

Quality Account

2017-2018

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Introduction from the Chief Executive Officer

I am delighted to welcome you to our 2017-2018 Quality Account. My gratitude is extended to the staff, volunteers and board of Princess Alexandra Hospital NHS Trust whose daily commitment and drive towards improving has ensured we deliver safe, high quality care to our patients.

This report shows the progress we have made during the year in meeting the quality objectives we set early in 2017. We were pleased that during the Care Quality Commission inspection in December 2017, they recognised the improvements we have made and we gained a rating of Requires Improvement. This is a significant achievement in getting out of special measures within 18 months. It shows the commitment and drive towards improvement delivered by our staff. All areas assessed made an improvement on this inspection and we achieved a Good rating for Effective, Caring and Well Led. I do hope our staff and volunteers will be able to share and enjoy this tremendous achievement.

In the year we have developed our 5 year Strategy: Your Future, Our Hospital and worked hard to embed this into our Trusts agreed values and behaviours. In developing our quality improvement objectives, we continue to focus on quality first as the main mantra for the coming year.

The creation of this Account has required the input and effort of many contributors and I wish to extend my thanks to them all. I hope they find the report beneficial reading. In this account we report our improvements made during the year and the future planned improvements. I hereby state that to the best of my knowledge the information contained within the Quality Account is accurate



Lance McCarthy, Chief Executive

Statement of Director's Responsibilities in Respect of the Quality Accounts 2017/18

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



Lance McCarthy

Chief Executive Officer

About this report

What is a quality account?

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

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

The report will tell you how well we did against the quality priorities and goals we set for the period of April 2017 to March 2018 and the areas we have made improvements through the year. It will also detail the priorities we have agreed for 2018/19.

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

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

Governance Arrangements

The Princess Alexandra Hospital NHS Trust (the Trust) Quality Account is prepared in line with the Quality Accounts toolkit guidance (2010-11). NHS England has advised that there is to be one change to the reporting and recommended audit arrangements for 2016/17. The Trust is required to

- Include a mandatory disclosure requirement relating to Learning from Deaths
- Include a statement on the implementation of the priority clinical standards for seven day hospital services

The Trust has established a working group of staff representatives to develop the content including all aspects identified for inclusion by NHS England. A timetable for the production of the quality account was presented and approved by the Executive Management Board in March 2018 and shared with the Trust Quality and Safety Committee in March 2018.

A draft was shared internally with the with the Executive Management Board members for peer review. It was shared with external stakeholders (Clinical Commissioning Groups, Healthwatch, Overview and Scrutiny committees for both Hertfordshire and Essex) and also external auditors at the end of April 2018.

The draft quality account was presented to the Quality and Safety Committee and Audit Committee for approval in May 2018.

The final draft document was recommended for Trust Board sign off.

Our New Strategy

Your Future, Our Hospital

Our long term plan

We launched our new Strategy in September 2017. Over 30 titles for our future plan were submitted and three were shortlisted by a multi-disciplinary group which included the Chair of the Trust Patient Panel. 548 members of staff voted on the final three and **'Your future, our hospital'** was chosen as the preferred title for our long term plan.

Your future, our hospital outlines the steps we need to take to get the Trust to a CQC rating of 'Outstanding' and to achieve a new building for the hospital. In the past there has been criticism that there has been a new plan developed each year. This has undermined confidence that the Trust has a credible long term plan for the future, which staff and wider stakeholders can believe in, engage with and support the delivery of. Your future, our hospital is a plan for the next 5+ years with a clearly described vision for the future: ***Delivering outstanding healthcare to our local community.***

To ensure "Your future, our hospital" is holistic in its approach there will be a focus in the following five areas, here forth known as the five Ps (see Figure 1):



Figure 1: Your future, our hospital – 5 Ps

Strategic implementation

To achieve engagement staff are encouraged to make personal pledges against each of the five Ps. These are then discussed amongst teams and line managers; ensuring front line staff contributes to local service five year plans. These local service plans feed into the larger departmental and Healthcare Group plans, which in turn inform the overall long term plan for the Trust: Your future, our hospital.

This will be an evolving process working from both bottom up and top down to achieve a Trust-wide 'Your future, our hospital' plan.

Trust objectives

To achieve our vision and attain an outstanding rating from regulators the Trust Board has approved 5 strategic objectives which are focussed around 5 important and interlinked components. These objectives are all based on the five P's which are **Our Patients, People, Performance, Places and Pounds** (see figure 2).

Each are as equally important if our journey to 'outstanding' is to be achieved and sustained. Working 'together in partnership' underpins the success of delivering our five P objectives. By structuring our 5 year

plans, around the five Ps we believe we have a great chance of delivering our strategic objectives and working towards our vision.

Our objectives are detailed below:






-  *We will continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures.*
-  *Our people will deliver high quality care within a culture that improves engagement, recruitment and retention reinforced by improvements in our staff survey results.*
-  *We will meet and achieve our performance standards, covering national and local operational, quality and workforce indicators.*
-  *We will maintain the safety of our places and improve the quality of our environment, whilst working with our partners to develop a strong case for a new build. This will be aligned with the development of a West Essex and East Hertfordshire Accountable Care Partnership.*
-  *We will manage our pounds and resources effectively to achieve our financial targets and control totals.*

Figure 2: Your future, our hospital – 5 P Objectives

Care Quality Commission rating

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

Our staff used the previous CQC Inspection outcome from 2016 as the foundation upon which to critically examine our services and to make significant improvements to the care we deliver at Princess Alexandra hospital. We have focused on how we plan and deliver the fundamental aspects of safe care and have taken decisive action to change everyday activities. Our staff have worked incredibly hard to deliver the improvements over the course of 2017.

In December 2017, the CQC carried out a comprehensive inspection of the Trust for six core services. These were: Urgent and Emergency, Medical, Surgery, Critical Care, Children and Young people and End of Life Care.

The outcome of this inspection was received in March 2018 and reported an overall improvement in our rating. We are now rated as **Requires Improvement** and have been removed from Special Measures.

Some of the feedback received from Ted Baker, CQC Chief Inspector of Hospitals stated:

- "Our inspectors found dedicated staff at the trust who had worked hard to ensure improvements were made"
- They also witnessed a number of areas of outstanding care, particularly in the children and young people's service"
- The trust's staff and leadership should be proud of their achievements so far and they know what they must do to ensure any remaining improvements are made"

Removal of special measures within 18 months and at the first inspection after receiving an inadequate rating is a tremendous achievement and is a testament to the dedication of our staff who have worked tirelessly to improve. We are thrilled that the work undertaken by our teams has delivered the improvement we intended following being placed in special measures and this was recognised by the CQC inspection team. The improved rating and end to special measures has delivered a huge boost to staff morale as we continue our improvement work towards a rating of good and onwards to outstanding.

There are currently no areas rated as Inadequate. Two services: Critical Care and End of Life have improved from Inadequate to Good. The Trust received a rating of **Good** for three domains of care: Effective, Caring and Well-Led, see Figure 3 and table 1.

Ratings	
Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Figure 3: Overall CQC ratings for the Trust

Ratings for The Princess Alexandra Hospital

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

Table 1: CQC rating for all 8 core services

The CQC told us that there were 17 actions we must take to bring services into line with legal requirements. These actions related to six services and the trust overall.

The CQC also identified 14 areas where we should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services. These actions related to five services and the trust overall. The services were urgent and emergency services, medical care (including older people's care) surgery, critical care, children and young people's services and end of life care.

We are working with our staff, health and social care partners and other stakeholders to deliver the required changes which will make a difference to patient care and experience.

These are detailed in the Trusts Quality Improvement Plan and our aim over the coming year is to continue to improve aiming for a rating of Good at our next inspection.

Quality First

Quality First is defined as our approach to quality improvement and organisational development; enabling the workforce and bringing about change in a sustainable fashion. 'Putting quality first will be our approach in everything we do as we strive for excellence' (Lance McCarthy, CEO), which means we have an aspiration to make putting quality first as everybody's business and this will become 'the way we do things around here'. For us quality improvement is 'working together in partnership to make the sustainable changes that will lead to excellence for our patients, people, places, performance and pounds.'

The Quality First Team

The Quality First Team is a multidisciplinary team who lead, facilitate and support quality improvement. The team's key functions are:

- To assist in the improvement initiatives; which may include cost improvement plans. This will be aimed at reducing variations in outcomes and staff practice and improving productivity.
- To support the delivery of our long term plans as part of **Your future, our hospital.**
- To lead and support our teams to improve quality of care across the Trust.
- To coordinate the delivery of all quality improvement projects across the hospital.

Improvement Partnership

The 'Improvement Partnership' was established as a method of enrolling, engaging, involving and developing our staff, so they are supported and motivated to make the changes they want to see for the benefit of our patients, staff and the wider community. Figure 4 details the 4 key elements of the improvement partnership.

The Improvement Partnership was formally launched during the national event "Fab Change Week" (13th - 17th November 2017) and was part of the launch for the Quality First team's 'best practice guidance of managing and leading quality improvement projects'. This is supported by standardised project documentation as well as a learning and development session for staff to book on to.

More than 150 Trust staff completed the 'leading change' learning and development session. From 27 February 2018 we have commenced the second training session called 'leading projects'. Following completion of both training sessions, our staff will be asked to implement a quality improvement project. Staff will receive ongoing support and guidance from the Quality First Team with their project. Once the

project is completed, the staff member will be enrolled into the 'Improvement Partnership'. We expect to see outcomes from the Improvement projects during 2018/19.



Figure 4: The four elements of improvement partnership

Priorities for Quality Improvement 2018 - 2019

Each year we assess our performance against previously identified quality priorities and patient outcomes; we make sure we are taking account of national reports, feedback from regulators patients and staff as well as learning from incidents.

This year the outcomes from the Care Quality Commission (CQC) inspection report (December 2017) has afforded us an opportunity to build upon our programme of improvement which is underpinned by the Quality 1st approach.

Our plan now is to work towards achieving the grade of "Good" at the next inspection. 2018/19 will see the Trust focus on addressing the recommendations from the recent CQC inspection report.

Table 2 is the Trusts quality improvement priorities for 2018/19. Achievements will be monitored through each sub-committee of the Board and progress will be reported to Trust Board.

Priorities for Quality Improvement 2018/2019				
Ref:	Quality Improvement Area	What we are trying to improve	What success will look like	How we will monitor progress
1. Our Patients: Improve Standardised Mortality Rate (HSMR)				
1.1	Reduce mortality and improve the Trusts HSMR	Reduce the number of excess deaths (not due to chance). Reduce HSMR from 116 higher than expected to as expected grade or less	<p>HSMR will be in the as expected range</p> <p>A reduction in the number of mortality outlier alerts from 12 by 50% = 6</p> <p>Reduced mortality from Acute Kidney Injury by 10%</p> <p>90% of patients who meet sepsis criteria will be screened for sepsis by 1/10/18</p> <p>90% of patients identified as having sepsis receive appropriate treatment within 60 minutes of diagnosis by 1/10/18</p>	<p>Sepsis and AKI board to monitor compliance</p> <p>Monthly mortality review</p> <p>Compliance checks reported through Quality dashboards and presented in line with the Governance reporting framework</p>
1.2	Improve our patients experience	Ensure patients receive personalised care and are satisfied with their experience	<p>Improved inpatient survey results, ensuring we reduce and eliminate questions that were rated in the lowest 20%</p> <p>Ensure 10 questions are placed in the top 20%. From this we want the following 3 questions to be rated in top 20%:</p> <p>Question 27: Scored 22 Confidence and trust in nurses</p> <p>Question 39: Scored 23 Care and privacy when discussion my condition</p> <p>Question 54: Scored 43 discharge support from health or social</p>	<p>Monthly report to Quality and Safety Committee</p> <p>Healthcare group performance review meetings</p>

			<p>care professional</p> <p>Reduction in complaints received from 229 by 10% = <206</p> <p>Increase the number of PALs concerns from 2923 successfully resolved and not proceeding to be complaints by 10% = 3215</p>	
2. Our People				
Ref:	Quality Improvement Area	What we are trying to improve	What success will look like	How we will monitor progress
2.1	Recruitment and retention of Registered Nurses	<p>Increase the numbers of registered nurses working across the Trust</p> <p>By reducing the vacancy rate and decreasing the turnover rate of registered nurses</p>	<p>A nursing vacancy rate of equal or less than 20%</p> <p>Staff are retained and working in the Trust for longer periods. Reduce turnover from 17.3 by 2% to 15.3%</p> <p>Develop initiatives to retain staff</p>	<p>Nursing and Midwifery retention group</p> <p>Workforce Committee</p>
2.2	Staff Culture and well being	Our staffs experience will be consistent with the Trusts Strategy, Vision, and four Values of Respectful, Caring, Responsible and Committed	<p>Every member of staff will feel the Trust values are demonstrated and evidence will come from the 2018 National staff survey.</p> <p>Ensure the following questions receive an improvement in the scores</p> <p>No.17a scored 94% staff not experiencing discrimination from patient/service users</p> <p>No.17b – scored 91% staff are not experiencing discrimination from manager or colleagues</p> <p>No.18a scored 71% staff had training and development</p> <p>No.18b scored 80% staff reported training helped me to</p>	<p>Bi-monthly review at Workforce Committee</p> <p>Health and Safety Committee</p> <p>Local staff surveys and cultural barometer to measure success</p>

