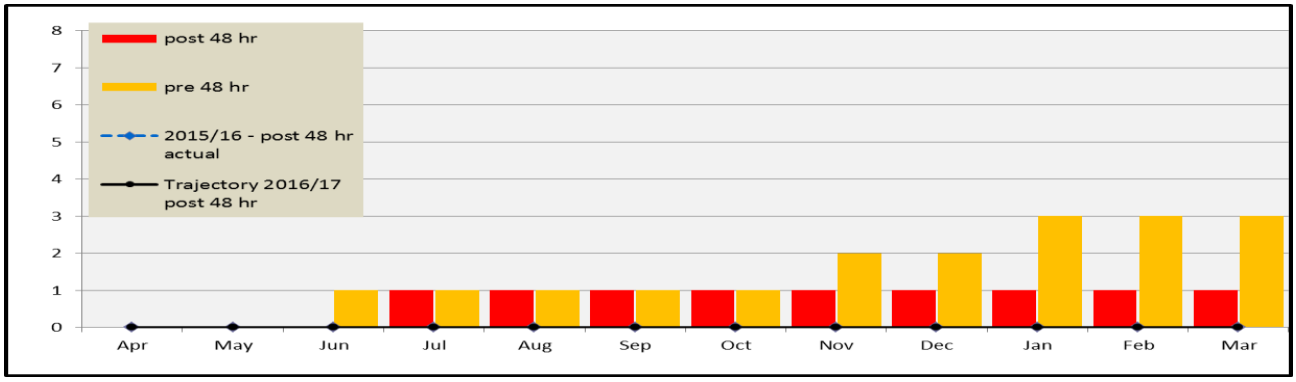
There are four key alert organisms that the Trust is required to report performance on, and these are published by PHE. The Trusts numbers of MRSA, Meticillin Sensitive *Staphyloccous Aureus* (MSSA), *Escherichia Coli (E.coli)* and *C difficile* cases, are published, nationally and in the East of England. Until 31st March 2017, trajectories were only set for MRSA and *C.difficile*, whilst MSSA and *E. coli* were reported on, but no target or financial penalty attached. Going forward, a trajectory for *E. coli* blood stream infections has now been announced from 2017-2018.

Those organisms that have upper levels set nationally for the Trust are assigned as either Trust or non-Trust apportioned (sometimes referred to as pre or post cases) and this is based on the timeframe that the specimen was taken as well as consideration of clinical details. In some cases, a 'third party assignment' may be decided upon because the acquisition of infection cannot be determined. In the graphs detailed below, the numbers of Trust and non-Trust apportioned cases for the four organisms are shown.

**MRSA Bacteraemia**

There is a trajectory of zero tolerance for MRSA blood infections (bacteraemia) across the NHS. At the end of March 2017, the Trust had reported one case; our first case in two years. However, this case was assigned as third party as it could not be identified with certainty where the patient acquired the infection. A full investigation of the case was undertaken and 'lessons learnt' (though not contributing to the patient acquiring MRSA) were shared across the organisation to improve practice.

**Cumulative MRSA Bacteraemia cases 1 April 2016 – 20 March 2017**:



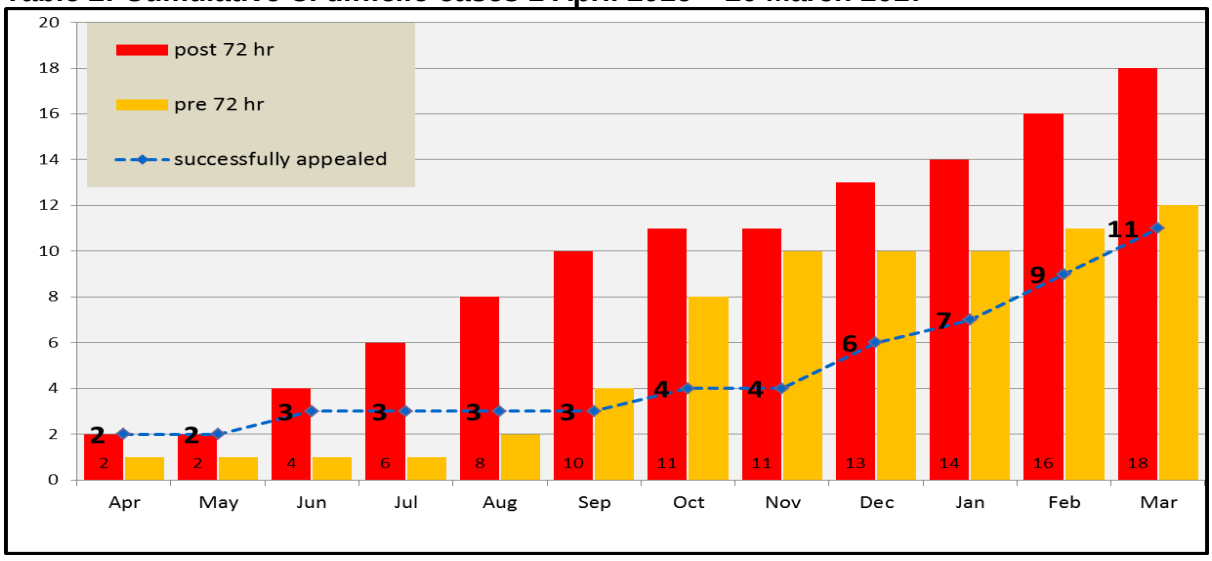

***C.difficile***

Once again, the Trust has met the *C.difficile* trajectory for 2016-17 and remains in the top performing third of all Trusts nationally. Although we ended the year on a total of 18 cases, only seven of these were considered to be Trust-attributable, with the remaining 11 cases successfully appealed (at the North Essex HCAI Scrutiny Panel). Appeals are successful when there is demonstrable evidence that there were no lapses in care that contributed to the case. This indicates that our infection control and prevention measures are safe and effective. In terms of the contractual arrangement with commissioners of our services, there will be no financial penalties associated with the final year end position; this is a cost avoidance of £80,000. The PHE national database will, however, still show the Trust as having 18 cases.

We have achieved this through hard work and effort from all staff at the Trust who have remained vigilant and committed to infection control procedures throughout the year. We have a robust Root Cause Analysis (RCA) process in place which is significant in contributing to shared learning amongst staff. Our success reflects our compliance with infection control and antimicrobial prescribing policies. This is despite the challenges of PAH being an old hospital and coming through a difficult winter. It should also be noted that we had a lower trajectory than our neighbouring Trusts; this reflects our excellent rates in previous years, but means we face a tighter target than other hospitals that have had higher cases.

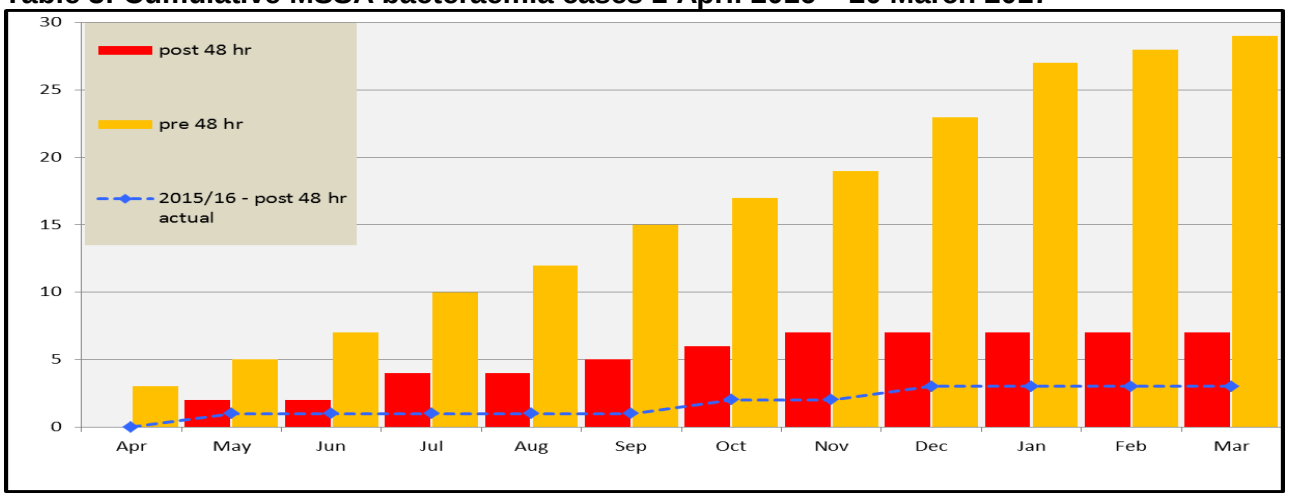
**Table 2** shows cumulative cases of *C. difficile* for 2016 -2017 and PAH attributable cases

**Table 2: Cumulative *C. difficile* cases 1 April 2016 – 20 March 2017**



**Meticillin Sensitive *Staphylococcus aureus* (MSSA)**
The Trust is one of the top performing NHS organisations in the country in terms of our low MSSA blood infections (bacteraemia). This year there have been seven Trust apportioned cases, as demonstrated in **Table 3** below:

**Table 3: Cumulative MSSA bacteraemia cases 1 April 2016 – 20 March 2017**

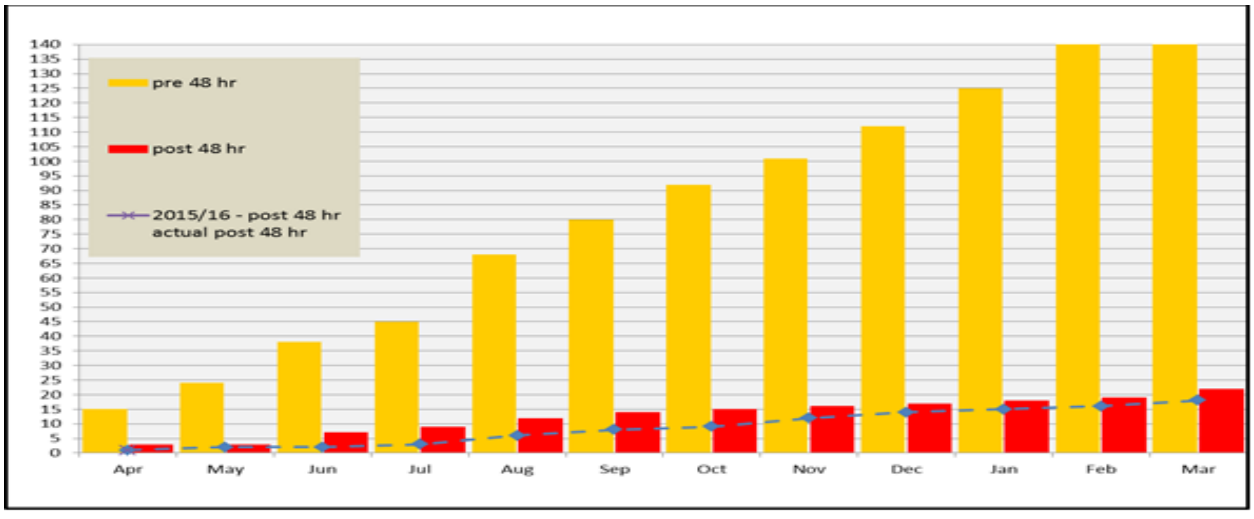



***Escherichia Coli (E.coli)***
Numbers of Trust-apportioned *Escherichia Coli (E.coli)* cases are low and the Trust remains in a favourable position when compared with hospitals nationally. During 2016-2017 we had 22 cases of Trust-apportioned cases, (**Table 4** below). This demonstrates the largest proportion of *E. coli* bacteraemia are from the community.

The Secretary of State for Health will be introducing a new infection control trajectory from 2017-2018 to reduce Gram-negative blood infections by 50% by 2021. This is because these infections are thought to have contributed to many patient deaths in the NHS. *E.coli* blood infections represent 55% of all Gram-negative bacteraemia.

By showing the figures for *E. coli* cases on wards, and making them visible to patients and visitors in the same way that MRSA and C. difficile cases are currently displayed, we will be ensuring that there is equal focus on these infections. *E. coli* blood infections have increased by a fifth in the last five years. By reducing these infections, apart from the obvious benefit of not having an infection, it will help control antibiotic use. This will in turn reduce antimicrobial resistance.

**Table 4: Cumulative *E-coli* Bacteraemia cases 1 April 2016 – 20 March 2017**



**Infection Prevention and Control Incidents and Outbreaks**

In line with national requirements, infection rates associated with orthopaedic surgery (hip and knee prosthesis) are monitored. The data is used to identify improvements in surgical orthopaedic pathways to reduce infection rates for patients even further. Towards the end of 2016/17, a small number of infections were identified in patients that had undergone hip/knee joint replacements. These cases are being fully investigated and several measures have been implemented to ensure we have addressed all possible sources. Monitoring of interventions and surveillance continues.

In addition to orthopaedic surgery, this year we also introduced surveillance of elective caesarean sections; to date we have not identified any infections in this category; however, there is still further work being undertaken to ensure that all eligible women are being included.

As part of our routine water management plan, water outlets are tested for the presence of water-borne organisms. At the end of January 2017, Legionella was detected from outlets at Birchwood House (St Margaret's Hospital). All water outlets were immediately taken out of use and temporary portable water supplies were implemented whilst remedial works were undertaken (chlorination of pipework). No patients or staff members were affected (meaning that although legionella was detected, nobody acquired a Legionnaires disease infection). The water outlets have all been re-tested and are clear; the service has now resumed as normal.

In 2016/17 there were six confirmed Norovirus (viral gastroenteritis) outbreaks in the inpatient wards. When Norovirus is suspected, the Trust teams work together closely to contain such outbreaks and prevent spread of the infection. The outbreaks were well controlled and contained to the ward affected. Wherever possible, outbreaks are managed by closing the bay affected rather than the whole ward; this is to ensure minimal disruption to the service.

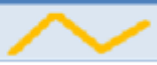
During November 2016, NHS Improvement (NHSI) carried out an IP&C inspection at the Trust. Whilst there was some positive feedback, there was a requirement to implement measures to address some issues identified in relation to cleanliness. NHSI returned to the Trust in February 2017, to undertake a follow up inspection. Improvements were identified across all wards visited, including general cleanliness of the environment and patient equipment, good hand hygiene, compliance with dress code and personal protective equipment and all commodes were clean. The inspector left the Trust feeling assured that IP&C practices were satisfactory, and the Trust was given a compliance rating of 'green' (compliant).

**Patient Led Assessment of the Care Environment (PLACE)**

The annual Patient Led Assessment of the Care Environment (PLACE) is undertaken each year; the assessment covers four key areas including:-

- Cleanliness
- Food & Hydration
- Privacy, Dignity & Wellbeing
- Condition Appearance & Maintenance

The table below shows the 2016 Trust position compared to previous years.

| Year | 2013 | 2014 | 2015 | 2016 | Trend |
|---|---|---|---|---|---|
| 1. Cleanliness | 95.16 | 98.56 | 95.53 | 97.63 |  |
| 2. Food | 83.51 | 84.01 | 80.71 | 86.59 |  |
| 3. Privacy Dignity & Wellbeing | 77.73 | 87.05 | 80.12 | 79.78 |  |
| 4. Cond. App & Maint. | 88.06 | 92.4 | 85.88 | 93.83 |  |

Following on from the results in 2016, an improvement plan was developed and all actions were completed prior to the 2017 PLACE inspection which took place on 21 April 2017.

**Domestic Services**
The domestic service continues to deliver a good standard. We are currently planning to invite an external audit provider to review cleaning standards on the main hospital site as well as satellite sites. We anticipate that this work will be concluded over the coming 6 months.

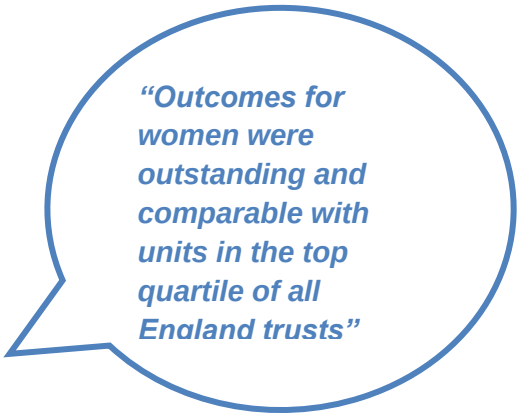
We are actively recruiting to all vacancies within the domestic team and have successfully purchased new equipment to ensure that cleaning can take place during normal working hours with minimal risk to users of the service.

30 new cleaning trolleys were purchased in 2016/17; used throughout the hospital; these are lockable which complies with legislation. Alongside the trolleys we also purchased new decontamination and scrubbing equipment, thereby promoting the quality and responsiveness of cleaning at the hospital.

**Images of new cleaning equipment purchased in 2016/17**


## Our Outstanding Maternity and Ambulatory Gynaecology Services

The achievement of an "Outstanding" rating for maternity and gynaecology services in the Trust's 2016 CQC report is testament to the dedication of an exceptional team of staff.




**The CQC observed that staff were dedicated, compassionate, caring and they consistently went beyond the call of duty to deliver the best experience possible for their patients.**

### Our environment

In 2016, the number of women accessing maternity services continued to increase. Going forward numbers are set to rise even higher due to new housing developments locally. The current maternity unit was built to accommodate 2,500 births per year; we are now seeing 4300 births per year.

Improvements to the current building and environment have been made to optimise the facilities for women and their partners but in order to bring the department into the 21st century a new unit is desperately required.

In 2017-18 the Trust will be pursuing a second maternity operating theatre in line with national requirements for maternity units. This will improve the women's experience and optimise their safety. Currently measures are in place to mitigate risk; this involves women been transferred from the maternity department to the main operating theatres.

### Staff recruitment and retention

In 2016/17 the department achieved a midwife to birth ratio of 1:30 despite the national shortage of registered midwives. Success is in part due to the friendly atmosphere, aligned with a flexible and dynamic approach to providing excellent care to women, recognising the increasing clinical needs of women.

The multi-disciplinary team work hard to ensure high quality safe care is provided to all women and their families. Our staff are able to access personal professional development opportunities including preceptorship, mandatory training as well as national and local leadership development programmes.

This year the department is undertaking a pilot study aimed at improving safety within the labour ward. The project will review and identify ways of improving communication amongst our multi-professional team including shift handovers.

There was further success in accessing training money which will be used to enable members of the multi-disciplinary team to attend pertinent courses which will ensure the unit has a well-trained group of professionals.

Listening to the feedback from women and their families is really important to us as we continually strive to provide the very best service that we can. All compliments are shared amongst the whole team and every single complaint or cause for concern is fully

investigated and a response provided. The learning from investigations and any actions taken are shared with all staff.

**Bereavement Services**
The bereavement service is led by a full time Bereavement Midwife.

There is a dedicated en suite room (STAR Room) located in the maternity department. The room has recently benefited from refurbishment including sound proofing; the work was made possible because of charitable donations. As a direct response to family feedback, we have also decorated the courtyard outside the Star room with flowers and plants in order to provide a more pleasant outlook from the room.

A 'just giving' page has been set up as families often request to donate directly to the bereavement service in maternity and so far we have received £3800 in donations. The money is utilised to improve the services offered to the families.

Mandatory training for staff has been extended to 3.5 hours sessions using a multidisciplinary approach with really positive feedback. An annual memorial service is held in June at Greenacres Burial Park which is very much welcomed by families as it provides them with an opportunity to attend a service in memory of the baby they lost.

Counselling for families is provided by PETALS based at Addenbrookes hospital in Cambridge. The service is free for families and includes access to psychotherapists and counsellors specialising in pregnancy loss, death of a baby/child and decision making relating to termination of pregnancy for abnormalities. The feedback from the families has been positive.

All families are invited to return for a follow up visit with the Foetal Medicine Consultant and the bereavement midwife at six to eight weeks after pregnancy loss. A letter regarding this visit is then sent to the GP and to the family to ensure effective communication.

In 2016 the following incidents occurred

- 9 unavoidable stillbirths,
- 2 neonatal deaths (less than 24 weeks gestation)
- 1 medical termination of pregnancy (after 24 weeks gestation)

The stillbirth rate corrected was 2.14 per 1000 births compared to the national average of 4.2 per 1000 births.

**Mothers and babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)**
All of our data is entered on MBRRACE and Trust staff have participated in the MBRRACE panel, reviewing national cases. This helps to improve sharing of information and identifying areas that where we could further improve the services we provide.

**Birth Reflections**
This is a service offered to all women who wish to discuss their birth, go through their notes and reflect on their experience. In October-December 2016, 56 women took up the Birth reflections service; an increase from the same time last year.

The meeting is documented and, where appropriate, the output is shared with teams so that learning is always encouraged.

**GYNAECOLOGY**
At the 2016 CQC inspection, the Early Pregnancy Unit (EPU) and Gynaecological Ambulatory service (GAMBU) were rated as providing an excellent service for women and the Termination of Pregnancy service was rated outstanding.

Inpatient gynaecology services were identified as not meeting regulatory requirements; providing a poor experience for women. A working group was set up to address the issues raised and a number of actions have already been taken to improve the service.

The CQC report also identified that women undergoing elective and emergency gynaecology procedures were placed on a number of wards. Women having planned surgical procedures were not always returning to the same ward post operatively. These issues were having a negative impact upon the women's' experience. Since the middle of January 2017, Melvin Ward has been identified as the gynaecology ward and all attempts are made by the Clinical Site Team to ensure that women are admitted or repatriated to the ward as soon as possible.

A Gynaecology and Early Pregnancy Unit (EPU) booklet describing the available specific clinical pathways has been produced and is now available for clinicians via the Trust Intranet. This has been supplemented by intensive training from the Bereavement and Pregnancy Loss Matron, for staff working in the Emergency Department and relevant wards.

To support the specific clinical pathways for gynaecology patients, clinical guidelines have been developed; these are available on the Trust intranet and easy to access for all staff.

A new gynaecology competency booklet has been developed to be used for all nursing staff who will be working on Melvin Ward or who have contact with gynaecology women.

The staff from Melvin ward are being given the opportunity to rotate for a shift working in the Early Pregnancy Unit to provide them with insight and experience in the care of women undergoing an early pregnancy loss.