		Our staffs health and well-being will be improved	<p>do my job</p> <p>No.18c – scored 82% training helped me stay up to date professionally</p> <p>No.19 scored 97% staff had mandatory training in last 12 months</p> <p>Improvement in the nursing vacancy rate</p> <p>50% of staff will feel engaged and take up involvement in local events such as:</p> <ul style="list-style-type: none"> - Weight loss - Stop Smoking - Local gym membership - Happy to share mental health concerns <p>Reduce sickness absence rate by 0.5%</p> <p>Increase in numbers of staff taking up the flu vaccine from 70% to 75%</p>	
3. Our Performance				
	Quality Improvement Area	What we are trying to improve	What success will look like	How we will monitor progress
3.1	Improvement in Emergency Department 4 hour access standards	<p>Improve the numbers of patients that receive timely treatment in the Emergency Department (ED)</p> <p>Reduce the time for patients arriving by ambulance to be handed over from ambulance to Trust staff.</p> <p>Reduce Length of stay for conditions currently outside the benchmark best practice</p> <p>Timely transfer of critical care patients to wards</p>	<p>The department will achieve 90% standard by 30/9/18</p> <p>Achieve 95% standard by 30/3/19</p> <p>Reduce the length of time patients spend in the ED (focus on Minor Injuries and paediatric areas)</p> <p>Reduce ambulance delays</p> <p>Reduced length of stay for outlier conditions and variations</p> <p>Improve numbers of</p>	<p>Improvement in access standards monitored through IPR</p> <p>ED delivery board</p> <p>Length of time patients spending in the ED monitored through performance reviews</p> <p>Patient experience monitored by patient survey and feedback</p> <p>Monitor length of stay at performance reviews</p>

			discharges earlier in the day Reduce the number of patients delays of more than 4 hours Improve patient experience	
3.2	Improve performance against access standards for: Referral to treatment (RTT) Cancer performance	Recovery of performance against the RTT incomplete to the national Standard across the Trust and in line with the NHS constitution Maintain performance against all national cancer standards, including recovering the Urology position No patients to be over 104 days on cancer pathways, unless clinically appropriate or the patients choice	Delivery of RTT incomplete standard by the end of June 2018 Consistent delivery of the cancer national standards and the internal PAH 7day standard Extend the one stop diagnostic services already available in Breast and Urology to other key specialities Maintain delivery for the rest of 2018/19	Monthly through Patient Target List meetings Access Board Cancer board Performance and Finance Committee Trust Board IPR Trust Board
3.3	CQC preparation to obtain Good at time of next inspection	Ensure PAH is regulation ready Deliver objectives detailed within the Quality Improvement Plan (QIP) Ensure Trust maintains all the improvements implemented during 2017 Use the appreciative enquiry model for teams and staff preparation Staff to be clear about what it takes to achieve both good' and 'outstanding	Implement and deliver CQC preparation plan Deliver all items on QIP as underlying causes and root cause Improve services graded as Requires Improvement and maintain or improve position Focus on Well led to maintain and improve position	Quality Improvement Plan (QIP) milestones and output tracker. Monthly internal review at Quality and Safety Committee System Improvement Board (with local partners) CQC inspection report
4. Our Places				
	Quality Improvement Area	What we are trying to improve	What success will look like	How we will monitor progress
4.1	Clinical areas and critical functions to be refurbished	A clear risk assessed and prioritised list of Estates works fully costed.	Plan for implementation approved by the Board of Directors Bring the orthopaedic fracture clinic back on the Harlow site Refurbishment of our cancer care facilities	Compliance with agreed milestones and outputs. Monitored through the Health and safety Committee Quality and Safety Committee

			Create an onsite education facility	Risk committee
			Refurbished the lifts	
			Complete work to upgrade the electricity systems	

Table 2: Trusts quality improvement priorities for 2018/19.

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.

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 bi-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.
- Weekly 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. 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.
- Bi-monthly progress will be discussed with NHS Improvement and our partners.
- The bi-monthly report will be shared on the Trust website for staff and service users.

Statements relating to quality of care provided

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

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

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

Table 3: Directory of Trust Services

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 2017 -2018 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 2016 – September 2017	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 HSMR 118.4 – Higher than expected	1.09	100.0	The Trust's mortality falls into the 'as expected' range when compared to national data baseline. The Trust is one of 105 non specialist hospitals in this group The Trust is continuing to conduct actions in line with our Morbidity and Mortality Strategy, which includes learning from all deaths.
12b	The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	2.78%	3.66%	Further training for staff to understand and implement more robust clinical coding – improved from 1.88% in 2015/2016. Better communication between coders and doctors and Advanced Practitioners. Continuation of escalation process for coding difficulties.

Table 4: Standardised Hospital Mortality Indicator
Source of data NHS Digital

Learning from Deaths

Mortality Reviews

The Trust has developed a process to ensure that there are review and internal reporting and learning from all deaths that occur at the Trust. This process also includes the feedback from families and carers if they raise a concern as they are integral to the process.

Policy - The Trust implemented Learning from Death Policy in April 2017. This is available on the intranet for all of our staff.

Death Review – We have formed a Mortality Steering Group, which is made up of doctors who are responsible for undertaking reviews of care given to patients who have died in the hospital. If concerns are identified, the doctors escalate them using the Trust incident reporting process. A modified version of the Royal College of Physician Mortality Review tool is used to complete these reviews. A named reviewer within each Healthcare group is the nominated lead. The Trust is also making progress with implementing Medical Examiner reviewers.

Reporting to Trust Board & Committees - The Trust provides Mortality information to Trust Board since July 2017. A monthly report on mortality is shared at both the Patient Safety and Quality Group (PS&QG) where senior clinical leaders review the detail and decide on actions to be taken. The Quality and Safety Committee (Q&SC), a sub-committee of Trust Board has oversight to ensure that there is assurance around the quality and safety of care across the Trust.

In September 2017 the Chief Medical Officer led a training session for Trust Board members to explore how they can demonstrate learning from deaths.

Involvement of Families – The Trust has carried out two bereavement surveys. The first survey highlighted some concerns around communication with families which we are addressing. The findings from the second survey are due to be shared in the summer of 2018.

At every Trust Board meeting, a patient story is shared with Board members. The patient or their family may present with a video and audio recording of their experience of care at the Trust. The aim is to share the impact of care given from the perspective of the patient and their family. Where gaps in service delivery are identified a discussion with the service leaders takes place to seek assurance that improvements have or are being implemented. Where good practice is presented, it is shared and feedback given to individual teams.

End of Life Care

We have worked with our doctors and nurses to improve the quality of completed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms and instructions. Using best practice standards, we regularly review the completed forms to ensure that the decisions being made with patients and their families are well documented and meet internal professional standards. The reviews include exploring what was discussed with patients and family members; this allows us to identify good practice and also areas for improvement. All of the findings are shared with staff to ensure that we are continually improving.

Mortality Alerts & Coding

All deaths occurring in the Trust are examined as part of our Mortality reviews. We use a company called Dr Foster who analyse all patient deaths across England; this gives us helpful comparisons, of how we are performing against other hospital Trusts. From this comparison every Trust is assigned a rating of how they are performing overall for patient deaths. The ratings are:

- lower than expected
- as expected
- higher than expected

At the Princess Alexandra hospital NHS Trust we use the monthly comparison of our performance against other Trusts to help us to identify the areas where we need to improve. Dr Foster provides alerts to those highlight clinical conditions where we have received a rating of worse than expected, when compared to other Trusts in England.

Whenever the Trust receives an alert, we examine the healthcare records in order to review and assess the care given to those patients whose deaths are part of the alert. The clinical staff completes a written report highlighting any areas where we need to make improvements as well as highlighting good practice. All of the findings are shared at the Trust PS&QG and the Q&SC in order to oversee the improvements that are required.

In 2017 the Trust commissioned an extended review of coding by the consulting firm, Maxwell Stanley and this revealed that the quality of coding could be improved if we adjusted the number and skills of the Coding team. Work has started to improve the process for coding healthcare records by creating closer working relationships between the coders and doctors prior to completion of the death certificate.

Learning from Deaths of People with a Learning Disability

All deaths of people with learning disabilities and/or autism are also reviewed by the learning disabilities team to determine any commendable practice or areas for improvement. The Learning Disability Team regularly attend the Mortality Steering Group.

The Trust participates in to the national review of deaths in people with learning disabilities (LeDeR) facilitated by 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. In circumstances where the independent review identifies any areas of concern, the death will be referred for a secondary multidisciplinary review. The aim of the scheme is to identify themes which may have contributed to the

death of the person, and to highlight good practice. The work is designed to enable the collection of data to examine why people with learning disabilities statistically die younger than the general population.

At the time of preparing the Quality Account, there has been one completed review of the six deaths that have been reported to LeDeR. This review was called to a multidisciplinary meeting by the external reviewer. The feedback was as follows:

- Poor communication with the family. They felt they could have been kept up to date in a more timely way.
- Poor communication between healthcare professionals from within the hospital e.g. our nutrition multi-disciplinary team clearly documenting that the patient was not suitable for a specific type of feeding (PEG). Whereas the documentation in the notes stated that that the patient was on the waiting list for a PEG tube to be inserted.
- Inappropriately worded DNACPR documentation. Poor communication with the family and carers about the DNACPR decision.
- Making the decision at a late stage that the patient should be for end of life care.
- Confusion around discharge planning for the patient once the end of life care decision was made.
- The family and carers wanted to take the patient home to die but due to the seemingly inadequate discharge planning the patient unfortunately died in hospital.

Since this review, the Trust has implemented a revised DNACPR form. In addition we have rolled out Treatment Escalation Plans which are completed to guide clinical staff as to how much treatment should be undertaken for patients who are coming to the end of their life. The changes are aimed at improving clinical decision making and strengthening communication with the patient and family at end of life.

All the DNACPR forms completed for patients with a learning disability and/or autism are audited by our learning disability team and any that are inappropriately completed are escalated to the medical doctors. The learning disability team have included end of life training to increase awareness of end of life care for people with a learning disability and/or autism and to improve awareness on the importance of maintaining communication with family and carers.

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 which the patients should bring in with them. Detailed in this will be the reasonable adjustments and in-depth holistic assessments of the patient. This will ensure our clinical staff are aware of all relevant information about the patient.

Risks and challenges: We continually strive to improve our patient's outcomes and decrease mortality. Despite our on-going efforts and improvements implemented this year our hospital standardised mortality continues to remain at higher than expected.

This risk is reflected in our Board Assurance framework and in the service Risk Registers.

We are optimistic that from implementing the mortality review process, learning from deaths and the planned move towards medical examiners in each service, this will result in further improvements. We will continue to give specific focus to all clinical conditions where our performance is outside that of peer Trusts.

The number of preventable deaths is identified as low, less than 1%. We intend to further review this information over the coming year. We will continue to undertake a regular case reviews to review care given and discuss the details of care to look at service speciality cases.

The challenge going forward is to continually improve against a back drop of high hospital attendances, delays to the admission to the hospital, the admission of patients with multiple

complex health issues and an increasing elderly population.

This is a Board priority and is point 1.1 on our improvements for 2018/19

Patient Reported Outcome Measures (PROMs)

PROMs are measures of health outcomes in patients undergoing four planned surgical procedures: hip replacement, knee replacement, varicose vein and groin hernia surgery. In England all patients having these procedures should receive a questionnaire both before and after surgery.

Data was collected on varicose vein and groin hernia procedures in England, however following on from a NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Finalised data for varicose vein and groin hernia procedures for period April 2017 to September 2017 is detailed in table 5.

The data for hip and knee replacement surgery covers the period April 2017 to December 2017 and is detailed in table 5

Improvement Rate by Procedure and Measure for April 2017 to September 2017

PAH	National
EQ5D Index Groin Hernia: 50.0% Varicose Vein: 36.4%	EQ5D Index Groin Hernia: 51.3% Varicose Vein: 51.1%
EQ-VAS Groin Hernia: 28.6% Varicose Vein: 41.7%	EQ-VAS Groin Hernia: 39.1% Varicose Vein: 39.6%
EQ5D Index Hip Replacement: 93.8% Knee Replacement: 86.3%	EQ5D Index Hip Replacement: 90.2% Knee Replacement: 83.2%
EQ-VAS Hip Replacement: 66% Knee Replacement: 54.7%	EQ-VAS (Primary) Hip Replacement: 68.4% Knee Replacement: 58.6%

Table 5: Trust data on Patient Reported Outcome Measures
Source of data NHS Digital

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	National Average	Improvement action Plan
	October 2017 – September 2018	Updated 2013	
Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period		National Acute (Non Specialist) 8.1% observed Lowest 5.8% Highest 10.5%	<i>NHS Digital has suspended the updating of this information from December 2013 pending a review of the methodology.</i>
(i) % of patients 0-15 years of age	PAH 0-14 5.0% observed	National Acute (Non Specialist) Aged 0-14 9% Observed Lowest 4.1% Highest 14.4%	
(ii) 16 years and over	PAH 15 or over 7.7% observed	National Acute (Non Specialist 15 or over 8.0% observed Lowest 5.8% Highest 10.8%	Flagging of patients on re-admission Priority referral to home team (who are familiar with patient and are able to make the best plan for the patient) 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

Table 6: Trust data on Percentage of Patients readmitted within 28 days

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 experience of care.	2016 -2017	2017-18	Improvement action plan
	Number of PALS cases resolved	<p>79% (n=2119) of 2683 cases resolved within 48 hours</p> <p>No national comparison available therefore</p> <p>Highest Month 250</p> <p>Lowest Month 164</p>	<p>9% increase to 2923 cases received</p> <p>Of those received: 53% were resolved within 48 hours 77% within 2 weeks 96% within 2 months</p> <p>Lowest number per month: 197 Highest number in a month: 290</p>	<p>The performance of the Trust in resolving PALS cases at a local level has deteriorated.</p> <p>There is evidence of operational pressure particularly due to elective cancellations over the Winter have affected the pace at which these cases are being resolved.</p> <p>We believe the significant changes to be made in 2018-19 will support an improvement in this performance.</p> <p>Actions:</p> <p>1. Move Patient Advice and Liaison Service to the main entrance to be part of the meet and greet volunteers and Chaplaincy Services. The aim is to improve access and reduce the time to a resolution.</p> <p>2. Support the development of an Information and Signposting Hub in Main Entrance to enable access to information and proactive support from specialist and voluntary sector teams.</p>

Table 7. Trust responsiveness to personal needs
Source: Trust held data on Datix

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 2017	Trust's nationally set target for this question	Improvement action plan
	<i>Friends and Family Test - staff</i>	<p>75% of staff</p> <p>637 staff responded</p>	<p>DoH Target is 67%</p>	<p>Improve communications with all staff around survey to ensure more respondents.</p> <p>Continue to provide information and briefings to all staff on improvements.</p>

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

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 2017-18	National Average	Improvement action plan
	Friends and Family Test – patients	<p>94.75</p> <p>Lowest average across four data sets is 57% on Kingsmoor Ward in September 2017</p> <p>Highest average score 100% on Alexandra Day Surgery Unit with consistently good scores throughout the year.</p> <p>Followed by Penn Ward with 99.8% average over 12 months</p>	National average is 93%	<p>Implementation of Patient Experience Minimum Standards actions to include:</p> <ol style="list-style-type: none"> 1. Implementation of Talk to Me campaign across all HCGs 2. Development of Sensory Ambassadors 3. A volunteer on every ward, every day with buddying so that staff support volunteers and monitor experience. 4. The Electronic Feedback System will go live with a patient app, staff app and ward level, wall mounted touch screen feedback devices.

Table 9: Patients Friends and Family test results
Source: NHS Choices

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 2017	March 2018	National target	Improvement action plan
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	98.7%	<p>98.3%</p> <p>Trust internally set target is 98%</p>	<p>95.36% England Average Q.3</p> <p>October – December 2016</p> <p>Lowest 76.08% Highest 100%</p> <p>National target is 95%</p>	<p>Continue failsafe check lists at ward level.</p> <p>Continue using the VTE risk assessment proforma.</p> <p>Patient leaflets available in clinical areas.</p> <p>Patient Safety Thermometer includes a question about preventative (prophylaxis) medications being given.</p> <p>Process for poor compliance shared with all ward and departments.</p> <p>Continue with Anticoagulation Nurses undertaking teaching at ward level and for all new doctors.</p>

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

24. The Princess Alexandra Hospital NHS Trust considers that this data is correct at time of writing the report

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 April – March 2017 to 18	PAHT Target	Improvement action plan
	<p>C-Diff - cases on national surveillance database</p> <p>C-Diff - cases attributable to PAH (total less successful appeals)</p> <p>Therefore rate per 100,000 bed days for PAH = is 7.86</p> <p>This is a reduction from 2016/17 when the rate was 10.7</p>	<p>Trust apportioned 14</p> <p>8</p> <p>7.86</p>	<p>10</p> <p>Latest National Figures for England C.Diff rate per 100,000 bed days</p>	<p>Continue with personal protective equipment and hygiene by clinical staff. Monitor compliance</p> <p>Continue responsible use of antibiotics</p> <p>Timely isolation of patients</p> <p>Continue thorough cleaning and monthly cleaning and hygiene code audits</p> <p>Continue hydrogen peroxide decontamination.</p>

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

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 <u>severe</u> harm or death.	*Number of Severe harm/ Serious Incidents and incidents resulting in death	*Severe Incident National Average from 1 April to 30 Sept. 2017	Severe harm Incident for Trust Average from 1 April to 30 Sept. 2017	Incidents resulting in death. National Average from 1 April to 30 Sept. 2017	Incidents resulting in death for the Trust Average from 1 April to 30 Sept. 2017	Incident reporting rate National Average from 1 April to 30 Sept. 2017
	<p>The total number of incidents in 2017/18 was 9580</p> <p>From this the total number of incidents of 7,083 have been uploaded onto the NRLS during 2017/18.</p>	<p>14 Severe harm incidents at time of data submission to NRLS and on (StEIS)</p> <p>1 Death on NRLS at time of data submission.</p> <p>31 Serious Incidents uploaded to StEIS.</p>	0.39%	<p>14 incidents</p> <p>0.16 per 1,000 bed days</p> <p>of all incidents</p> <p>SI Trust Average is 2.6 SI's/month</p>	<p>1 incident per 1,000 bed days</p> <p>0.03% of all incidents</p>	0.03%	<p>Trust rate 3,565 (39.92% per 1,000 bed days)</p> <p>The national data for organisations within Trust cluster (Acute non-specialist) is 42.23 incidents per 1000 bed days.</p>

Table 12: Rate of safety incidents

Reference for National Data is as provided for Acute (non-specialist) organisation in the NRLS organisation patient safety report on six months data from 1/4/2017 to 30/09/2017 - data is only provided on severe harm levels not serious incident numbers.

26. Statement on Seven Day Hospital Services - As a Trust we are working towards implementation of seven 7 day services.

Our assessment of the current position against each of the 10 clinical standards for a seven day service is:

1. Patient Experience – partially implemented (real time feedback will commence by 30/9/2018)
2. Time to first consultant review – partially implemented
3. Multi-disciplinary team review – partially implemented (core MDT services are available for 7 days per week)
4. Shift handover – fully implemented
5. Diagnostics – partially implemented
6. Interventions/key services – fully implemented (using hub and spoke model for services we do not operation at the Trust)
7. Mental health – work in progress (we are working with our colleagues in mental health)
8. Ongoing review – partially implemented
9. Transfer to community, primary and social care – fully implemented
10. Quality improvement – fully Implemented

27. Hospital Deaths

Hospital Deaths: 2017/18		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
27.1	Patient deaths in hospital	253	247	301	382	1183
27.2	Case reviews completed by clinical teams	51	24	47	66	188
27.3	Estimated number of deaths where case review identified problems with care provided	0	0	2 (0.66%)	0	2

Table 13: Hospital Deaths

We have several processes whereby we undertake a review of care given for all patients that die. This includes mortality and morbidity reviews, responding to Dr Foster alerts and national audits in which we have participated. The Trust has an adapted mortality and morbidity review tool for use across all services. The Trust has developed concise and comprehensive root cause analysis investigation templates that are used for all Trust investigations.

Using the root cause analysis templates, the two cases detailed in 27.3 both showed some areas of concern in relation to care or service delivery but did not identify any direct contribution to the death of the patient.

The mechanism for capturing all case reviews has been variable in 2017/18. Our process for tracking case reviews undertaken on a monthly basis requires urgent revision to ensure that we can detail with confidence the total number of reviews completed in 2018/19.

27.4 A summary of what we have learned from the case reviews and investigations identified in 27.3

- Variable standards of recordkeeping associated with cardiac arrests
- A requirement to introduce debriefing for all staff involved with the unexpected cardiac arrests
- Decision making is not always shared with the whole team
- A requirement to review supporting policies and procedures related to a particular clinical intervention associated with the death of a patient

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

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

- Over medicalisation: The Trust has introduced treatment escalation plans for patients who have been identified and assessed as in the last year of life. The use of the new plan is ensuring that staff talks to the patient and their family/carers early about the prognosis, treatment options and outcome of their illness. This enables the patients to have a say in how much ongoing treatment they want, this will include discussing the full range of treatment options. The patient or their family and the doctors then set a ceiling on the level of treatment to be given.
- Inaccurate clinical coding: Consultants now review the notes of all patients who have died to ensure the correct diagnosis is listed to ensure we correctly code the treatment given. In addition we have improved the dialogue between the clinical and coding staff.
- Inaccurate diagnosis of COPD: has been addressed through the provision of education and training for our local GPs and junior doctors.
- Timeliness of access to theatre for patients with a broken hip: We now run an additional emergency operating list at the weekend which means that we can operate on this group of patients on a daily basis.
- Compliance with the six key initial actions for suspected sepsis: This year we have improved significantly on our audit of treatments given to patients.

- Standardisation of care: The Trust has introduced treatment bundles (which are separate items of treatment and care given for a particular diagnosis) and introduced this for patients being treated for pneumonia and sepsis.
- End of life pathways: In 2017 we welcomed a new specialist consultant and allied health professional in end of life care. This means that we are now able to provide the service six days per week; all patients are seen within 24 hours of referral. We have worked closely with our community partners to aid the discharge home for patients who want to spend their last days of life in their own homes.
- Failure to manage a deteriorating patient: Alerts are sent to senior staff (nurse in charge, doctors) when a patient's clinical observations deteriorate. We have improved the quality of documentation associated with cardiac arrests.

27.6 The impact on the actions detailed above has been:

- There has been an improvement in the clinical coding which is demonstrated through the annual audit and use of the palliative care code.
- We have improved the capture of data to monitor our compliance with the six key standards of care for sepsis and can evidence that it is robust. The performance in 2017/18 has been variable but we are assured that the data is completely accurate.
- End of life patients are all reviewed by a member of the specialist palliative care team within 24 hours of referral. We opened Gibberd ward as our dedicated area with the facilities and staffing to support patients and families at the end of life. Full details of the improvements made to the care given to this group of patients and their family is detailed in section 1.4.
- During 2017/18 the Trust has not had any patient deaths as a result of a failure to manage clinical deterioration.

27.7 The number of case reviews or investigations completed in 2017/18 relating to care given to patients in 2016/17 was four.

27.8 From the case reviews and investigations completed in year relating to care in 2016/17, we estimate the number of deaths as a result of problems in the care given to patients to be zero.

27.8 From the case reviews and investigations completed in year relating to care in 2016/17, we estimate the number of deaths as a result of problems in the care given to patients is 1

The tool used for these reviews is a modified version of the Royal College of Physician Mortality Review tool is used to complete the mortality reviews. The Trust has developed a concise and a comprehensive root cause analysis investigation template that is used for all Trust investigations.

27.9 A revised estimate of the number of deaths during the previous reporting period detailed in 27.3 (2) and the additional case detailed in 27.8 (1) is a total of 3 patients. The total number of deaths identified in 2017/8 found to have been the result of care or service issues is: 0.25%

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 fortnightly Operational Data Quality Group, the Performance and Finance Committee and Board of Directors.
- We continue with clinical validation of medical records coding to ensure the accuracy of data for national and local benchmarking.
- The use of data quality risk registers to manage data quality risks/issues and monitor the actions the Trust takes to mitigate those risks.
- The Data Quality dashboard is published weekly to support monitoring and operational resolution of data quality issues

- NHS Data Quality Maturity Index overall the Trust scored 97.1% (July-September 2017) 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 2017/18 as at February 2018 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 (2016/2017 in brackets).

Which included the patient's valid NHS number was:

- 99.7% (99.7%) for admitted care
- 99.8% (99.7%) for outpatient care
- 98.3% (98.1%) for accident and emergency care

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

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

Information Governance (IG) Position Statement

The Trust's Information Governance Toolkit (IGT) publication score for 2017-18 (V14.1) was 82%, with no requirements showing below level 2. The Trust remains satisfactory and continues to be rated green.

The General Data Protection Regulations (GDPR) will be replacing the Data Protection Act on the 25th May 2018. The Trust has been preparing for this in the following ways:

- We have setup a working group of key staff members as our stakeholders to oversee the implementation of GDPR and our action plans.
- We have implemented a robust Data Protection and Privacy Impact Assessment process, as required by the GDPR.
- We are reviewing our contractual arrangements with any processors, to ensure they are protecting personal data through robust technical, security and organisational measures.
- We have begun an information audit to identify all data flows, as required by the GDPR.
- We have added GDPR-focused sections to our Information Governance training handbook, so staff are aware of the requirements and are able to implement projects with the changes and privacy by design and default in mind.
- We are updating our existing procedure's to deal with data subject access requests, deletion requests, and disclosure of information requests.
- We are repeatedly assessing our Information Governance program as central guidance and Health and Social Care interpretations of GDPR are released.
- We have drafted our fair processing notice to ensure that we are open and clear about the information operations we carry out to ensure we are processing your information accordingly, securely and efficiently.

Clinical Coding Audit

PAH was subject to an Annual Information Governance clinical Coding Audit that was carried out by Clinical Classifications Service Approved Clinical Coding Auditors using the NHS Digital Clinical Coding Audit Methodology Version 11.0.

A total of 200 finished Consultant episodes across a range of specialities were audited. The accuracy rates report at the time is detailed in table 13 for Diagnosis and procedure coding was:

PAH Attainment Level for Information Governance Purposes		
<u>Subject Area:</u>	<u>(%)</u>	<u>Level</u>
Primary diagnosis	91.5	Level 2
Secondary diagnosis	91.1	Level 3
Primary procedure	90.8	Level 2
Secondary procedure	86.9	Level 2

Table 14: Accuracy rates of diagnosis codes

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 that the overall standard of the coding at the Trust is of good quality, and coders demonstrate good abstraction and code assignment skills, notably in the coding of complex cases and within the Obstetric speciality. The audit found that all recommendations in the previous year's audit had been actioned. The Trust will continue to improve its accuracy of coding, and will be focusing on improvements to address recommendations made as part of this audit.