It has been many years since the hospital had a gynaecology ward. Having a recognised dedicated ward for gynaecology is a very exciting and wonderful opportunity to improve the care and experience of women undergoing emergency and elective surgery.

# Safeguarding Adults and Children

There are seven main strands to the Princess Alexandra Hospital NHS Trust Safeguarding Services:

1. The undertaking of child protection (CP) medicals excluding sexual abuse Medicals
2. The provision of education for staff in relation to safeguarding vulnerable adults and children
3. The provision of supervision to Trust staff
4. The provision of ad-hoc Child Protection advice as required by any Trust employee where it relates to patient care
5. Supporting staff to make referrals to adult and children's social care and/or advice to social care relating to injury, abuse or neglect
6. Deprivation of Liberty Safeguards (DOLs)
7. Adherence to the Mental Capacity Act

The Chief Nurse is the Executive lead for all aspects of both adult and children's safeguarding. Professor Fontaine attends both the Essex Safeguarding Adults Board (ESAB) and the Health Executive Forum which informs the Essex Safeguarding Children's Board.

**Safeguarding Adult activities in 2016-2017**

- The Trust continues to identify and apply for Deprivation of Liberty orders for individuals who are vulnerable and do not have the mental capacity to make informed decisions about their own safety. This work is undertaken in partnership with the supervisory body which ensures that the Trust meets the necessary requirements for all applications.

- Staff in the Trust can now access a bespoke training day which enables them to develop and enhance their knowledge and skills in relation to safeguarding, domestic abuse and PREVENT.

- Additional funding was secured to support the delivery of training for staff who are required to undertake Mental Capacity Assessments or applications for DOLs.

- Sustained delivery of the 'DAISY' project for the Trust; which supports disclosure of domestic abuse and provision of on-going plans of care for individuals.

- Embedded the joint adult and children's safeguarding post which supports both adult and children's Lead Nurses in the delivery of safeguarding services.

- Updated the Safeguarding Adults policy in line with the Care Act 2014

- Implemented Adults Safeguarding supervision support, accessible to all staff.

- Implemented a Safeguarding electronic Dashboard which has enabled collation of all referrals and captures training data.

**2017-18 Safeguarding Adults Work Plan**

- To strengthen staff knowledge and skills in the application of the Mental Capacity Act for the care of patients.
- Further develop the provision of supervision for all staff in all aspects of safeguarding. This will include development of a database.

- Review training requirements and availability of courses to ensure our staff can develop knowledge and skills in relation to safeguarding, relevant to their roles.
- Continue to work with all partners across the health and social care economy including ESAB and NHS England; sharing the learning from safeguarding incidents, networking and participating in projects to further develop Safeguarding services.

**Safeguarding Children activities in 2016-2017**

In 2016/17 there was a steady increase in the number of consultations as well as social care referrals made by the hospital in relation to safeguarding children. This demonstrates that our staff are recognising safeguarding concerns and are ensuring safe outcomes by referring to social care. In the second half of the year we saw a drop in the number of serious safeguarding incidents being discussed at the Trust Serious Incident Group; the reason for this is directly linked to improvements in the immediacy of actions taken by staff to protect the vulnerable.

The improvements have been achieved because of a number of activities that have been happening over the last 12 months:

- A new safeguarding dashboard to monitor safeguarding activity has been devised; this helps us to capture the number of referrals made to children social care by the Trust, the number of Child Protection medical assessments undertaken as well as monitoring our training figures.
- A high risk maternity database has been developed to monitor updates or progress from community midwives regarding vulnerable pregnant women allowing hospital based midwives access to 'live' information that they need to have when supporting women whilst in hospital.
- Following the implementation of a new maternity information sharing process, a joint audit with community health partners was done. This audit assesses any improvements in the flow of shared information between maternity, health visiting and GP services for vulnerable pregnant women.
  Regular peer review had been taking place with involvement from our community paediatric colleagues from the child development centre and on a quarterly basis includes support from the Designated Doctor for Safeguarding Children
- A hub and spoke approach is being adopted to ensure that all Paediatric and Obstetric staff are able to access supervision appropriately, according to their role. Staff members have been identified to attend the NSPCC supervisory skills course. Once they have successfully completed the course, they will be able to support the safeguarding supervision plan under the guidance of the safeguarding team for quality assurance.
- Weekly 'safeguarding huddles' have been introduced the children's ward, maternity department and the children's emergency department. The 'huddle' focuses on lessons learnt, recent cases that have gone well or could have been managed in a different way.
- Changes to the provision of training including expanding provision of annual level 3 safeguarding training to obstetricians, orthopaedic consultants and staff form the adult Emergency department. Bespoke training has been provided to departments who struggle to be released to attend classroom training such as operating theatre staff.

As we move forward into 2017/18 we shall continue to focus our efforts on improving compliance with training in order to ensure that our staff are skilled, competent and supported to provide the very best support and advice in relation to safeguarding children.

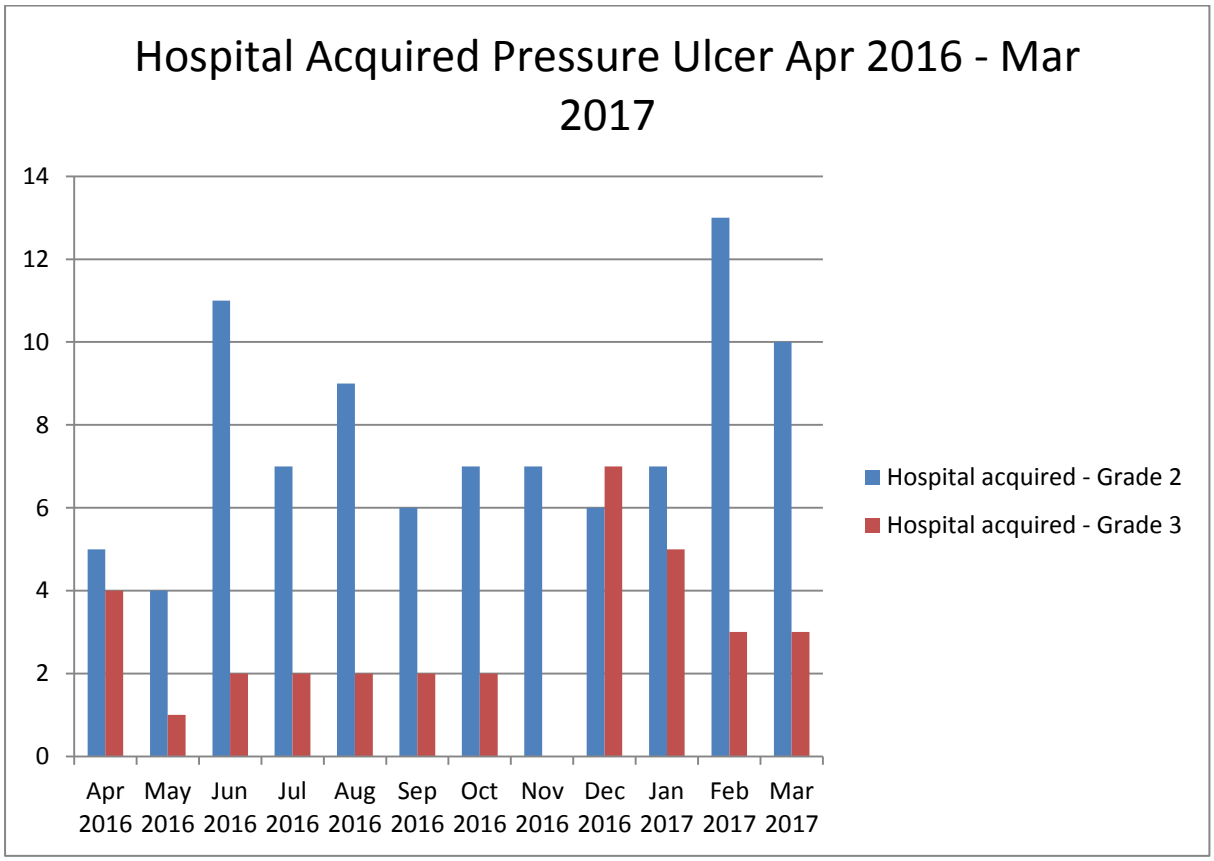
## Leading the change in Tissue Viability

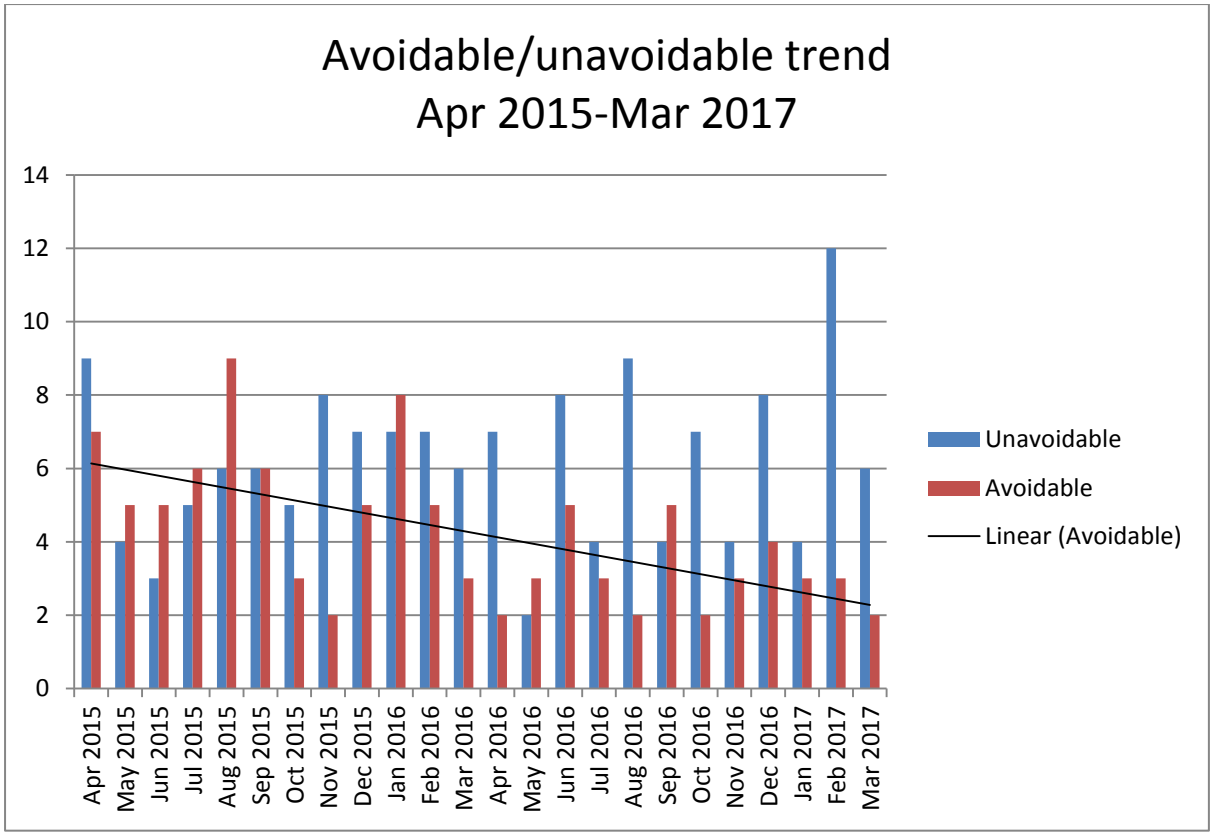
**Pressure Ulcers**

As always our goal is to strive for **"Zero tolerance of Hospital Acquired Avoidable Pressure Ulcers".** In spite of the challenges, staff are passionate about skin care and continue to keep pressure ulcer prevention high on their agenda. There continues to be a clear downward trend with a fantastic 43% decrease in avoidable pressure ulcers.