Achievements and challenges in 2017-2018

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

1.0 Safety Culture

1.1 Deliver getting the basics right and improve the compliance with essential safety standards

Our aims for 2017/18: To improve compliance with essential safety standards of emergency equipment controlled drugs and drug fridge temperature monitoring.

Our achievements:

- We implemented a daily safety checks with supporting documentation to use to monitor emergency equipment in the resuscitation trolleys, review of stock levels for controlled drugs and confirmation of daily monitoring of drug fridge temperatures.
- At the end of the month all wards and departments enter their daily compliance information on a shared data base. Table 15 shows the Trust results broken down by quarters and over the year. The standard we expect is 98%.
- Where an area falls below the 98% standard the staff will undertake safety huddles to understand

the reasons for variable practice. Sub optimal performance.

- Performance is challenged at the face to face Executive Challenge meetings with every service

	Q1	Q2	Q3	Q4	Trust Overall
Resus Trolley Checks	97.3%	99.7%	98.9%	97.4%	98.3%
Controlled Drugs Checks	95.4%	99.0%	98.9%	95.1%	97.1%
Fridge Checks	98.5%	99.0%	98.7%	96.4%	98.2%
Difficult airway trolley checks	82.1%	97.3%	98.9%	98.9%	94.3%

Table 15: Trust compliance for safety checks during 2017/18 Accuracy rates of diagnosis codes

Outcome: Fully embedded in practice.

Resuscitation Improvements:

Our achievements:

- The old system of checking a resuscitation trolley required **256** individual items to be reviewed. Compliance was **38%**.
- In year the resuscitation team have changed the stocking, checking and replenishment system for the Trust that makes the process easier for staff.
- Significant improvement as a result of implementing the new trolley packs which reduces the number of items to be checked to 64 per week. This has also resulted in a cost saving of £97.00 per trolley; we have 42 trolleys across the Trust. Picture 1-2 shows resuscitation trolley packs.
- The resuscitation team audits completed every 3 months, show improved compliance from 38% in 2016/7 to **98%** last year.



Pictures 1-2: Resuscitation trolley packs.

Resuscitation Training – We have

- Expanded the curriculum of resuscitation education in line with national recommendations and deliver Advanced Life Support (ALS) to senior doctors and nurses who respond to emergencies.
- All our junior doctors attend the ALS training to ensure they are safer clinicians
- Changed focus from reacting to emergency situations to preventative strategies which is completely in line with National Institute for Health and Care Excellence (NICE) and The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations. The training covers how to recognition and prevent a patient deterioration, manage a patient deteriorating, how to recognise Sepsis and Acute Kidney injury.
- Introduced Paediatric Level 3 courses: Compliance 84%.
- Introduced Adult Level 3 courses: Compliance 77%.
- Developed an E-Learning package to support Level 2 education
- The resuscitation service have presented in year at the European Resuscitation Congress, Patient Safety First Conference and Scottish Resuscitation Officers Scientific symposium.

Outcome: Fully embedded in practice

1.2 Improve the identification and treatment of patients with Acute Kidney Injury:

Our aims for 2017/18:

To ensure patients who are leaving hospital are aware if they have an acute kidney injury (AKI) to facilitate monitoring in primary care.

Our achievements:

- Upgraded the laboratory computer system to allow the Trust to provide real time electronic alerts to our doctors. When alerts are received, if deterioration has occurred a senior doctor is available to advise staff about the appropriate monitoring and what actions to take next.
- Training is given to all junior doctors when they join the Trust every August during their induction and senior nurses also receive training.
- Improved patient outcomes demonstrated through:
 - The % of patients in whom state of AKI improved increased from 2.5% to 10.9%.
 - Percentage of patients whose AKI has deteriorated has reduced from 11% to 5.1%.
- We have a Board to monitor the progress of AKI. The board are responsible for ensuring we are continually improving and will monitor progress against the annual objectives. As patients with AKI often have Sepsis we have set up a joint board to oversee our performance for patients with one or both of these conditions.

Outcome: Partially embedded in practice

1.3 Improve timely identification and treatment of Sepsis in the Emergency Department and on inpatient wards:

Our aims for 2017/18: Early recognition and treatment with improved antibiotic prescribing. Patient with sepsis receive appropriate treatment within 60 minutes of diagnosis of sepsis. Reduce antibiotic consumption.

Our achievements:

- Appointed a Consultant and a nurse to lead the project
- A board has been developed to monitor the improvements for patients with either Sepsis or AKI
- Identification of sepsis within 1 hour target: Emergency Department (ED) improved from 74% to 86%. Ward performance has reduced from 100% to 90%. To rectify this deterioration a plan is in place to undertake specific ward training programmes to improve the knowledge of staff in recognition of sepsis across inpatient areas
- Timely treatment of sepsis in ED has reduced from 92% to 87%. A specific group of patients identified in those not treated within one hour were on chemotherapy and they initially presented to the hospital by going to the chemotherapy day unit where they have their chemotherapy. By the time they were seen and then directed to the ED, a considerable part of the one hour timeslot in which we aim to give antibiotics had passed. We are undertaking work jointly with the chemotherapy unit to address this.
- Administering antibiotics on wards within one hour of identification of sepsis has improved from 78% to 82%.
- Antibiotic consumption has increased in year to 5.5%
- All staff now receive training on recognition and management of Sepsis as part of Adult and Children Life support training

Outcome: Partially embedded in practice

1.4 Continue to enhance the care people receive at end of life while in hospital.

Our aims for 2017/18:

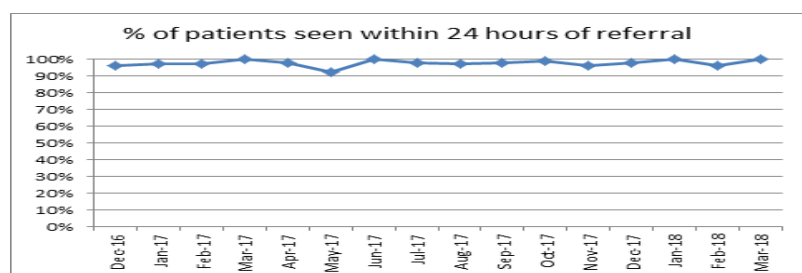
To provide an appropriate care plan, agreed with the patient and their appropriate next of kin when approaching the end of their life.

To enable early transfer to the patients preferred place of care.

Our achievements: The assessment of our end of life care moved from a grade of Inadequate to Good

Specialist Palliative and End of Life Care Team:

The service has expanded during 2017/18 and as a result the team are available to deliver specialist advice, education and support over 6 day a week, including bank holidays. Since this expansion the majority of patients referred are seen within 24 and all within 48 hours, results detailed in graph 1.



Graph 1: Percentage of patients seen within 24 hours of referral to the specialist palliative care team

The expansion is the result of:

In May an Occupational Therapist post was extended to full time hours to further enhance end of life care by being able to respond rapidly to patient requests to go home.

We recruited a substantive Consultant who started with the Trust on 30th October 2017.

- **Documentation:** an individualised care plan for the anticipated last days of life was developed and has been in use since 3 March 2018.
- **Ceilings of Treatment:** It is nationally recognised that identifying patients in their last year of life is a challenge. To address this, the Trust employed a Ceilings of Treatment Senior Nurse Advisor. Our senior nurse advisor worked with the multi-professional team, our local health partners and the National Health Service Improvement (NHSI) End of Life Collaborative project. The outcome was the implementation of a Treatment Escalation Plan (TEP) which was successfully piloted and rolled out across the hospital. This innovation received national recognition when the NHS Improvement End of Life Collaborative announced us as the winner of the “Most Inspiring Trust” Award this year.
- **Patients at the heart of the hospital:** To enhance staff awareness of patients at the end of their life we now use the symbol detailed in figure 5, with patient/carer’s permission, above their beds so that visiting staff to the area can maintain sensitivity around the vicinity.

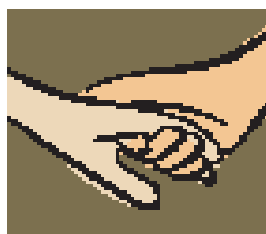


Figure 5: Symbol for a patient on End of Life Care

- **Gibberd Ward:** Provides 24 hour specialist care to meet the needs of patients living with dementia and also for those who are approaching the end of their life. The unit is staffed by a Multi- Disciplinary team who are trained to support patients and their family/ carers. Patients are transferred to Gibberd ward from other wards within the Trust if they are identified as likely to benefit from the specialist setting. The unit has 27 beds, including 6 single rooms. All single rooms have ensuite toilet and shower facilities. Families with loved ones on Gibberd have said

“A big thank you for the excellent care that their mother was given whilst in the care of Gibberd ward”.

Late patients’ son would like to thank Gibberd Ward staff. “It made all the difference being over in that

ward. Staff were so kind and helpful. Everyone should have this quality of care at the end of life. Made it so much easier, thank you”.

- **End of Life Champions:** The Trust had previously not implemented the End of Life Champion role but over the course of this year we have received requests from 58 staff from all areas. So far 17 staff has successfully completed their training and now wears a Champion badge to make them easily identifiable.
- **Support and development of Staff:** All new clinical staff that joins the Trust receives End of Life training as part of their mandatory induction to the organisation. As a result we have raised awareness of resources to support in the recognition and delivery of required care.
- **Carers:** We offer open visiting, including overnight when a patient is nearing the end of their life. Family members and carers are given carers cards which is an invitation to visit for as long and as often as they wish. They also receive, concessionary car parking and offers of refreshments. We believe that the care of family members and carers is of equal importance as the care of the patient.
- **Bereavement Survey: In October 2017** the Trust undertook our first bereavement survey with support from members of our Patient Panel. With participant consent, a telephone survey was conducted with 32 recently bereaved families. The feedback received overwhelmingly identified that the care the patients and families received was kind and compassionate. The findings (some described below) were discussed at the End of Life Steering group. Going forward questions will be adjusted to enable us to explore where further improvements need to be made.
- **Butterfly Volunteers:** - On 15 January 2018, we launched the Butterfly volunteers in collaboration with the Anne Robson Trust. This is a charity which aims to develop end of life care. The volunteers will visit patients at the end of life and provide respite and support for patients, families and loved ones. All volunteers have all received training to undertake the role and many are Trust employees, picture 3.

So far evaluation of the role has received positive with feedback received from families, loved ones and Trust staff, see figure 6-7

Even though mum is end of life, staff maintain her dignity at all times. This ward is better than any five star hotel we have ever stayed in. We don't want mum moved to a hospice as she is getting such wonderful care exactly where she is. Each and every one of them have done everything they possible could for mum and us, going above and beyond.

Figure 6: Family member's feedback of Butterfly volunteer role



Picture 3: Two Butterfly volunteers, Left to right: Jo Corscaden of Anne Robson Trust, Arzum Tuzci, Voluntary Services Manager and Jodie a new Butterfly volunteer



Figure 7: A tweet from the @AnneRobsonTrust twitter account telling the story of volunteering in end of life care since the beginning of 2018

Outcome: Fully embedded in practice

1.5 To embed a learning culture:

Our aims for 2017/18: To improve process to capture learning from all safety incidents feedback. To improve the process of raising concerns, identifying root causes and to demonstrate improvements. To implement a process to support learning from every death.

Our achievements:

- The trust updated the Sharing the Learning procedure which was introduced in June 2017. This is used for sharing the learning across the Trust
- The incident management system (called Datix) has a function whereby a manager can give feedback and detail the actions undertaken to manage the incident to the staff member that raised the concern. The use of the feedback facility to staff was 31% in April 2017 and it is now consistently above 80% per month. This is the first step in the sharing the learning.
- Each Healthcare Group shares learning from incidents that have occurred in their wards and clinical departments so everyone working in the speciality understands the learning.
- In year the Trust has undertaken two training events for staff on how to undertake an investigation into a safety incident, called Root Cause Analysis. A total of 35 staff attended and being trained.
- Two sharing the learning events have taken place in the last year.

Outcome: Fully embedded in practice

1.6 Embed and sustain Safeguarding processes for children and adults.

Our aims for 2017/18: To improve safeguarding for all our patients through training of staff. To ensure that evidence based, consistent processes are in place and investigations into incidents associated with safeguarding are completed in a timely way with evidence of learning.

Our achievements:

- Our Safeguarding policies have been reviewed and are up to date.
- Training for staff has been reviewed and where applicable, revised' to ensure that it reflects up to date regulations and meets the needs of staff relevant to their role.
- We reviewed how we trained our staff at a). At induction b). Then every 3 years and we expect a training compliance rate of 90%.
- There is a range of training delivered to staff depending on their role, how much patient contact they have and if they are involved in important decision making about vulnerable patients. This training is mandatory for all members of staff working for the Trust. Our level 1 training programme is given to all staff members that do not have contact with patients and their families but work for the Trust. Level 2 training is given to all clinical staff who works with adults. Level 3 children's training is given to staff that work closely with children and their parents.
- We deliver Level 1 training using our training booklet, and in year the compliance has improved from 72% to 92%.
- The compliance of Level 2 training for clinical staff has improved from 55% to 79%.
- Level 3 training is given to staff that work closely with children & parents. Compliance has dipped from 81% to 63% over the year but this is as a result of increasing the numbers of staff who should complete it.
- Improvements are being made steadily over the year for all safeguarding training topics but this is not yet at the internal standard we have set ourselves of 90%. This is a key focus for managers across the Trust. We do have evidence that we are maintaining safety for our patients, through the increase in the numbers of safeguarding referrals made by staff and appropriate management of care.
- For clinical staff working with adults it is essential that they understand their responsibilities under the mental capacity act (MCA) and its application to staff involved in the protection and care, treatment and support of people over the age of 16 years who are vulnerable. We undertake bespoke Mental Capacity Assessment (MCA) Training.