There have been zero grade 4 pressure ulcers this year. Our last avoidable grade 4 pressure ulcer was in April 2013 and the last unavoidable grade 4 was August 2015. We believe this is a remarkable achievement considering the nursing staff vacancy rate on wards.

This year the percentage of pressure ulcers that were deemed unavoidable following scrutiny was 68% with 32% being avoidable. This is comparable with last year when there were 69% and 31% respectively. However there has been a 10% reduction in the total numbers of pressure ulcers (123).






**Secondment**

This year has been an exciting one for the Tissue Viability Nursing team (TVN's); following interviews in September the TVN's took on their first secondment nurse. The 4 month secondment post has facilitated the development of new skills not just in tissue viability but also in leadership and professional development. As part of her secondment, Carina Pimenta was asked to write an abstract for the Tissue Viability Society Conference. She wrote about the secondment and her experiences and was chosen to present a free paper at the Birmingham conference in April 2017. The organisers were so impressed with her presentation that she won the Best Free Paper Award which she was presented with that evening. There is a shortage of TVN's in the UK and we believe that the approach we are taking is providing a way of developing the next generation of specialist nurses. Our next secondment nurse is due to start in June 2017.

**Agents for Nutrition and Tissue viability (ANT's) Programme and Training**

The ANT's programme provides additional knowledge, skills and competencies for registered nurses, practitioners and healthcare support workers. This additional level of expertise supports assessment and intervention for patients in relation to optimising their nutrition and hydration as well as preventing avoidable skin damage whilst in hospital.

Our aim is to provide an ANT on every shift, on every ward and the programme continues to go from strength to strength with over 200 ANT's already trained.

ANT projects have been diverse and very impressive in some cases which have had a real impact on patient experience and care. These have included:

- An Operating Department Practitioner (ODP) in Theatres and her plastic feet that she uses to teach colleagues about pressure ulcer grading; (commended by the CQC during the 2016 inspection)
- Staff member on Harold ward with his novel way of persuading patients to reposition
- An Health Care Support worker on Lister ward ensuring patients get the correct meal

A programme of mandatory training continues to be delivered on the wards. Taking the training to the wards is proving a viable tactic in maintaining attendance. The TVN's also provide intensive support where needed. Trends in ward pressure ulcer rates are monitored and scrutinised to alert for any potential problems.

**Complex Wound Care**
Whilst pressure ulcers constitute 50% of the Tissue Viability workload, the other 50% includes complex wounds. This year the team were involved in a very complex case where a patient had a wound 90 cm x 60cm. He was treated and successfully transferred to Broomfield hospital for specialist interventions after 14 days. Following his discharge and recovery, the patient came back to visit us to express his thanks. A real success story.

**System-wide Working**
With the large numbers of patients being admitted to hospital with pressure ulcers (around 50 patients per month) the health system-wide group was set up to address this. Hospital pressure ulcer data was analysed and it was found that the majority of patients coming into hospital with pressure ulcers were being admitted from their own home. Sessions have been set up aimed at patients and carers (informal and formal) to raise awareness and dispel the many myths around pressure ulcer care. The first 2 sessions went well and further sessions are now planned with targeted audiences to ensure the message gets out to the right people.

**What's next?**
We are currently reviewing our Wound Care formulary where there are potential cost savings to be made through appropriate use of barrier products. We are planning to launch a new pathway for this is shortly.

We are also undertaking a trial of hybrid mattress products from April 2017. Hybrid mattresses are now widely available and many trusts have already converted over to these. They stay in situ on the bed for low risk patients. When a dynamic surface is required, a powered box can be attached without moving the patient or posing potential manual handling risk to nurses (through lifting heavy mattresses on and off beds).

If the trial is successful and we implement hybrid mattresses, this has huge potential for freeing up nursing time to deliver care and enhancing the patient experience as well as releasing time for porters, nurses, health care support workers and ward clerks. The speed in which a mattress can go from being static to dynamic is also reduced and therefore patients can be managed on the correct surface in a more timely way. There is some research evidence that the use of hybrids can reduce pressure ulcer rates.

# Falls prevention in hospital

The Trust employs a full time Falls Prevention Practitioner (FPP); there has been regular falls training on the wards and clinical areas as well as training provided on Clinical Updates, newly qualified nurse development programme, EU Nurse Induction, Junior Doctor Induction, Student Dr's, Vulnerable Adult Study Days, Health Care Support Worker programme and ad-hoc for professional staff groups.

The FPP continues to work with fellow falls leads across the county and within West Essex specifically. As a result the Trust has become more proactive in terms of Falls Prevention as now staff are comfortably using the new Multi-factorial falls paperwork which replaced the older 'risk prediction' tool. Harm levels are still commendably low from our falls; 98% of all hospital falls in 2016/17 resulted in low or no harm to the patient.

However overall falls rates are still higher than is deemed acceptable and although this is certainly partly due to the ageing local population there is still plenty we can do. We need to become better at performing basic routine tests such as lying/standing blood pressures and also acknowledge fully the harm that occurs by indirectly encouraging patients to remain sedentary for far too long. These aspects are being addressed and we are moving forwards positively in terms of falls prevention.

**Falls by Severity 2016-2017 Financial Year:**

| | Death | Severe | Moderate | Minor | None | Total |
|---|---|---|---|---|---|---|
| Apr 2016 | 0 | 1 | 3 | 22 | 51 | 77 |
| May | 0 | 1 | 1 | 28 | 59 | 89 |
| June | 0 | 0 | 1 | 25 | 81 | 107 |
| July | 0 | 0 | 1 | 31 | 68 | 101 |
| Aug | 0 | 1 | 1 | 36 | 60 | 98 |
| Sept | 0 | 0 | 2 | 17 | 67 | 86 |
| Oct | 0 | 0 | 0 | 21 | 69 | 90 |
| Nov | 0 | 0 | 4 | 31 | 84 | 119 |
| Dec | 0 | 0 | 3 | 27 | 67 | 97 |
| Jan 2017 | 0 | 0 | 1 | 19 | 83 | 103 |
| Feb | 0 | 0 | 0 | 16 | 51 | 67 |
| March | 0 | 0 | 1 | 18 | 72 | 91 |
| Total | 0 | 3 | 18 | 291 | 812 | **1124** |

**Scrutiny Panel Decision on falls**

We continue to analyse in detail all falls that result in moderate or severe harm to patients at our regular Essential Care Scrutiny panel which is chaired by the Deputy Chief Nurse. The scrutiny focuses on whether the patient received comprehensive assessment of the risk of falling whilst in hospital and whether the correct actions were taken to minimise the risk. If there is evidence that every possible action, based on recognised best practice, was taken to reduce the risk, the panel will declare the fall unavoidable.

| **Essential Care Scrutiny Panel decision** | **April 2016 – March 2017** |
|---|---|
| **Avoidable** | 7 |
| **Unavoidable** | 12 |

A number of measures have been put into place to maximise patient safety, improve patient care and to reduce the overall number of falls in hospital. Patients who have fallen while in hospital or who are admitted due to a fall are now considered high risk.

**Work undertaken in the last 12 months includes:**

- Working in the local community with charities and Council colleagues, and also contributing to the falls mapping exercise currently run by the Clinical Commissioning Group (CCG).
- The New Falls Care plan has become embedded within the Trust and addresses current NICE guidelines and actions.
- The importance of preventing patient deconditioning has been made a priority and the FPP is currently working on a communication strategy to promote this more widely.
- Detailed patient falls prevention brochures have been shared widely and provide patients with a wealth of information around falls and well-being.
- The FPP has contributed to national teaching resources used in medical schools to educate future medics on the effectiveness of exercise in preventing falls.
- The importance of syncope (transient loss of consciousness or fainting) has been made a priority on the falls paperwork and this is getting regularly audited and improvements are starting to be seen in terms of compliance.
- The falls newsletter continues to raise awareness of the Trusts performance and share information about community falls prevention services.
- Falls meeting has reverted to Quarterly arrangements to facilitate more productive and valuable meetings.

Significant amounts of patient safety equipment have been purchased following fund-raising by the FPP. Money raised =

- £10519 from National Skills Academy for Health (for a wide variety of equipment including: Tissue Viability Doppler probes, Dementia signage, Crash mats, Projector and screen, Dementia friendly books, mouth care training tools, interactive autism trolley) (image attached)
- £996 from External Charity for the Carers Cards and Lying/Standing BP Lanyard Cards (images attached)
- £500 from External Charity for Deconditioning Banners and patient Information leaflets (images attached)


**Further work to be taken forward in 2017/18:**

- Syncope still needs to be pushed further up the clinical staff priority list in regards to patients and so this is on-going work.
- The Royal College of Physicians have launched a new Vision assessment tool and so this will need to be included within the falls care plan.
- The quarterly falls meeting still requires better attendance and an action plan to address this needs formulating by FPP.
- The Royal College of Physicians will re-audit our service in May 2017.
- On-going continuous falls teaching is required to ensure embedded falls prevention knowledge across all staff to counteract the high rate of staff turnover.
- We need to become more integrated with the community services to facilitate better discharge and fewer admissions to hospital due to falls in the first place.
- The FPP will continue to support the Frailty unit as this is a critical service that could prevent potentially high risk of falling patients from being admitted long term.

# Improving dementia care

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 volunteers**
The Trust now has 4 Dementia volunteers as of March 2017 with a continuous recruitment initiative in place for further Dementia volunteers. The role of the dementia volunteer is varied but includes

- Supporting the completion of the 'This is me' documentation and the carer's survey
- Visiting/befriending patients
- 1 to 1 activities, e.g. reading, games, reminiscence, crafts, visits to the
- shop/chapel
- Group activities e.g. reminiscences, news discussion
- Assisting at meal times
- Signposting patients and carers to other support services
- Talking to and supporting carers

**Dementia Support Practitioner**
In July 2016 the Trust appointed a Dementia Support Practitioner (DSP) on an initial 1 year secondment. The role of the DSP has been to facilitate, support and encourage staff to improve dementia care across the Trust. The DSP has had a significant impact already and has received some very positive feedback from carers and patients. Here is just one example:

*"I wish to extend my gratitude to the outstanding support & help received from one of your dementia support team namely David Page. I am a care support worker for a patient who was admitted on 13th Feb. David is a welcomed relief & visited the ward on most days ensuring the patient's needs were met. He immediately implemented some fundamental practices which were to be of great help and assurance i.e. the use of the Forget Me Not logo and the This Is Me Booklet which would raise awareness to nursing staff.*
*I cannot emphasise strongly enough the vital need for this support within the hospital environment & the relief & assurance it provides to families knowing that their loved one's basic needs are understood & provided for.*
*I truly champion the work of David and the Dementia Care Support Team at PAH and cannot speak highly enough of the level of assistance and support received from David or of his complete dedication in support."*

**National Audit of Dementia**
The Trust successfully participated in the National Audit of Dementia between April 2016 and October 2016. Results are to be published in 2017 with further National Audits planned for 2017. Our aim will be to utilise the results from the audit to strengthen our approach to delivering the best possible care and support to people living with dementia.

**Johns Campaign**
The Trust joined the nationwide "Johns Campaign" in April 2016, whereby family members and carers of patients with Dementia have open access visiting and greater input in the overall care their loved one receives**.**

**Dementia Friendly certificate**
The Trust was recognised by the local Dementia Action Alliance as being a Dementia Friendly Organisation in December 2016 for the previous and continued work to make the Trust as Dementia Friendly as possible.

**Dementia/Delirium strategy steering group**
The steering group continues to meet quarterly and is overseeing the implementation of the revised strategy.

**Training**
The Trust remains committed to ensuring that staff are suitably trained and experienced in the care of patients with dementia.

Dementia awareness sessions remain mandatory for all clinical staff and as of February 2017, 66% of staff had completed this session.

The Trust has been successful in obtaining a grant from Health Education England to train Virtual Dementia Tour (VDT) facilitators. 7 staff so far are trained and the VDT was launched across the Trust in May 2016. To date over 247 staff have attended a session. The sessions are proving to be very effective and going forward we aim to hold at least 2 sessions each month.

The Dementia Champion's programme was launched in July 2014. The aim of this 6 month programme is to give selected staff members an enhanced understanding of dementia so that they are able to lead on dementia improvements in their local area as well as contributing to the Trust's overall agenda. The aim is to have at least 2 champions in each clinical area. The third cohort has now completed their training bringing the total number of champions to 25; a further programme is scheduled for 2017.

**Find Assess Refer**
Following changes to the electronic patient record (COSMIC) system and an intensive education programme, the Trust is now consistently achieving over 90% in each of the categories.

- A) 90% of patients aged 65 years or older admitted as an emergency are asked the case finding question: *Have you been forgetful in the last 12 months to the extent that it has significantly affected your daily life?*
- B) 90% of patients answering positively to the case finding question, having diagnostic assessment.
- C) 90% of patients having a positive diagnostic assessment referred in line with agreed local pathways.

**Supporting carers**
The Trust is required to survey carers of patients with dementia and report the results to the Board. In August 2016 a new approach to the monthly distribution and collection of Carer surveys was put in place in an effort to improve the quantity of feedback. Between August 2016 and February 2017, 239 surveys were given to carers and 35 were completed and returned. The results of returned surveys are collated and presented monthly to the dementia steering board and quarterly to the Quality and Safety Committee. Thematic evidence is used to inform the Trust's dementia strategy.

**Frailty Assessment Service**
In 2016/17, we had a renewed focus on the traditional ways we provide care for our older adult population. The NHS publication *'Fit for Frailty'* suggested a re-design of the pathways for these patients through the Emergency Department of Acute Trusts. The document

explained the benefits of a comprehensive geriatric assessment (CGA) for patients who are frail – i.e. not able to walk independently without aids or support.

A CGA is a determination of the individual's medical, psychological, social and functional capabilities, with a view to developing a co-ordinated and integrated plan for treatment and long-term follow up. National and international pilot schemes have shown that this approach improves the care of this particular group of patients and reduces hospital re-admissions.

A Frailty Assessment Unit (FAS) was opened at Princess Alexandra Hospital in October 2016. This service has reduced the length of time older patients spend in our Emergency Department and facilitated a reduction in length of stay in hospital before patients return to their domicile in the community.

Initially, the unit consisted of four assessment spaces within a ward environment. The service was managed by a Lead Frailty Consultant Physician and a Lead Frailty Practitioner with dedicated Therapy support. Gradually, the unit has received additional enhanced support from diagnostics, social services, community services and the Patient at Home team.

In January 2017, the entire ward area was transformed into a short stay ward for our older patients, providing care for up to a 72 hours stay. The unit now consists of 22 inpatient beds in addition to the 4 assessment spaces. The unit also accepts direct referrals from GPs allowing patients to bypass the Emergency Department entirely.

Feedback for the service has been very positive from patients, friends and family as well as GPs.

Currently, the assessment unit is open Monday-Friday but plans are being developed to extend these hours. The unit has also joined the National Acute Frailty Network with the aim of sharing our experiences and learning from other units across the country.

# Improving care for patients with learning disability and autism

**Learning Disability (LD) Steering Group**
The steering group continues to meets quarterly and is overseeing the implementation of the Improvement Plan. The previous non-executive director who was chair of the steering group has now left the Trust. The new Chairman has been asked to appoint a new non-executive chairperson.

**Working with External Stakeholders**
In addition to the external members of the learning disability steering group, the Trust is actively working with other external stakeholders involved in learning disability care. Currently, the Learning Disability team works closely with Community Learning Disability Teams both in West Essex and East Hertfordshire, our commissioners and other external voluntary and non-voluntary organisations. Our LD Team have undertaken numerous joint home visits with the Community Learning Disability Team to patients who have LD and/or autism and who may have challenging behaviour or be hospital phobic. The aim of this work has been to desensitise the patient to the hospital setting whilst they are in familiar surroundings, as well as meeting the hospital LD Team prior to hospital admission. We are then able to ensure that any reasonable adjustments that need to be put in place can be organised before the person gets to the hospital.

Our LD team have also engaged with the staff at Action for Family Carers; working closely together to develop a carers policy that will meets the needs of all carers of patients when within the hospital. A close working arrangement is in place to support families or carers who require additional support or input when in the hospital.

**Training**
The Trust remains committed to ensuring that all staff have sufficient knowledge to enable them to appropriately care for patients with learning disabilities/autism.

Learning Disability and Autism awareness training continues to be covered in the Vulnerable Patients Study Day. This awareness training is also delivered on the Induction Programme for all new starters. In addition, the learning disability team undertake targeted training sessions on any area where there have been concerns raised or where the area receives a greater number of patients (such as gastro-enterolgy) who also have a learning disability or autism..

A second cohort of Learning Disabilities Champions completed their training in March 2017. In total, 9 staff have committed to this six month programme which aims to provide them with an enhanced understanding of learning disabilities and autism so that they can lead improvements in their work area. As a result of this programme, there have been some excellent projects developed by the champions in their clinical areas. Three examples of the excellent initiatives are

1. A photographic journey through radiology has been produced by a member of staff that can be used to help patients with a learning disability and/or autism prepare for their visit.
2. The maternity champion has redeveloped the care pathway for pregnant women who have a learning disability and/or autism.
3. There is now a learning disability/autism friendly mortuary viewing room.

A further programme is scheduled to commence during the latter half of 2017.

**Learning from Incidents and Complaints and deaths**
The Learning Disability team 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.

2016/17 has shown a rise in the amount of reported instances. This is mostly due to an increased understanding amongst staff of the need to report all instances, changes to the Datix reporting system to make reporting simpler and also due to the changes to the requirement to make Deprivation of Liberty safeguards (DoLs) applications. A DoLS authorisation allows a care provider to lawfully provide care and or treatment to an individual who is unable to validly consent to the care and or treatment, where they are not free to leave the care environments and are under the supervision and control of others where the deprivation is likely to be for a prolonged period.

The common themes that appear to be arising from the review of incidents and complaints are poor communication between hospital to hospital staff and hospital staff and residential/care staff and poor discharge planning. As a result of this, our LD Team have engaged ward areas in bespoke ward based training to focus on these themes and are planning specific training for the discharge team within the hospital. They also share the learning during the LD/Autism awareness training, delivered on both the Trust Induction Programme and Vulnerable Patient Study Day.

All deaths of people with learning disabilities and/or autism are also reviewed by the learning disabilities team to determine if there are any themes or instances of diagnostic over shadowing. Since the Death Review Process has commenced there have been two deaths where concerns have been highlighted; the issues related to end of life care and assessment. The learning from the reviews will be shared and will support improvements in the way in which we provide care.

The Trust has formally joined the newly established national review of deaths in people with learning disabilities. This is a national scheme facilitated by the University of Bristol. All deaths of people with Learning Disabilities will be reported to a central database and then will be subject to an independent review. Should this independent review identify any areas of concern, the death will be referred for a secondary multidisciplinary review. The aim of the scheme is to identify areas of poor care which may have contributed to the death of the person. It is also designed to obtain data as to why people with learning disabilities statistically die younger than the general population.

The Learning Disability Liaison team continues to attend any relevant Essential Care Scrutiny Panels and Serious Incident Group meetings to ensure any areas for learning are identified following incidents or complaints. The themes from incidents, complaints and deaths and any learning points are discussed during the mandatory training sessions. For example, within the training sessions, there is a strong focus on good communication and liaison with the patient/family/carers whilst in the hospital, ensuring staff are aware of the Hospital Passport/Purple Folder/reasonable adjustments and good, in-depth and holistic assessments of the patient to ensure clinical staff are aware of all relevant information about the patient.

The learning disabilities team has significantly increased the amount of pre-admission familiarisation visits for patients and also home visits – which aim to ensure the patient recognises a "familiar face" when they are admitted. This has proven very successful for patients who may otherwise have been too anxious to attend their hospital appointment. For example, our LD Team visited a patient with autism who was acutely phobic of hospitals, but had an appointment for a CT scan. Our team conducted a joint home visit with the patient's community Learning Disability Nurse to meet the patient and family and discuss the procedure. The patient's anxiety was better managed and he successfully attended the hospital for his CT scan.

# Stroke Services

A difficult decision was made to temporarily suspend stroke services at PAH in March 2016 as it had not been possible for PAH to recruit any substantive Stroke Consultants. An interim plan was put into place where individuals with suspected stroke were taken to other hospitals if picked up by ambulance, or transferred out to Queen's Hospital if identified at PAH.

Although we had intended to reinstate the Stroke service at PAH, this has not been possible in 2016-17. We have worked closely with our partners and our commissioners, continuing attempts to recruit to the consultant posts and considering other options for delivering the service. However, recruitment remained unsuccessful during the year and our commissioners therefore made a decision that stroke services for patients in our catchment area would continue at other providers. This means that individuals with suspected stroke continue to be taken to their next nearest hospital or to Queen's Hospital if they present at PAH.

As there were a number of patients who were on our stroke caseload due for outpatient follow up at the time the service was suspended, we worked closely with our commissioners to identify a suitable plan to manage these patients safely. All patients were reviewed remotely by Queen's Hospital to identify whether or not they required a Stroke Consultant follow up or could be discharged to the care of their GP. All patients were informed by letter and those requiring an appointment were seen at Queen's Hospital or, if required, transferred to another hospital nearer to them. We have successfully worked in collaboration with Queen's Hospital to complete this entire review.

We have worked hard during 2016-17 to ensure that the new pathway for stroke patients is implemented consistently throughout the hospital – in other words to make sure that anyone who presents with suspected stroke symptoms in our Emergency Department or on our wards during an admission is transferred to Queen's for treatment. This has involved an extensive training programme and by the end of the year over 80% of the staff involved in diagnosing stroke and making the necessary arrangements will be trained.

We will review stroke services for patients in our catchment area in the future to identify whether or not a local service can be reinstated.