- A key supportive process for our staff is the availability of Matrons and Clinical site Managers who can go to wards and support staff who are making safeguarding and MCA clinical decisions. These staff are available 24 hours per day to advise, support and participate in the safeguarding and MCA process on the wards.
- Domestic Abuse training is delivered monthly.
- Safeguarding Scrutiny Panel: We have introduced a monthly safeguarding scrutiny panel to ensure investigations are completed in a timelier manner and following a robust process.
- Significant increase in the number of adult safeguarding consultations undertaken with 42% increase over two years.

Outcome: Partially embedded in practice

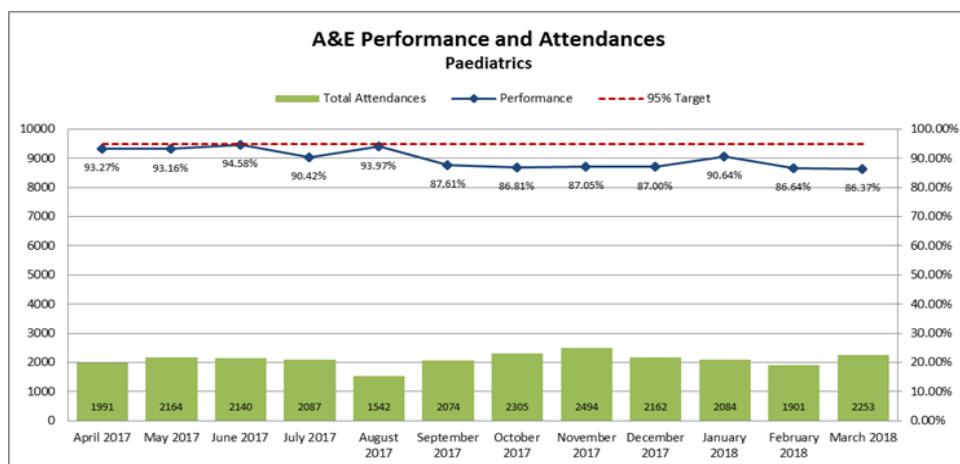
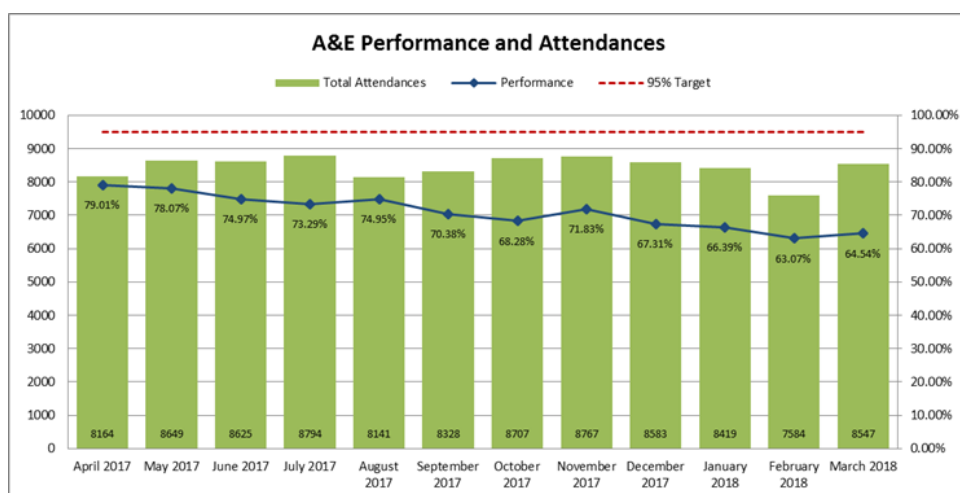
2.0 Patient Focus

2.1 Transforming our care (In and Through and Out)

Our aims for 2017/18: To establishing a high performing Frailty Unit, and ambulatory care and short stay units. Use the recognised tools to aid the improvement of patient flow (called SAFER and Red2Green)

Our achievements:

- During this year the rating of the Emergency department by the CQC has improved from Inadequate to Requires Improvement. No safety concerns were raised.
- Over the year our performance against the emergency department 95% access standard has been 71.07%, see monthly breakdown on graphs 2 and 3



Graphs 2 and 3: Monthly performance for overall emergency department and paediatric emergency department attendance

- **IN:** At time of Admission: Throughout 2017/18 we redesigned and refurbished the Emergency Department to create clear visibility of patients in the waiting area with reception staff available 24 hours a day, picture 4.
- We now have the immediate staff who review patients to ensure they are directed along to the correct pathway (called streaming) co-located these are the Emergency Nurse Practitioners and the GP services.
- The children's emergency department and ambulatory care unit has been moved so is now completely separate but co-located to the main Emergency department Paediatric services have a purpose built ED and Ambulatory care area.
- The handover from the Ambulance staff to the Trust has been reviewed and improved with recruitment of Trust paramedic staff to enhance the skill mix and safety in the department. In year we have a mixed picture at reducing the handover delays between ambulance service and the Trust. Delays of 15-30 minutes have improved by 4%, delays of 30-60 minutes increased by 5.7% and delays of over 60 minutes have decreased by 3.2%.



Picture 4: ED waiting area

- Staff now reviews all patients attending the department at the outset using guidance from recognised best practice a process to assess and then direct each patient onto the right pathway of care to meet their needs which is called the Rapid Assessment and Treatment (RAT). RAT is recognised to have the potential to deliver a positive impact on patient care in terms of timeliness to treatment, direction to the correct speciality team and timeliness of leaving the department. Approximately 66% [200 per day] of patients are clinically review by a senior healthcare professional using this process.
- Improvement in the achievement of the four hour standard has remained challenged throughout the year. Our yearly performance has been 71.05%, this is a 1% drop in the year.
- The quality First Team within in the Trust has commenced a piece of work to look at, develop the roles and responsibilities within the department. In particular the Nurse and Consultant in Charge. This an 8 week piece of work which is expected to be complete in April 2018.
- The Trust has implemented real time data, which is visible and available for all staff in the Emergency Department to allow them time to escalate concerns to relevant staff that can assist and move staff to areas of need.
- **THROUGH:** Signs of an improvement are now been seen following completion of all the structural changes and the creation of a medical and surgical assessment areas and the frailty unit. These areas are improving our patient's experience.
- Monitoring patients length of stay and our readiness to discharge patients continues to be monitored using our processes called Red 2 Green and SAFER which are fundamental to how we monitor the patient flow through the hospital.
- In year our length of stay has remained identical to last year with an average of 2.5 days

- **OUT:** reduction in delayed transfer of care (DTOC) where a patient requires assistance at home before they can be safely discharge home, has been successful and reduced during this year. This has enabled greater discharges from the Trust and we are performing below the national average. Our performance was 4.45% in April 17 and we have averaged over year a rate of 3.71%
- Patients medically fit to transfer has stabilised with further work required to improve discharge rates.
- Timing of discharges remains a challenge which the teams are working hard to address.
- Outcome: Frailty unit and assessment units are fully embedded in practice; Emergency Department performance and length of stay improvements remain work in progress.

Risks and challenges: Despite our on-going efforts to improve our emergency department performance in year was 71.07%.

This risk is reflected in our Board Assurance framework and in the service Risk Registers.

We are optimistic that following the structural work undertaken in the department and the opening of the medical and surgical assessment areas this will improve. An essential part of the improvement plan is our focus on the length of stay and discharge process. The quality first team will be working with all clinical teams to improve our performance for effective and timely discharge of patients from hospital. As it is recognised that blocks to the discharge of patients is directly impacting the emergency department performance.

Daily review in the emergency department and monthly review and scrutiny of performance continues to demonstrate that we have robust process in place to keep patients safe whilst they are waiting to be admitted. The challenge going forward is to continually improve against a back drop of high attendances to the hospital of patients with multiple complex health issues.

This is a Board priority and is point 3.1 on our planned improvements for 2018/19

Outcome: Frailty and assessment units are fully embedded in practice.

The work on in, through and out continues to be a work in progress.

2.2 Co-design personalised care

Our aims for 2017/18: Develop and implement the discharge to access model. Reduction in delayed transfers of care

Our achievements:

- Developed and implemented discharge Information booklet in partnership with patient panel and local voluntary sector organisations.
- Reduction in delayed transfers of care rates has enabled greater discharge flow with the Trust now being below the national average. Our performance was 4.45% in April 17 and our average over the year now 3.71%

Outcome: Fully embedded in practice

3.0 Our People

3.1 Recruitment and retention

Our aims for 2017/18: Develop and improve our ability to recruit and retain staff

Our achievements:

- Monitor the agreed workforce quality indicators through the Performance meetings
- The implementation of the electronic recruitment system (TRAC) in October 2017. This has improved accuracy of recruitment data and we can identify areas which require additional focus to eliminate delays.

- We have streamlined our reference process (using TRAC) which routinely chases outstanding references.
- The occupational health clearance process has been improved to assist new starters and support staff with disabilities.
- We have developed robust workforce key performance indicators which are monitored by the workforce committee.

Outcome: Partially embedded in practice

3.2 Staff engagement

Our aims for 2017/18: 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

Our achievements:

- Improved Statutory Mandatory training compliance from 58% to 84%.
- Introduced a new e-Learning system and Core (Statutory/Mandatory) training booklet covering all level 1 topics to improve accessibility of training.
- A total of 2621 staff have updated their core training compliance via the booklet since it was introduced in September 2017
- National staff survey improvements were identified in year especially for appraisals which improved from 69% to 84%, staff reported employee communication and management support improved in addition to feelings of health and wellbeing of staff.
- Staff Friends and Family Test scores in recommending the Trust as a place to work improved.
- GMC Trainee Survey feedback improved, staff reported the overnight 'Mess' area facilities positive.
- The Trust introduced a mock / interim GMC Survey to allow early identification of concerns prior to the full survey.

Outcome: Fully embedded in practice

3.3 Communication

Our aims for 2017/18: Achieve good quality, effective and clear communication throughout the hospital

Our achievements:

- Weekly CEO and executive staff briefings attended by any staff member. Those present can raise questions and expect an executive to respond.
- Weekly CEO update by email sent out on Mondays.
- In touch weekly newsletter sent out on Fridays.
- Our CEO invites and personally responds to questions from staff using the "Ask Lance" email address. Questions and responses are anonymised and published on the intranet.
- Messaging via computer and lap top screen savers giving staff an update on flow pressure through the hospital to communicate key messages and information.
- National staff survey improvements were identified in year and staff reported employee communication and management support had improved in addition to feelings of health and wellbeing of staff improving.
- Staff Friends and Family Test scores in recommending the Trust as a place to work improved.

Outcome: Fully embedded in practice

3.4 Fit and proper persons regulations

Our aims for 2017/18: Ensure compliance with all aspects of the fit and proper person's policy

Our achievements:

- Issued a new Fit and Proper Persons' Requirement (FPPR) policy in July 2017, reflecting the Regulations recommended by the CQC and Internal Audit. The new

policy covers all posts at a certain level as well as any with “Director” in the title.

- The new FPPR policy links to the Disclosure and Barring Service Policy, and Recruitment and Selection Policy. All policies were ratified and issued in 2017 and now are available to all staff through the Trust’s intranet.
- Annual declarations were completed during July 2017, with 100% compliance. This will be undertaken annually.
- Ongoing monitoring and reporting arrangements for FPPR are undertaken through the Trust’s Workforce Committee to provide assurance.

Outcome: Fully embedded in practice

3.5 CQC preparation

Our aims for 2017/18: Ensure PAH is regulation ready and there is also a focus beyond getting out of special measures with a clear understanding (plan) for what it takes to achieve ‘good’ or ‘outstanding’.

Our achievements:

- The Trust undertook a range of engagement meetings with staff to ensure they were prepared. Every clinical ward and team received two presentations led by a local manager and a senior Trust leader. This ensured bespoke training was given to all teams.
- Progress against the actions we must and should undertake following the 2016 inspection were monitored using a quality improvement plan. This was updated monthly and presented within the Trust and to our regulators and partners at the monthly Oversight Committee.
- The achievement of this objective has resulted in an improvement in our grade from Inadequate to Requires Improvement. With 3 domains achieving a rating of Good. The Trust was removed from special measures.

Outcome: Fully embedded in practice

3.6 Improving critical care

Our aims for 2017/18: Improve safety processes on the unit and ensure staff felt involved in the changes.

Our achievements

- The critical care unit delivered a significant improvement in its rating with the CQC, improving from Inadequate to Good.
- Improvements were delivered through the involvement of the whole multi-professional team ensuring all staff were involved, contributed and fully engaged in the change process. The team commenced protected team training days for the staff in January 2017 which has helped with team building, improved staff morale and this is evidenced from feedback given by the staff.
- The unit has delivered improvements to its safety indicators. This can be demonstrated by the patients on the unit have not had an avoidable pressure ulcers since February 2017. There has been no hospital acquired infections for MRSA and C difficile since March 2017. No avoidable patient falls have occurred since November 2017.
- Improvements to safety check compliance has been embedded and is regularly achieving 97%
- The team are continuing to improve the rates of achievements for staff appraisal and mandatory training.
- The team feel this has contributed towards a decrease in the numbers of nursing staff leaving the critical care unit.
- Feedback boxes are now used to capture the views of both patients and relatives and this is shared with staff at the monthly briefing. Any complaints received are discussed with the whole team to ensure learning is shared and the outcomes are displayed in the teaching room for all staff to view.
- Twice a weekly the team conduct mortality review meetings, led by the consultant involved and this enables all staff to discuss the care given in a timely manner.
- The team are working to improve the environment: in year they have introduced coloured curtains to highlight an infection risk when patients are cared for on the main open unit.