# Patient Experience and Engagement

**Highlights from 2016-17**

- The total number of complaints has dropped from 665 five years ago to 251 in 2016-17, evidence of the impact of a more proactive patient experience focus across the whole of the organisation.
- The Trust delivered 22% more PALS resolutions, where patients had a concern that needed to be resolved, that's 500 more problems solved.
- 1547 more compliments were recorded than last year, up 55% to 4350 from 2803.
- The Patient Experience Team was recipient of the regional NHS Living the Values Award for the East of England 2016-17.
- The Parliamentary and Health Service Ombudsman in 2016-17, considered only 7 complaints not to have been completely resolved at the local level, one of the lowest levels in the East of England and evidence of a highly effective complaints process.
- The number of members of the Patient Panel has continued to increase and we now have 22 hard working volunteers who have delivered exceptional outcomes for the organisation.
- This included hosting the first ever conference patient led conference on end of life care, well received by local staff and patients.
- The Panel delivered a learning event in partnership with Ipswich Hospital on 16 March 2017 to enable a wider group of Trusts to learn from the work of the two organisations.
- The Patient Panel hosts its fourth Annual Conference in June 2017 on the integration of health and social care with support from partners across the region, aimed at educating the public and staff about the discharge process.

**Listening, Responding, Improving**

With the significant increase in the number of compliments, the Patient Experience Team has worked hard to make this positive work visible through its Strategy of Listening, Responding and Improving. With the significant increase in the number of PALS cases resolved, 500 more this year than last and the accompanying increase in the number of compliments the team was keen to make this hard work visible.

That was the beginning of the compliments campaign which has seen the use of the Trust's outstanding patient experiences which have been delivered by our amazing people acknowledged all through the organisation. We expect to develop this further in 2017-18 with campaigns relating to ward and clinical areas.

We believe that we can always do more to gather feedback and so have been working to raise the profile of the feedback patients and carers have already provided.


Image: Ground Floor Staircase, compliments campaign petals

The compliments campaign was designed to support patient and staff experience by encouraging patients to come forward with their feedback, both positive and negative. The campaign includes information for patients about how to access the patient experience team and raise a concern with the team or praise the quality of care provided by our staff.


**Image: East of England Leadership Recognition Awards, 24 November 2016**

**Recognising achievement**
The Patient Experience Team were recipients of a regional award as a result of their work to implement values, standards and behaviours across all professional groups, to improve complaints processes and increase local resolutions of patient and staff concerns. They were recognised at a ceremony in Duxford, Cambridge in November 2016, the image here shows the team together with the Chief Nurse and judges from Health Education East of England.

**Supporting Staff Experience**
Staff responsible for safety and quality participated in a national staff experience programme sponsored by NHS England, the DNA of Care programme, contributing to the evidence base on staff experience and supporting those staff who participated to improve their practice.

**Relocation**
The Patient Experience Team have relocated; brought together to deliver a unified service at B20 and B21 which is allowing the team to better coordinate its work and increase impact. Evidence of this impact is clear from the number of cases the Patient Experience team now deals with. This has increased year on year for the last 5 years, illustrated by the graphic below.

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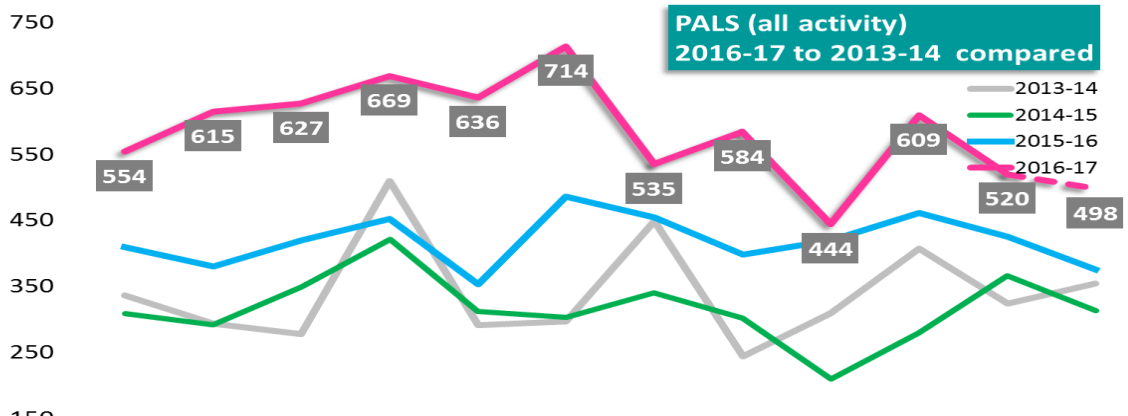


| | A | M | J | J | A | S | O | N | D | J | F | M |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013-14 | 336 | 293 | 277 | 509 | 291 | 296 | 448 | 243 | 309 | 407 | 323 | 354 |
| 2014-15 | 308 | 291 | 349 | 421 | 311 | 302 | 340 | 301 | 209 | 279 | 365 | 313 |
| 2015-16 | 409 | 380 | 419 | 452 | 353 | 485 | 454 | 398 | 419 | 461 | 425 | 375 |
| 2016-17 | 554 | 615 | 627 | 669 | 636 | 714 | 535 | 584 | 444 | 609 | 520 | 498 |

The pink line represents the number of cases dealt with by the Patient Experience Team at a local level. 2015-16 (blue line) saw the first ever year of 5000+ PALS resolved. 2016-17 will see the first ever year where over 7000 cases will have been recorded or resolved.

**Next Steps: Engaging local communities**
Building on the achievements of 2016-17 with a further increase in problems solved for patients, families and carer and expect to launch an outreach programme into local public spaces over the next year which will help us to achieve that, so expect to see us out in local libraries, shopping centres and public spaces offering assistance to anyone who would like to get a problems solved regarding their patient experience at the hospital.

**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 251 complaints in 2016-17.

Subjects of complaints
The most frequently occurring themes were medical care expectations, 68 complaints, communication with 41 and attitude 34.

How many were well founded
According to data from the Ombudsman of the 109 cases referred to the Ombudsman in 2016-17, 1 case was upheld and 5 were partially upheld.

**Actions taken**
Actions are taken over the year; the table below 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.


| Your concern | How we changed |
|---|---|
| Mum raised issues regarding her visit to paediatric A&E about waiting times and information. | A **patient information card** has been developed to be given out on arrival for every family who comes to **Children's Emergency Department.** |
| Patient had a procedure and stopped regular warfarin medication prior to ENT surgery but was not then given follow up anti-coagulants due to a communication failure. | The Consultant has led a **change in the patient pathway** to **reduce the likelihood of anti-coagulant errors** recurring working with the pre and post-operative assessment team. |
| Mum said her symptoms were ignored which she feels could have put her baby at risk. | A senior midwife has reviewed and **developed revised induction of labour guidelines** and the ward manager is using the patient story to share learning with staff. |
| Patient's family have concerns relating to cancer patient's end of life care. | The ward and team have worked with the family to put in place changes, address communication issues and respond in detail. The work has been shared at team meetings, presented to Board and **continuous audits of end of Life Pathways on the ward are being run** to avoid a recurrence of the multiple failings in care. |
| Patient has concerns regarding post-operative care and fully understanding the procedure. | The Trust **worked with the patient to review the patient information leaflet relating to consenting to a procedure** and made adaptations to the information to make the process suitable for vulnerable groups. |
| Patient had long delay waiting for cardiologist to review radiology report | **New process for radiology reports being received** and acted upon agreed with the radiology consultants including copying all correspondence to patients to ensure patients are aware of next steps at same time as Consultant. |

| | |
|---|---|
| Mother of twins says that a 'bug' should have been picked up sooner but results not acted on due to communication issue. | We have worked with mum to develop a **new information leaflet for parents about the organisation of the Dolphin Children's Ward** and now have a lead doctor for parent contact. |
| Patient unhappy about process when she came for procedure. Lengthy delay without water meant she was dehydrated. | **Revised guidelines for pre and post-operative management** have been published with a focus on hydration, so patients stay well hydrated before and after a procedure. |

# Our amazing Patient Panel

The Patient Panel exists as a mechanism to ensure patients receive the best possible care and we achieve that by ensuring the voice of the patient is heard by decision makers and service delivery teams at the heart of the organisation to help them consider that age old question, “What is it like being on the receiving end of me?”

The work of the Panel is in two parts, the first is the improvement of existing conditions, policies and processes such that they are co-produced with patients and so more patient centred. We could describe this as challenging existing practice. The second part is to encourage innovation and new thinking through partnerships, innovation and service audit.

**Patient-Led Innovation**

Image: Nearly 100 delegates participated in the Patient Seminar on 16 March 2017 in partnership with Ipswich Hospital, talking about the things we can do across the Eastern Region to better include, involve and co-produce services with patients, families and carers.

The Trust prides itself on being outward facing, always looking for the next innovation, and is always looking to share its own knowledge, experience and ideas with others. This is a great example of how the Patient Panel is really part of the way The Princess Alexandra Hospital works.

The Patient Panel established a partnership with IHUG (Ipswich Hospital User Group) a partnership for the benefit of patient groups across the region. Mollie Pattenden, our Nutrition and Hydration Steering Group lead presented her work on improving protected mealtimes in Harlow, Ann Nutt, Chair of the Panel presented on a number of innovations at the Trust including the Annual Conference, the Emergency Department Volunteering Programme, the Complaints Reference Group and work to better integrate complex discharge processes across East Hertfordshire and West Essex.

The Patient Panel delivered two conferences, one on end of life care and one on supporting patients to get involved in their local organisations, both of which delivered important public and staff education outcomes.


**Ipswich Hospital**
**16 March 2017**

**Patient Led Assessment of the Care Environment (PLACE)**

Princess Alexandra Hospital was first opened in 1965, and is now over 52 years old. The buildings and infrastructure have been partly upgraded at various times but nothing can hide the increasing evidence that an integrated acute hospital service cannot be sustained without major significant investment in the near future in the area.

For this reason the Patient Panel regard the Patient Led Assessment of the Care Environment Assessment (PLACE) as critical to their work, they make recommendations for improvement and maintenance of flooring, lighting, public amenities and numerous other areas which are part of the inspection and regularly report to the Trust Quality and Safety Committee on their findings. This is a great way to volunteer for the hospital, as it serves a useful purpose for staff by helping them to highlight areas requiring improvement in a systematic way, but also by giving patients the chance to comment on how well the environment supports the staff.

**Public Amenities**

The Panel has continued to pursue improvements in the estate to enhance the patient experience; two particular areas of focus are public toilets and the main entrance. The Panel continues to work with the Trust to enable these developments to ensure that patients, families, carers and members of the public receive an excellent service. The Panel believes that the main entrance needs to be refreshed so that patients can come in more easily by car and taxi drop off and that public transport areas such as the bus shelter are brought into line with other facilities in the area with live bus times and effective protection from the elements.

In order to achieve this, the Panel has encouraged Mystery Shopper led activity from patients and members of the Panel and the reporting of feedback to the Trust to challenge for improvement in a way which has been very effective.

**Challenging existing Practice**

An example of this work includes the Clinical Excellence Awards, where the Panel are responsible as part of a group including other medical and surgical consultants for decisions relating to performance which can be considered extraordinary. This involvement has been

very well received over the last year with evidence that the Panel is having a real influence on how patient centred the Awards programme is, consultants are now keen to demonstrate skills around shared decision making and pathway improvements which improve consent and communication processes with patients, families and carers.

Consultant doctor interviews are another feature of how the Panel has improved what we already do. By including members of the Patient Panel on consultant and Executive interview panels, patients are enabling the Trust to bring a more patient centred perspective to our recruitment processes. Patients are chairing consultant panels and asking the questions members of the public might like to ask when interviewing for new staff such as "What do you think is the role of patients in the planning and development of a new facility?". The Patient Panel is not there to say patients were included but to bring robust and refreshing challenge to our practice.

**Complaints reference group**
Complaints are often seen as one of the most sensitive areas of work at the Trust. So when we proposed a reference group to see how the Trust manages complaints and how quickly a response is made, with the idea that some external scrutiny would enable us as patients to feel assured about quality, it was expected that there may be some difficulty in making this work.

This has not been the case; the Panel challenged the Trust to improve both timeliness and communication and monitored this through its presence at the Quality and Safety Committee where complaints performance is reported. It is pleasing to report that at the last review no complaints were reported out of time and from the evidence seen by the Panel, overall time from receiving a complaint to making a response have gone down.

**Feedback to our regulators**
Members of the Panel were interviewed by the CQC during our inspection in June 2016; Inspectors commented that they had not seen this kind of integration or involvement in any other organisation they had visited. This was recorded as notable practice which they were keen to highlight to other organisations.

**Staff Awards**
The Annual Staff Awards have now become a permanent fixture in the work of the Panel and in 2016 the Panel presented the award to the two Student Ambassadors to the Panel; Amy Titmarsh and Gemma Louise Smith for exceptional participation and support of the Panel.

**Outreach Programme**
The local Chambers of Commerce, Harlow College, Harlow Christian and Muslim Groups were all represented at a recent meeting called to support the Patient Panel's work. The meeting has resulted in the development of live briefs, where students at the College deliver "live briefs". These are real life projects intended to give students experience of the real world of work. Other similar projects are also in development, with the local Rotary Club agreeing to support the development of green spaces and some members of the Panel helping out with gardening; planting perennials in courtyards, deadheading and maintaining patio plants in some areas.

**What's next for 2017/18**
The Patient Panel is keen to raise the tempo of its work with the hospital and has several exciting projects in the pipeline over the next year. We look forward to increasing the membership from our 20 existing members and reporting back to you in the next year.

# Optimising the hospital environment

Towards the end of 2016/17 the Trust commissioned work to develop a Strategic Outline Case (SOC) to address the hospital's estate challenge and to meet the future requirements for acute hospital services in the Harlow area. The first stage of this work is due to be completed and considered by the Trust Board in the summer of 2017.

Work conducted by the Clinical Commissioning Group (CCG) in 2016/17, identified that the current condition and poor clinical adjacencies of the estate at PAH was a legacy of historic underinvestment. Furthermore, over recent years several neighbouring hospitals have been downgraded increasing demand for emergency services at PAH. The site is landlocked; limiting the potential for future growth, and the hospital was built for a smaller population and is currently operating at full capacity.

The SOC, when completed in the summer of 2017, will set out the Trust's preferred option for meeting future estate requirements. The future footprint will be informed by two competing factors:

- The ambition to transfer activity away from the acute site through service reconfiguration and providing services in a community setting;
- The area's strategic housing and demographic growth, which will increase the size of the catchment population, requiring capital investment to meet the needs of the population in the long term.

A number of options are under consideration, including the refurbishment and development of the existing site through to a new build on an alternative site in the area.

Our Focus in 2016/17 has been to improve the maintenance of the hospital site; provide additional clinical areas and carry out extensive refurbishments.

**Backlog maintenance:** Every year we face the challenge of maintaining the hospital environment, buildings and grounds to ensure that we keep our patients, staff and visitors safe. In 2016/17 a wide range of work was completed including water safety, ventilation system maintenance, fire safety and repair of roofs, facia and guttering. A summary of the projects completed is included in the Trust Estates Annual report.

**Capital projects:** The Capital programme in 2016/17 was somewhat complex in as much as there was an urgent requirement to build additional resilience ahead of winter; to increase the overall bed capacity to support patient safety and flow through the hospital.

This resulted in the capital team having to realign a number of projects at pace to ensure delivery in year. Despite this, the team have delivered in full the equipment replacement programme for 2016/17 and been able to bring forward equipment purchased from the 2017/18 plan.

The team have also been instrumental in driving forward a very large amount of building and refurbishment to the hospital site in a much-reduced period resulting in staff and patients having access to new high quality environments. The highlights of these schemes are as follows:

**Development of a New Elective Orthopaedic Surgical Unit (OSU)**
This scheme involved the decanting and complete renovation of the old administration block into an 18-bedded Orthopaedic Unit with its own dedicated physiotherapy clinical area.

The refurbishment also included the construction of a new corridor link separating OSU from the Maternity Birthing Unit.



***OSU development***

**Refurbishment and full upgrade of Gibberd Ward into a new Dementia/Step down Unit**

This scheme involved the decanting and complete renovation of Gibberd Ward into a twenty-seven bedded Dementia/Step Down Unit. The refurbishment included the construction of six single en-suite rooms, four large five bedded bays with dedicated nurse stations and conservatories for patient relaxation area, a self-sustaining kitchen, a gym, main patient relaxation area, entrance reception and staff areas (Clean Utility, Dirty Utility, MDT room, staff room, two main nurse stations, staff toilets and changing rooms, cupboards etc.). Andy Dixon worked with the team and other experts from health care groups ensuring that the facility was suitable for dementia care patients from its' concept, design to hand over date, the completion of this project was at an accelerated rate the team are grateful for the input and continued support of those involved.


***Refurbishment of Gibberd Ward***

**Refurbishment of the Hospital Main Kitchen**

Following completion of risk assessments and taking into account the feedback from the Food Safety monitoring report, we decided to bring forward the programme of works for the hospital main kitchen from 2017/18 to 2016/17. The main kitchens have undergone a complete refurbishment including cladding the kitchen walls; installation of suspended ceilings incorporating LED lighting; and rewiring. Staff toilets, changing rooms, storerooms and the cleaner's cupboard have all been refurbished.

The challenge of refurbishing the main kitchens whilst still providing a catering service to our patients and staff was overcome by providing a temporary cook/chill catering service, bringing in modular freezers and fridges as well as providing a limited range of products in our main restaurant.

***Refurbishment of Main Kitchens***

### Drug Cabinets

The Trust identified 294 drug cabinets across all clinical areas that required upgrading; we also upgraded 16 drug storage rooms including installation of ventilation and temperature control systems; they are now environmentally compliant.

### Roads and Pathways

Investment in the Trust's infrastructure continued with the resurfacing and relining of the main patients, visitors and staff car park. This resulted in an additional 50 car parking spaces, with the introduction of barriers and one-way system ramps. This has significantly improved the site appearance; increased the number of car parking spaces available and improved the safety of our roads and pathways for patients and staff.

***Refurbishment of Roads and Pathways***

### New Windows in the Eye Unit

The replacement of the windows in the Eye unit has ensured that they meet current specifications.

***New windows in the Eye Unit***

## Plans for 2017/18

Capital Projects in 2017/18 will include development of the new Emergency Ambulatory Unit (EAU); refurbishment of Maternity Theatres and development of a new Fracture Clinic to support the repatriation of the existing fracture clinic onto the main hospital site in Harlow.

# Statement of Director's Responsibilities in Respect of the Quality Accounts 2016/17

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

**Alan Burns**

Chairman

**Trevor Smith**

Interim Chief Executive Officer

**Response to The Princess Alexandra Hospital NHS Trust (PAH) Quality Account 2016-17 from Healthwatch Essex**

Healthwatch Essex 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 services. We believe that health and social care services 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 PAH.

We recognise that PAH has been placed into special measures and that the trust was rated as inadequate by the CQC. However it is recognised that further improvements have still managed to have be made to the way that they manage patient and carer involvement. The Trust actively encourages feedback, learning from incidents, and the improvement of services. There is now a new programme Quality 1 which staff, volunteers, service users and families & friends can now judge the improvements against.

The Trust has an active Patient Panel, which has held events on emergency department changes and end of life care. In addition the PAH patient panel should be commended for their positive approach to best practice across the Eastern Region. The patient panel attend the Regional Patient Seminar and are now working in partnership with Ipswich hospital. These partnership strength the opportunity to look at co production of services, service provision and patient experience.

The Trust has seen a levelling of complaints reported 2016/7 is now at 251. There has also been an increase in the number of compliments. The Patient Experience Team where awarded the regional NHS Living the Values Award for the East of England 2017.

Once again Healthwatch Essex recognises that there is a general shortage of nursing staff in Essex and Harlow has additional retention issues because of its proximity to London. The Trust has recruitment and retention strategies in place and these must been seen as a long term solution. PAH have continued to develop the partnership with Education England to put in place to support new career development opportunities. This must remain a priority for 2017/18.

We again commend the Trust for its success in maternity services, achieving an 'outstanding' rating for Caring in the CQC inspection in 2016. Overall maternity services are rated highly alongside the gynaecological services. There was clear value in patient feedback and patient lived Experience.

Healthwatch Essex has worked closely with PAH in undertaking a research project to capture people's lived experience of hospital discharge. Due to the excellent co-operation from PAH, who engaged constructively in the light of some of issues identified in the analysis. Healthwatch Essex are

keen to work with PAH on a new research project around End of Life Care. This would be a positive step forward in find solutions to the End of Life services within PAH. This work would also support the improvement plan for PAH in this area of work and help promote best practice across Essex

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 PAH.

*Dr Tom Nutt*
*Chief Executive Officer, Healthwatch Essex*

*May 2017*

## Healthwatch Hertfordshire's response to Princess Alexandra Hospital NHS Trust (PAHT) Quality Account 2017

Healthwatch Hertfordshire (HwH) thanks PAHT for the opportunity to comment on their Quality Account.

This has been a challenging year for PAHT, having been placed in 'special measures' by the Care Quality Commission (CQC) following a grading of 'Inadequate'. The Quality Account very much reflects the actions and outcomes required to improve the Trust's performance. The priorities for 2017/2018 are therefore shaped around the themes from the CQC report, though in this document there are no timescales, percentage targets or person responsible noted for these priorities.

Despite the disappointing CQC rating there are a number of things that PAHT can celebrate and should be proud of. The 'outstanding' Maternity and Gynaecology services, the 'good' Outpatient Services, the Referral to Treatment performance, the diagnostic test performance for cancer patients and PAHT's active research programme are some of the highlights explored in this Quality Account.

Staff were also recognised by CQC as being caring and compassionate and involving and supporting patients in their care. The role of staff at all levels is a theme running through this report and there is evidence that staff are making tangible steps to ensure that patient safety and experience are improved.

As with many NHS Trusts, recruiting staff and retaining them is a problem so it is encouraging to see that the Trust is looking at a number of initiatives to attract and support staff and that appraisal compliance is improving.

Partnership working with Hertfordshire hospitals is demonstrated by the Pharmacy project and the Integrated Discharge Team work and HwH looks forward to hearing more about the impact of these projects.