- The staff move patients to prevent mixed sex breaches.
- Clocks showing the day, date, and the time are available for patient and individualised radios with ear phones are used for patient listening.
- The team are now using medication recycle bin to allow the return of unused drugs to pharmacy which reduces stock levels and saved £900 in the first week of use.

Outcome: Fully embedded in practice

4.0 Governance and Risk Management

4.1 Medical engagement and multi-disciplinary team working

Our aims for 2017/18: Strengthening capability and competence. Strengthening team working

Our achievements

- An external medical engagement survey was completed.
- Three workshops with clinical and managerial staff were undertaken to identify the development needs of the staff and areas for improvement.
- An organisational development programme concentrating on our senior clinical staff started in the second half of the year. In combination there were meetings with the Executives, clinical teams and junior medical staff.
- There are weekly meetings with the Chief Medical Officer and senior medical staff and monthly meetings with the speciality clinical leaders.
- A clinical leader's development programme was commissioned. One doctor attending a Yale University programme. Four staff attended a leadership programme at Addenbrooke's Hospital. Two staff are attending courses with Anglia Ruskin University

Outcome: Fully embedded in practice

4.2 Risk Management

Our aims for 2017/18: Robust risk identification and management

Our achievements

- The Trusts Risk Management Group has provided greater challenge and oversight of all risks in year. All areas participate in this challenge process.
- We have implemented RiskAssure, risk management software which ensures improved risk visibility and the facility to link risks from different services.
- Risk registers are now on the intranet and significant risks uploaded onto the Trust magazine In-Touch so staff are aware.
- The lead for Governance & Quality introduced a regular Risk Nugget section for in touch magazine in September 2017. To date, 15 nuggets have been published.

Outcome: Fully embedded in practice

5.0 Infrastructure

5.1 Strategic Estates issues

Our aims for 2017/18: Agree strategic intention and develop plans to ensure sustainability and service viability

Our achievements

A new hospital is essential for Harlow and a strategic outline case was submitted to the regulator, NHS Improvement, in July 2017 which explained the need for this. Over the remainder of 2018, work has started on completing an Outline Business Case, which considers in detail the potential location, size and cost of a new hospital. It is expected that this work will be completed

by late 2018.

Outcome: Fully implemented

5.2 Operational Estate Issues

Our aims for 2017/18: A clear risk assessed and prioritised list of Estates works fully costed.

Our achievements:

- The refurbished Adult and Children's Emergency departments opened in November which ensure all patient areas are clearly visible.
- The orthopaedic elective surgical unit opened in November 2017.
- A new retail facility with an upgraded Costa coffee area and a Marks and Spencer's opened in March 2018.
- The two new maternity theatres are built and expected to be in use from May 2018 onwards

Outcome: Fully implemented

5.2 Information Technology (IT) Infrastructure

Our aims for 2017/18: Full review of our IT needs, capability and capacity.

Our achievements:

- Creation of 5 year capital plan for IT
- Infrastructure refresh
- Replacement of legacy Wireless Network for the Trust and Guest Wi-Fi
- Cyber Security programme reducing risk of Cyber Threats
- Installation of network datacentre switches to support the Trusts Digital Imaging Strategy (PACS)

Outcome: Fully implemented

CQUIN achievement 2017/18

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 2017/18 undertaken by the Trust were:

CQUIN Achievement 2017/18

The Commissioning for Quality and Innovation (CQUINs) payment framework encourages care providers to share and continually improve how care is delivered. In 2017 NHS England published a 2 year scheme aimed at providing greater certainty and stability on the CQUIN goals, leaving more time for health communities to focus on improvement initiative.

The focus shifted away from local CQUIN indicators to prioritising STP engagement and delivery of financial balance across local health economies. This aspect of the CQUIN scheme has been assigned 1% of the financial value of the whole scheme with the remaining 1.5% assigned to clinical and transformational indicators.

Milestones for achievement are set nationally with no local agreements or negotiation. Table 16 and 17 details the actual schemes and financial value. Table 16 shows actual achievement for local schemes with the financial value. Specialist commissioning CQUIN outcome is expected to be confirmed in July but our expected achievement is detailed.

	Associated Financial Value	2017/18 Achievement	Actual Financial Achievement 17/18
1. Improving staff health and wellbeing	£419,713	74%	£279,696.42
2. Reducing the impact of serious infections	£419,713	74%	£274,118.74
3. Improving services for people with mental health needs who present in A&E	£419,713	74%	£377,741.25
4. Offering advice and guidance	£419,713	74%	£358,854.20
5. E-Referrals	£419,713	74%	£314,784.38
6. Supporting proactive and safe discharge	£307,804	74%	£251,827.63

Table 16: CQUIN achievements during 2017 - 2019

Specialist Commissioning CQUIN Schemes	Value	Expected 2017/18 Achievement	
1. GE3 Meds Optimisation	£223,800	83%	
2. CA2 SACT			
3. NHS E Non Specialised CQUIN Oral Health			

Table 17: Specialist commissioning CQUINS in 2017/18 – Confirmation from NHS England is expected in July after report goes to print

In 2018/19 the Trust will be pursuing the milestones associated with year the second year of the national CQUINs as well as commencing work on one additional scheme: Preventing ill health by risky behaviours – alcohol and tobacco. This CQUIN aims to support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.

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 views 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.

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

We are now in the top 20% best performing Trusts in the country for:

- The quality of staff appraisals
- Support given to staff by immediate managers
- Staff feeling confident and secure should you need to report unsafe clinical practice
- Effective team working
- Using the feedback we receive from patients and service users effectively

What staff told us has improved:

- Most staff received an appraisal in the last 12 months (*up from 14 in 20 staff, to 17 in 20*)
- Many staff agree that the Trust offer opportunities for flexible hours

- Communications between senior managers and staff
- Quality of patient care by reporting errors, near misses and accidents
- Care of patients being the Trust's top priority
- The Trust promoting your health and well-being

What we need to improve:

- Continue to be in the top 20% for appraisals, management support, safe clinical practices, team working and acting on patient feedback
- Continue to embed our improvements as detailed above
- Many staff said they felt under pressure at work
- Some staff feel our non-mandatory training could be improved
- Staff would like more opportunities for career progression
- Many staff work additional hours
- Some staff experience violence, harassment and abuse from staff, patients and visitors which is unacceptable

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

Workforce Race Equality Standard (WRES) - KF26 and KF21

Our staff survey results show that the following areas are to be celebrated in relation to equality and diversity across the Trust:

- We have seen a reduction in the percentages of our BAME staff experiencing discrimination from managers, team leaders or other colleagues, bullying and harassment from patients and staff.
- We have seen an increase in the percentage of BAME staff who believes the Trust provides equal opportunities for career progression or promotion.

In relation to KF26 and KF21 (see table 18) we are performing better than average for acute Trusts with the exception of BME staff experiencing harassment, bullying or abuse from other staff in the last month, where we recognise that our results are above (worse than) the average for acute Trusts. We are addressing this through our action below about effective and inclusive leadership. We have appointed two new Freedom to Speak Up Guardians who provide staff with an additional mechanism to raise concerns.

Workforce Race Equality Standard (WRES) - KF26 and KF21

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 25%	25%	27%
		BME 29%	27%	35%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White 85%	87%	82%
		BME 71%	75%	68%

Table 18: Specialist commissioning CQUINS in 2017/18

The following areas have been identified for further improvement from the staff survey results:

- i. 6.3% of survey respondents stated that they would prefer not to say which religion they held and 6.93% of respondents took this option in relation to their sexuality. Both of these are increases on previous years.
- ii. 2.41% of staff preferred not to state their gender; this is a full 2.41% increase on previous years which have been 0% for four years running due to the numbers of staff who did not complete this field.
- iii. 21.2% of staff in white ethnic groups reported experiencing discrimination on ethnic backgrounds, compared to 79.4% of Black and Minority Ethnic (BAME) staff.
- iv. Whilst there is an increase in the % of BAME believing that the Trust provides equal opportunities for career progression or promotion, there is a 15% difference in white ethnic groups who believe this (86.6%) compared to BAME staff (71.6%).

Our Staff

Without doubt, our staff are our greatest asset, regardless of their role. In 2018 the Care Quality Commission rating for staff was **good** for caring; the inspectors witnessed staff delivering care that was compassionate, involving patients in decision making and providing good emotional support to patients and those close to them. The care observed in the maternity services was rated **outstanding in 2016** with staff going beyond the call of duty to deliver the best experience possible for women.

We have a number of routes into employment with the Trust and we are proud of a number of achievements in Staff Training during 2017/18. For example, we:

Apprenticeships: Offering a wide range of new Apprenticeships using the Levy. 26 staff has, or is due to commence by May 2018

Foundation Degree: 17 staff have completed Foundation Degrees and another 11 are due to complete their degrees by April 2018

Care Certificates: 83 new healthcare support workers have achieved the Care Certificate this year

Work Experience Placements: We have supported over 170 people to undertake work experience placements this year. These were young people, aged 14 and over who either live or who are studying at schools/colleges in the local area.

Careers scenario day at Harlow College: This was attended by over 50, year 11, 12 and 13 pupils with an interest in NHS careers in our local area.

Facilitated a range of activities at schools and colleges: 2000 young people, their parents or carers, in our local area have been able to have discussions with our staff.

Health Ambassadors: We have 13 PAHT Health Ambassadors who are trained and registered with our local Science, Technology, Engineering and Maths Centre (STEM). They deliver a range of activities such as career talks, mentoring, practical workshops and exhibitions. The role is to inspire and enthuse the next generation of future PAH and NHS employees and bring a fresh and inspiring perspective to STEM subjects. Encouraging staff to become Ambassadors helps raise the profile of the Trust in the local community and develop a more motivated, skilled and enthusiastic workforce.

Practice Placements: We continue to support our partner Health Education Institutes by hosting over 200 practice placements for pre-registration students (nurses, midwives, AHP, paramedics, etc.)

National Staff Survey The 15th annual National NHS Staff Survey was completed during October to December 2017, and is a mandatory requirement for all NHS

organisations. The survey collected the views of staff about their work and engagement to their organisation, and gathers information that would help to review and improve the work experiences of staff so that they can provide better care to patients.

The initial results indicate that we have made a number of significant improvements since the 2016 survey, particularly in relation to:

- staff appraisals
- employee communication
- management support
- health and wellbeing of staff.

Over a third of eligible Trust staff completed the 2017 survey and from a total of 88 questions used in both 2016 and 2017 surveys, PAHT compared to 2016 was:

- significantly better in 23 questions
- has improved in 8 of the 32 key findings
- just under half of the key findings (15/32) compared PAHT as average to being in the top 20% when compared with benchmarked Trusts.
- in 17/32 key findings PAHT is below average when compared to benchmarked Trusts.
- only worse in 2 questions.

Following the survey each year we produce a comprehensive plan that drives further improvements, and each Health Group and Directorate creates an action plans specific to their area. This will allow localised issues to be addressed quickly by the staff involved.

Improved General Medical Council (GMC) Survey Results

The 2017 GMC survey produced vastly improved results for obstetrics, gynaecology and paediatrics. Their good practice is being shared with other specialties that did not do so well.

Surgery received poor results and had negative trainee feedback. To address this there were a series of staff and stakeholder meetings and workshops held in late 2017.

- From these the Trust has changed the working patterns for surgery doctors from January 2018. This should provide improved team working and better day-to-day support to Junior Doctors.
- Regularly planned additional surgical teaching sessions are being provided for the Foundation (trainee) doctors.
- Recent trainee feedback in surgery has vastly improved and progress will continue to be monitored via feedback and departmental meetings.

The GMC survey results from 2017 were presented to the October 2017 Workforce Committee and responses and action plans have been developed by each specialty.

- A replica in-house GMC survey was carried out in November/December 2017 to measure progress against the earlier 2017 national results.
- A series of actions have been implemented from the latest in-house survey which has resulted in the removal of all Health Education England (HEE) Training posts in the Urology surgical speciality. This group of trainees were redeployed both internally and externally in January 2018. The HEE Trainees will not be returned to urology until the department has implemented an improvement programme and provided evidence of sustainability. The action has the support of HEE and the posts will remain in the establishment for the current academic year.
- The results of the Trust survey have been shared with HEE and all Medical Royal College Tutors in the Trust and was discussed at the March 2018 Workforce Committee. Progress against actions will be presented to the Workforce Committee in May 2018.

Increased involvement of junior doctors in training with quality improvements

The Junior Clinical Management Fellow programme has been refreshed as the Clinical Innovations Fellowship Programme and was re-launched on 5 January 2018.

Dr Pratik Solanki, Senior Clinical Teaching Fellow, is leading on the programme under the mentorship of Dr Morris, Chief Medical Officer.

14 trainees have signed up for the programme and projects to be undertaken include

- PAH Performance for Staff Wellbeing
- Nerve Centre – electronic observation tool
- Development of a Falls Sticker for notes
- Development of an App for Trust Guidelines
- A trainee doctor has been heavily involved in the Sepsis project and has presented at several Trust forums including the weekly Grand Round meeting (March & November 2017).

Staff Friends and Family Test (FFT)

This national survey is made available to all staff employed in the organisation on a quarterly basis. Results for 2017/18 show little change from the 2016/17 year. There was however a drop in the score for recommending the organisation as a place to receive care in quarter 3. An analysis of this identified that the main difference related to the fact that the question was amended and this appears to have changed the staff response:

Q1, 2 and 4 question: *'How likely are you to recommend this organisation to friends and family if they needed care or treatment?'*

Q3 question: *'I would be happy with the standard of care provided by this organisation'*

Responses from the last year's Staff Friends and Family Test (Staff FFT) results are below:

2017 Quarter 1 = 73% (75% in 16/17)

2017 Quarter 2 = 75% (76% in 16/17)

2018 Quarter 4 = 70% (68% in 16/17)

2017 Quarter 3 = 58% (58% in 16/17)

(DOH target is 67%)

The organisation is monitoring the feedback on a quarterly basis and linking it to national staff survey results. We will continue to progress improvements for the benefit of patients and staff.

Staff engagement

Staff engagement features strongly within the culture, health and wellbeing pillar of our People Strategy. As part of our commitment under this element, we will:

- Continue to celebrate the great work that our staff do through annual awards ceremonies, long service awards, employer based awards, "daisy chain" awards for acts of kindness and compassion, and "Our Amazing People" programme which highlights the achievements of our staff through various communications channels throughout the hospital.
- The picture 5-9 show our amazing people award winners in 2017.



Picture 5. Kevin Fitzpatrick,
Porter, Award Winner for Living
the Values - Caring



Picture 6. Dave Page,
Dementia Support
Practitioner, Award Winner
for Living the Values - Caring



Picture 7. Nathaniel Green,
Medical Equipment
Librarian, Award winner for
Non-Clinical Staff Member
of the Year



Picture 8, Medical Records Team, (Left to right) Alan Hobbs, Victoria Taylor, Nicola Faber, & Tanya Taylor, Award Winners for Team of the Year (Highly Commended)

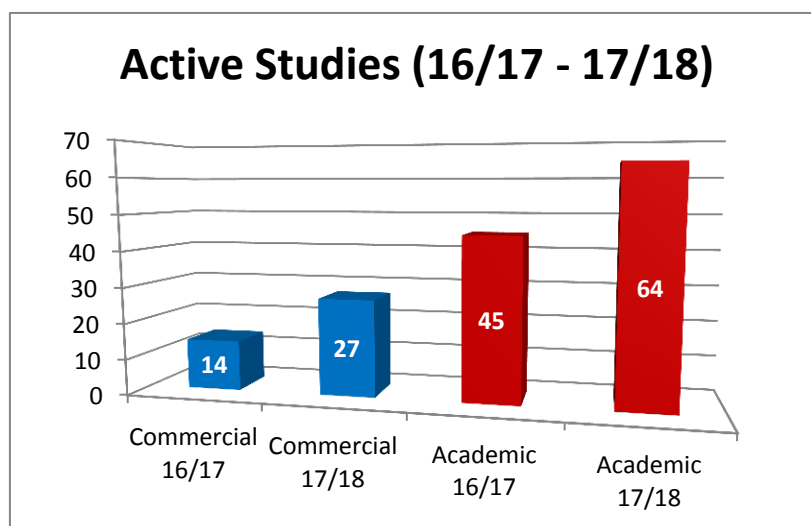


Picture 9, Practice Development Team (Left to Right) Victoria Andrews, Saritha Prathipati and Charlotte Quirke Award Winners for Team of the Year

- Implement a range of new programmes to improve the health and well-being of our teams, following the success of the staff counsellor and health improvement initiatives in 2016/17. A task and finish group was established in January 2018 to capture ideas and initiatives from staff, culminating in a targeted HWB survey. We have used a range of feedback to identify appetite for exercises classes, gym memberships, and a staff choir. We are also using the Public Health England calendar to inform the work we are doing in support of health and wellbeing campaigns.
- Build on new staff engagement initiatives which were introduced during 2017/18, including Facebook for Staff, direct communications sessions for Bands 6+, a new staff council and regular engagement activities involving our CEO from “the big conversation” open to all staff, Chief ‘s briefs” where our CEO visits a specific staff team, the Bands 1-4 forum and band 5 forum, where colleagues can feed back issues in a supportive environment.

Research Development and Innovation

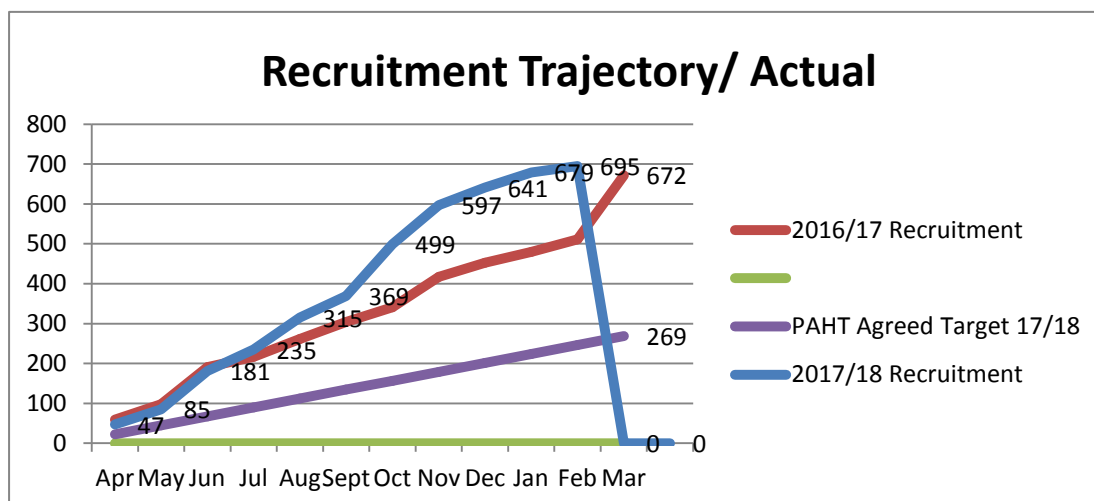
Every year we participate in a wide range of research studies. The studies vary in their purpose and may be academic or commercial in nature. A commercial study is one that is developed by the pharmaceutical/device company, whereas an academic study is developed in a university teaching hospital environment.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



Graph 4: Active research studies

Recruitment Target

At the beginning of 2017/18, it was agreed with North Thames Clinical Research Network that The Princess Alexandra Hospital NHS Trust would recruit a target of **269** participants into National Institute for Health Research (NIHR) portfolio adopted trials. Nearing the end of the fiscal year, the number of participants recruited into research for this financial year is **695** as of 28th February 2018. Details on graphs 4-5 and table 19.



Graph 5: Number of people participating in our research studies

Recruitment per Speciality

Recruitment	Speciality	Directorate	Commercial/Non Commercial
Portfolio Activity			
327	Cancer	C,C & CSS	Non – Commercial
1	Emergency	Medical	Non – Commercial
1	Diabetes	Medical	Non-Commercial
11	Dermatology	Medical	Non – Commercial
48	Survey	Medical	Non – Commercial
25	Maternity	F & W,S	Non – Commercial
2	Ophthalmology	Medical	Non – Commercial
70	Respiratory	Medical	Non – Commercial
20	Rheumatology	Medical	Non – Commercial
7	Surgical	Surgery	Non – Commercial
6	Cancer	C,C & CSS	Commercial
10	Cardiology	C,C & SS	Commercial
8	Ophthalmology	Medical	Commercial
3	Rheumatology	Medical	Commercial
135	Emergency	Medical	Commercial

Table 19: Spread of people participating in research by speciality area

GOOD NEWS STORIES

- Penthrox Pass Study - To date, the Trust has recruited 98 patients out of the overall national study target of 282 patients, 35% of the total needed. We are the top recruiter to the patient-arm of the study.

- Trial Data Manager appointed in November 2017
- R&D £20k funding awards given to projects covering:-
 - End of Life
 - Frailty
 - Delirium
 - Patient Panel
 - Breast
 - Diabetes
- The Research illustration for PAH has now been completed, and will be shown in designated areas across the Trust and various social media.
- PAH has a Patient Research Ambassador – Phillip Wingfield, who is currently on the STAMPEDE study. Philip will be assisting with a number of projects within the department, including the International Clinical Trials Day scheduled for May 2018
- Our first interventional study in the Respiratory specialty is now open, the CLEAR study.
- The department received Research Capability Funding in June 2017 to the sum of £20,000 which is awarded for recruiting in excess of 500 participants from 1 October, 2015 to 30 September, 2016. There is an expectation that the Trust will receive this funding again for this previous year's award period.

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.

Learning from Incidents

A patient safety incident or adverse incident is defined as 'any unintended or unexpected incident which could have, or did lead to harm for one or more patients receiving NHS funded care'. This includes all terms such as adverse incidents, adverse events and near misses, where an incident was recognised and averted.

A total of 9580 incidents were reported on the Trust's Datix incident management system, as having occurred in PAH. This a 3.1% increase when compared with 9283 over the same period last year. A high number of incidents raised is a positive step if it is coupled with low levels of patient harm.

The majority of incidents reported were no and low harm incidents (9186) representing 95.9% of the total incidents for this period. With the remaining (394) 4.1% being moderate and severe harm. Of this (375) 3.9% were Moderate harm. See graph: 6

The incidents relating to patients and harms reported to the National Reporting and Learning System (NRLS) now part of NHS England to enable learning and comparison with similar sized organisations to occur.

We have increased use of feedback to staff after an incident occurs to consistently above **80%**

Themes of Serious Incidents

There have been 31 serious incidents (SIs) at the Trust in 2017/18. This excludes SIs that have been de-escalated by the CCG as there were no care or service delivery problems or they were found not to meet the SI threshold with the emergence of further information.

Although there is an increasing focus on safety across the organisation, 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 the discussion and review of incidents on a case by case basis and a discussion of the level or degree of harm caused.

The Trust ensures open and honest review and discussion of SIs takes place through the Serious Incident Group (SIG). The group is chaired by either the Chief Medical Officer or Chief Nurse and time is scheduled every day from Monday to Friday to ensure that there is no delay. All potential serious incidents 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'.

Never Events

There were no Never Events in 2017/18.

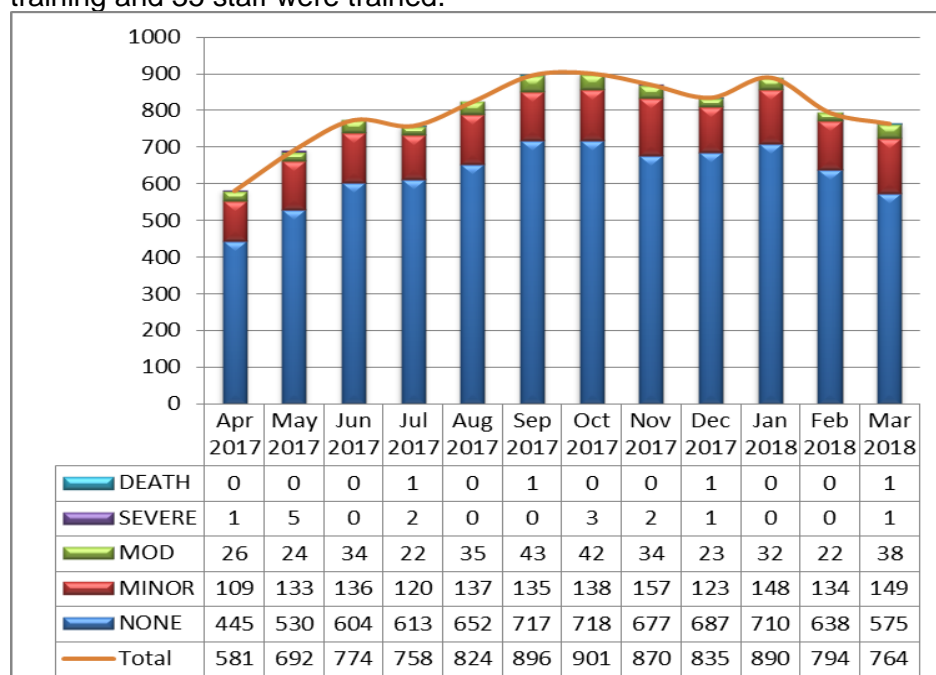
Sharing the Learning Events

The Trust's central Patient Safety and Quality Team worked with relevant experts to organise and facilitate two sharing the learning events during 2017/2018:

- **10 October 2017: Focus on Consent & Duty of Candour.** Following the revision of the Trusts consent policy, it was decided to use the next STL event to launch the policy and share learning & cases stories around consent with staff. The central PSQ team, working closely with our Panel solicitors, Kennedys and NHS Resolution, reminded staff of their duties around consent and also watched a patient story around Duty of Candour.
- **12 January 2018: Focus on Research, Development & Innovation** – The last STL for the year was devoted to celebrating the learning and successes of Research, Development & Innovation at the Trust.

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

The Trust continues to invest in Root Cause Analysis (RCA) investigation training and ensure that staff are supported in Being Open/ Duty of Candour conversations with patients and families when things go wrong. In year the Trust held two training sessions on Being Open/ Duty of Candour and two sessions on RCA training and 35 staff were trained.



Graph 6: Severity of incidents reported (numbers) from 1st April 2017 to 31 March 2018

Clinical Effectiveness

Clinical Effectiveness:

The Trust is required to participate in National audits to ensure that we are taking every opportunity to learn and improve. During the period 1 April 2017 to 31 March 2018, we participated in 33 national clinical audits, and 5 national confidential enquiries, covered NHS services that the Princess Alexandra NHS Trust Hospital (PAHT) provides.