It is difficult to comment on the progress of last year's priorities, as much of the data was missing from the draft report sent to us for comment. It would be good if this was addressed next year by organising the report sign off so that stakeholders see the full information in time for the Quality Account response.

Some of the technical terms and language used in the Quality Account are not always fully explained and though there was a section on safeguarding children there was nothing on safeguarding adults. However there was some good information on learning disability and autism, dementia and frailty though a few more patient stories in these sections and in the beginning of the report would have been welcomed.

The work of the Patient Panel at PAHT looks impressive and we are pleased that an HwH representative is now a member of the panel.

PAHT has demonstrated an interest in working more closely with Healthwatch Hertfordshire, and hearing the perspectives of Hertfordshire residents who use their services. We are currently discussing how we can communicate more frequently through regular meetings, data sharing, and potentially some project work in partnership. We therefore look forward to a productive year ahead working together to further improve patient experience.

*Michael Downing, Chair Healthwatch Hertfordshire, May 2017*

The Essex HOSC discussed its approach to Quality Accounts at its last meeting on 20 March 2017. Due to imminent county council elections, the Essex Health Overview and Scrutiny Committee does not intend to comment individually on NHS Quality Accounts this year. This should in no way be taken as a negative response. The Committee has, in the main, been content with the engagement of local healthcare providers in its work over the past year. In particular, the HOSC has worked with PAH in the last year in seeking reassurance about actions being taken to address CQC quality concerns and you hosted a very informative site visit in January to support that.

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.

Regards

**Graham Hughes**

**Scrutiny Officer**

**Democratic Services**

**Corporate and Customer Services**

**Essex County Council**

**E2 (Zone 4) County Hall, Chelmsford**

Telephone: 033301 34574

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***Have you visited www.essex.gov.uk/scrutiny yet?***

**Statement from West Essex Clinical Commissioning Group**

West Essex Clinical Commissioning Group is responsible for commissioning of acute health services from The Princess Alexandra Hospital NHS Trust for the citizens of west Essex.

The Trusts Quality Account focuses on the actions that have been and are to be taken in respect of the CQC assessment of the Trust as inadequate (report published October 2016). This required the Trust to be put into "special measures" to support the necessary transformation plans.

The Trust has reported against last year's quality priorities but it is not clear from the narrative whether these priorities were achieved or not. In some cases though end of year data is not available because of the timing of the draft report, year to date information has not been supplied so it is difficult to gain a sense of the level of achievement.

For 2017/18 the Trust will be concentrating on its Quality First programme. The quality priorities are intrinsically linked to Quality First under the following themes:

- Our People
- Getting the Basics Right
- Patient Focus
- Infrastructure
- Governance, Risk Management and making informed decisions.

The Trust staffs are working in collaboration with NHS Improvement, the CCG, NHS England and the CQC to ensure that patients receive the best and most appropriate care and that all aspects of the Quality First programme are addressed in a robust, timely and sustainable way.

The Trust has identified many departments and speciality teams within which improvements have been made in the last year, most notably the Endoscopy department successfully becoming accredited with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) , introduction across the Trust of an electronic system to record patients observations which sends alerts to specific staff when observations are abnormal and significantly improving the referral to treatment waiting time for patients with the median waiting time being 6 weeks (by the end of January 2017).

We would be grateful if the Trust would include 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 would also appreciate if the Trust would consider the use of the Crystal mark standard for plain English in future reports.

We could suggest that readers of the account are likely to find a glossary of terms useful, as there are many abbreviations in the document.

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.

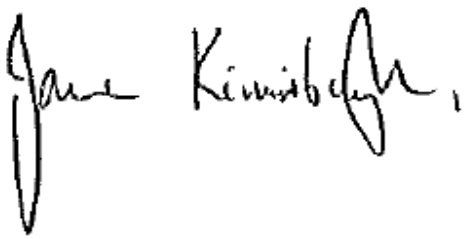
Some of the data that is required to be include for example, a comparison of the Trust results to the highest and lowest scores of other organisations has not been included, we expect this will be addressed in the final version.

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. However, there is a required section on the Trusts participation in and review of national audits and their local audit activity that was not included in the draft we reviewed, we expect this will be addressed in the final version.

The Trust is required to ensure all stakeholders have 30 days to comment on the draft quality account. On this occasion the CCG were given less time than that mandated in the Quality Account legislation.

We believe that the Account is a fair, representative and balanced overview of the quality of care at the Trust.



Jane Kinniburgh

**Director of Nursing and Quality**

**West Essex Clinical Commissioning Group.**

May 2017

**East and North Herts Clinical Commissioning Group's Response to the 2017 Quality Account provided by Princess Alexandra Hospital NHS Trust**

East and North Herts CCG (ENHCCG) has reviewed the information provided by Princess Alexandra Hospital NHS Trust (PAH) and we believe this is a true reflection of the Trust's performance during 2016/17, based on the data submitted during the year as part of the on-going quality monitoring process.

During 2016/17 ENHCCG has met regularly with both the host commissioner, West Essex CCG (WECCG), and PAH to review progress in relation to quality improvement initiatives.

The CQC inspected PAH services in July 2016, with the Trust rated overall as 'inadequate'. The CCG recognises the positive actions that the Trust are undertaking to address the concerns raised in the CQC report and their commitment to delivering against their ambitious Quality Improvement Plan. The focus on PAH staff being a key asset to the delivery of quality services is recognised, and the CCG is pleased to see that this was highlighted by the CQC's rating of 'GOOD' for caring.

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

ENHCCG notes the positive work in relation to improving complaints handling and the on-going patient engagement and patient experience work of the Trust, in particular related to PALS and complaints.

The Trust's 2017/18 Quality Priorities demonstrate the commitment to further improve the quality of care provided to patients and improve staff experience. ENHCCG is also pleased to see the on-going focus on improving sepsis identification and treatment, improving the quality of end of life care and improving outcomes for patients with AKI, building on the work undertaken in 2016/17.

Overall we acknowledge the quality work undertaken during 2016/17 in response to the CQC inspection findings; however ENHCCG wishes to see the momentum created by the inspection to be sustained and for significant focus and drive to continue to ensure on-going improvements in the quality of services delivered to patients.

ENCCG looks forward to working with and supporting PAH in further developing and monitoring the quality of services it provides for patients in order for the next CQC inspection to provide a more positive outcome and for long term improvements in quality to

be sustained. We hope the Trust finds these comments helpful and we look forward to continuous improvement in 2017/18.

Beverley Flowers
Chief Executive

**INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST ON THE ANNUAL QUALITY ACCOUNT**

We are required to perform an independent assurance engagement in respect of The Princess Alexandra Hospital NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. 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 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

**Scope and subject matter**

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Percentage of reported patient safety incidents resulting in severe harm or death
- Rate of clostridium difficile infections.

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

**Respective responsibilities of Directors and auditors**

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the 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 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 line with the criteria set out in 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 Choices 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:

- Board minutes for the period April 2016 to March 2017;
- papers relating to quality reported to the Board over the period April 2016 to May 2017;
- feedback from the Commissioners East and North Hertfordshire Clinical Commissioning Group 6 June 2017 and West Essex Clinical Commissioning Group dated May 2017;
- feedback from Essex Healthwatch and Hertfordshire Healthwatch dated May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated May 2017;
- the latest national patient survey dated February 2017;
- the latest national staff survey dated January 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 17 May 2017;
- the annual governance statement dated 30 May 2017;
- the Care Quality Commission inspection report dated 19 October 2016.

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.

This report, including the conclusion, is made solely to the Board of Directors of The Princess Alexandra Hospital NHS Trust.
We permit the disclosure of this report 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 permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Princess Alexandra Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- 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.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**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. 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.

**Conclusion**
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- 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 LLP

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15 June 2017

The maintenance and integrity of The Princess Alexandra Hospital NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the Quality Accounts since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of the Quality Accounts may differ from legislation in other jurisdictions.

# Glossary of terms

**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 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.

**Appraisals**
An act of assessing something or someone.

**Avoidable**
See unavoidable

**Board Rounds**
Visits to clinical areas of the Hospital by a Director and Non-Executive Director to assess compliance and gather patient feedback.

**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.

**Chemotherapy management system (CMS)**
CMS is a web-based solution for prescribing, scheduling and managing therapies for chemotherapy patients.

**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 inot 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.

**Clinical Pathway**
Care placed in an appropriate time frame, written and agreed by a multidisciplinary team.

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

**Compliance**
The action or fact of complying with a wish or command.

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

**CPD**
Continuing Professional Development 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.

**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**
Supplier of patient safety incidents healthcare software and risk management software systems for incident reporting and adverse events.

**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.

**Deprivation of Liberty Safeguards (DoLS)**
Part of the Mental Capacity Act 2005, DoLS aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

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

**DNA**
Did not attend (in this instance in the context of a missed hospital appointment).

**DNACPR**
A do not attempt cardio-pulmonary resuscitation order tells 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.

**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.

**EFQM**
European Foundation for Quality managemnt

**End of Life (EOL)**
End of life care includes palliative care to control pain and other symptoms and offers psychological, social and spiritual support.

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

**Electronic Patient Record (EPR)**
A series of software applications bringing together key clinical and administrative data in one place.

**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 [ward/A&E department/maternity service] 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 brand of medicine relating to the genital and urinary organs.

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

**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.

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

**Integrated Performance Report (IPR)**
A monthly report including all aspects of the Trust's performance, including quality measures.

**Malignancy**
The state or presence of a malignant tumour; cancer.

**Mealtime Buddies**
A group of volunteers who help feed patients during mealtimes in Princess Alexandra Hospital.

**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 and Healthcare Products Regulatory Agency (MHRA)**
The MHRA determine whether a product falls within the definition of a medicine – 'medicinal product' or a medical device and provides information on whether a product is a medicine or a medical device or not

**Meticillin-Resistant Staphylococcus Aureus (MRSA)**
Type of bacterial infection.

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

**National Early Warning Score (NEWS)**
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

**NCEPOD**
National Confidential Enquiry into patient Outcome and Death

**Neonatal**
New born children.

**Nervecentre**
A computer software company with a track record of providing electronic observations and handover technology

**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**
The guidance surrounding the development neutropenia. Neutropenia relates to a patient with 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 foundation trusts and NHS trusts, 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.

**Obstetrics**

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

**Oncology**
The study and treatment of cancer and tumours.

**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.

**Picture archiving and communications system (PACS)**
A medical imaging technology that provides storage and convenient access to images from multiple sources.

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

**Patient Panel**
A group of volunteers who represent patients, families and carers of The Princess Alexandra Hospital NHS Trust.

**Post Myocardial Infarction**
Commonly known as a heart attack.

**Preceptorship**
A period of practical training for a student 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.

**PREVENT**
Safeguarding people and communities from the threat of terrorism

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

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

**Respiratory**
The act of breathing.

**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.

**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.

**Service Level Agreement**
A contract between a service provider and a customer.

**Special Measures**
A status applied by regulators of public services in Britain to providers who fall short of acceptable standards

**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.

**STEIS**
Strategic Executive Information System

**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.

**Senior House Officer (SHO)**
Junior doctor undergoing training within a certain speciality.

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

**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.