During that period the Trust participated in 91% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audit and national confidential enquiries that PAHT participated in during 2017/18 are as indicated in Tables 20-23

Name	Participation	% Cases or Number submitted
Acute Coronary syndrome or Acute Myocardial Infarctions (MINAP)	Yes	100%
Adult Cardiac Surgery	Not applicable to PAHT	
BAUS Urology Audits : Cystectomy	Not applicable to PAHT	
BAUS Urology Audits : Nephrectomy	Not applicable to PAHT	
BAUS Urology Audits: Percutaneous nephrolithotomy	Not applicable to PAHT	
BAUS Urology Audits: Radical prostatectomy	Not applicable to PAHT	
BAUS Urology Audits: Urethroplasty	Not applicable to PAHT	
BAUS Urology audits: Female Stress Incontinence	Not applicable to PAHT	
Bowel Cancer (NBOCAP)	Yes	Data collection period not elapsed
Cardiac Rhythm Management (CRM)	Yes	100%
Case Mix Programme (CMP)	Yes	72%
Child Health Clinical Outcome Review Programme	Yes	100%
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	Data collection period not elapsed
Endocrine and Thyroid National Audit	No	
Falls and Fragility Fractures Audit programme (FFAP)	Yes	Falls – 100% - Hips – 100%
Fractured Neck of Femur		64
Head and Neck Cancer Audit	Not applicable to PAHT	
Inflammatory Bowel Disease (IBD) programme	No	
Learning Disability Mortality Review Programme	Yes	Data completion period not elapsed
Major Trauma Audit	Yes	Data completion period not elapsed
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Data completion period not elapsed
National Audit of Breast Cancer in Older People	Yes	100%
National Audit of Dementia	Data not collected 2017/18. This audit commences April 2018	
National Bariatric Surgery Registry (NBSR)	Not applicable to PAHT	

National Cardiac Arrest Audit (NCAA)	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme (Secondary care work stream)	Yes	114
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Not applicable to PAHT	
National Comparative Audit of Blood Transfusion	Yes	100%
National Diabetes Audit – Adults (Inpatient)	Yes	60
National Emergency Laparotomy Audit (NELA)	Yes	Data completion period not elapsed
National End of Life Care Audit	The Trust has registered its interest to participate – data collection will be during 2018	
National Heart Failure Audit	Yes	Minimum 100 achieved. Data completion period not elapsed
National Joint Registry (NJR)	Yes	86% (for 2017)
National Lung Cancer Audit (NLCA)	Yes	Data collection period not elapsed
National Maternity & Perinatal Audit	Yes	100%
National Neonatal Intensive and Special Care (NNAP)	Yes	100%
National Ophthalmology Audit	Yes	Data completion period not elapsed
National Vascular Registry	Yes	Data completion period not elapsed
Neurosurgical National Audit Programme	Not applicable to PAHT	
Oesophago-gastric Cancer (NAOGC)	Yes	Data completion period not elapsed
Paediatric Intensive Care Audit Network (PICA)	Not applicable to PAHT	
Pain in Children	Yes	52
Prescribing Observatory for Mental Health (PHMH-UK)	Not applicable to PAHT	
Procedural Sedation in Adults (care in emergency departments)	Yes	25
Prostate Cancer	Yes	Data collection period not elapsed
Sentinel Stroke National Audit programme (SSNAP)	Not applicable to PAHT	
Serious Hazards of Transfusion	Yes	100%
UK Parkinson's Audit	No	

Table 20: National Clinical Audits and Clinical Outcome Review programmes the Trust participated in.

NCEPOD Study Title	Participation	% Cases Submitted
Acute Heart Failure	Yes	100%
Perioperative Diabetes	No cases at PAH	
Chronic Neurodisability	Yes	100%
Young People's Mental Health	Yes	100%
Cancer in Children, Teens and Young Adults	No cases at PAH	

Table 21: Summary of NCEPOD studies that the Trust was eligible to enter data for

The reports of a number of national clinical audits were reviewed by PAH during 2017/18.

Examples of action taken to improve the quality of healthcare provided can be found in Table 22.

Name of national audit	Actions completed / achievements
National Hip Fracture Audit	<ul style="list-style-type: none"> 71% had surgery within 36 hours of admission; 3% improvement from previous year Saturday Trauma Lists commissioned in 2017 9% improvement from previous year for patients admitted to an acute orthopaedic ward within 4 hours of presentation
National Comparative Audit of Blood Transfusion	<ul style="list-style-type: none"> In 2017 there were 105 Massive Blood Loss calls activated with 11 actual events (reduction of 7 events from 2016 figures) Tranexamic Acid administered early in 10 out of the 11 events Patient outcome continues to improve with 9 patients discharged; 2 died but not as a result of haemorrhage Blood wastage cost reduced by 66% from 2016 figures Blood cost for 11 events reduced by 50% from 2016 figures Massive blood Loss and Reversal of Anti-coagulants and Anti-Platelets Care Bundle has been copyrighted and ready for printing Copy forwarded to Regional Trauma Committee and Regional Transfusion Committee to cascade out to other Trusts
National Audit of Inpatient Falls	<ul style="list-style-type: none"> Mobility aid provision 90% - 34% improvement on 2015 Call bell access 87% - 16% improvement on 2015 Vision assessment 48% - 34% improvement on 2015
National Heart Failure Audit	The heart failure team has now met its fully funded establishment leading to an increase in cases submitted for audit

Table 22: Examples of actions taken following review of national clinical audit reports

The reports of 28 local clinical audits were reviewed by PAHT during 2017/18. Examples of action planned/taken to improve the quality of healthcare provided can be found in Table 22

Local audit	Actions completed
The effect of an oblique view on the frequency of fracture detection: a retrospective study	Based on the findings of this study, the radiographic technique manual has now been updated to include an additional oblique view as well as the standard dorsipalmar and lateral examinations in all adult trauma imaging.
Indications for Plain Abdominal Films from the Emergency Department	A flyer is in the ED radiology department to highlight and remind staff of the indications required when justifying abdominal x-ray requests to ensure compliance with Royal College of Radiology guidelines.

Table 23: Examples of actions planned / taken following review of local clinical audit reports

Information and Technology Achievements

- There has been continued investment in the electronic observations solution (Nerve Centre) as doctor's handover processes have been embedded. In addition, we have purchased and are preparing to implement a bespoke module for the Emergency Department. The advantage this brings to patients is that staff are notified when patients vital sign observations become abnormal thus improving patient safety.
- Real-time A&E reporting was implemented in late January 2018 to support patient flow within the department is communicated to everyone. Large screens have been deployed to ensure visibility in key areas
- We started preparing for the implementation of the General Data Protection Regulations (GDPR) on 25 May 2018 and have established weekly meeting with stakeholders to maintain momentum.
- We were successfully selected as one of sixteen pilot sites that received funding to implement NHS Wi-Fi for patients and guests that went live in January 2018. This service also enables our guests and staff access to text messaging and Wi-Fi enabled calling in areas of the hospital where mobile phone coverage is poor.
- The Wannacry malware attack hit the headlines in May 2017. In order to protect key services the Trust took the decision to disconnect the Trust from servers such as the internet. As a result, there was very minor disruption to clinical services. However, the full IT team were onsite throughout the weekend to ensure that hospital IT services were made safe and available early on the Monday morning when full services were resumed. Following this event the team have worked tirelessly to ensure that services are secured from future attacks. We now have a regular routine upgrades for firewalls and antivirus software.
- The Business Intelligence function has continued to support the use of QlikView for self-service reporting. This means that the information team have worked with services to develop area specific dashboard to present information in a visual and graph format that demonstrates current performance and improvement. This information is presented at Trust board using our Integrated Performance Report (IPR)

Nursing and Midwifery Recruitment and Retention

The challenges associated with recruitment of nurses against a backdrop of a national shortage continued throughout the year. We have continued to pursue recruits from around the world as well across the UK. Following feedback from staff and applicants regarding the protracted length of time for recruitment, we have introduced a couple of process changes to simplify and speed up the pathway from selection to appointment.

- Nurses already employed in the Trust are able to transfer into other vacant posts providing they can demonstrate their compliance with all standards of practice in the area where they are working.
- Student nurses and midwives in placement with the Trust are automatically offered employment providing they had met all of the standards required in their training and placement assessments.

Retention: In July 2017 the Trust was invited to participate in a Retention Support Programme launched by the national team at NHS Improvement. This opportunity allowed us explore and refresh established activities already in place as well as introducing new ideas to promote retention of existing staff.

With a central ethos of strengthening staff wellbeing, we have brought all of our ideas together and on a monthly basis we monitor our progress and the impact of each new way of working.

Training and development: We extended our support and development of registered nurses by extending the Preceptorship programme to 12 months. On completion each member of nursing staff is then

immediately enrolled on to a “next steps” programme; inviting them to attend a selection of master classes on a wide range of subjects. The purpose of this addition to the programme is benefiting nurses in the clinical setting preparing them for career advancement.

It is important that our staff are provided with opportunities to learn and develop the skills required to deliver compassionate and competent care. In 2017 68 healthcare support workers successfully completed the Care certificate and a further 55 are in the process of completing in early 2018.

Registered nurses and midwives are also afforded development opportunities to ensure that they have what it takes to lead the delivery of excellent care to patients. The leadership development courses are designed to ensure that the organisation is preparing staff for promotion. Fifteen ward managers and forty junior sister/charge nurses have completed leadership development courses in 2017.

Stay at Harlow: We introduced a confidential email address for staff who may be thinking of leaving the organisation; individuals are followed up and have access to a senior nurse to talk through their personal needs and opportunities within the organisation.

Career clinics: Open to all levels of nursing, midwifery and care staff; the clinics are facilitated by a variety of experts in a range of specialities, training and practice development. Our aim is to offer a personal and individualised opportunity to explore and devise a personal career pathway.

New roles: Recognising the national shortage of registered nurses, we have focused on creating and supporting new roles to support the delivery of care to patients. One of the great successes has been optimising career progression for our health care support staff. Many people join the Trust with an ambition to become a registered nurse; for many attaining direct entry onto a university nursing degree programme has been out of reach. With our support to access training and education, many staff members have been able to improve their maths and English standards, enabling them to commence a foundation degree programme. Once achieved, opportunities to complete a condensed programme in pursuit of nursing degree are available.

In 2017 twenty two of our staff completed a foundation degree in healthcare and are now employed in the hospital as Assistant Practitioners. Ten of these individuals are going on to top up their education, knowledge and skills at university in April 2018 and this will lead them to become Registered Nurses.

We have also released three staff to undertake the new Associate Nurse University programme; although initially this is small number of individuals, as the role develops we will continue to release staff and have nine applicants pursuing places for May 2018.

In 2017 we introduced a senior staff nurse role; supported by a development programme, the aim was to encourage staff to remain at the Trust whilst receiving bespoke training to optimise their likelihood of success when applying for promotion opportunities. This role has proven to be very popular; twenty seven staff were successfully appointed.

Risks and challenges: Despite on-going efforts to recruit, our vacancy rate for registered nurses remains above 20%, some areas with more than 50% vacant posts. This risk is reflected in our Board Assurance framework and in service Risk Registers.

We are optimistic about the introduction of new roles and implementing ideas to retain staff but these take time to yield benefits.

A new contract with our temporary staff provider started in April 2018; we await the improvement in filling vacant shifts.

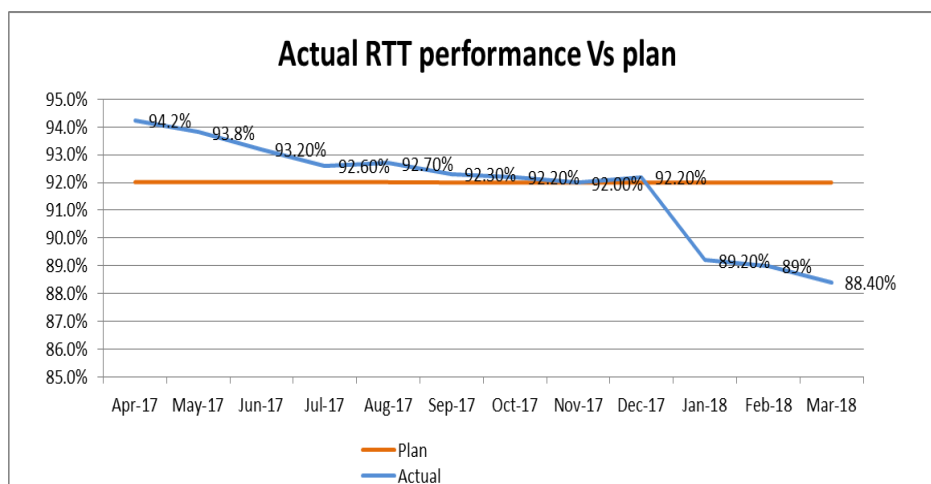
Monthly review and scrutiny of patient experience and safety continues to demonstrate that all of the steps we have put in place are keeping patients safe. The challenge going forward will be in sustaining safe care against a back drop of high nurse vacancies.

This is a Board priority and is point 2.1 on our planned improvements for 2018/19

Planned Care Standards

The Trust continues to be one of the few organisations consistently delivering the Cancer and Diagnostic national standards. The delivery against the 18 week Referral To Treatment (RTT) target was achieved between August 2016 & December 2017.

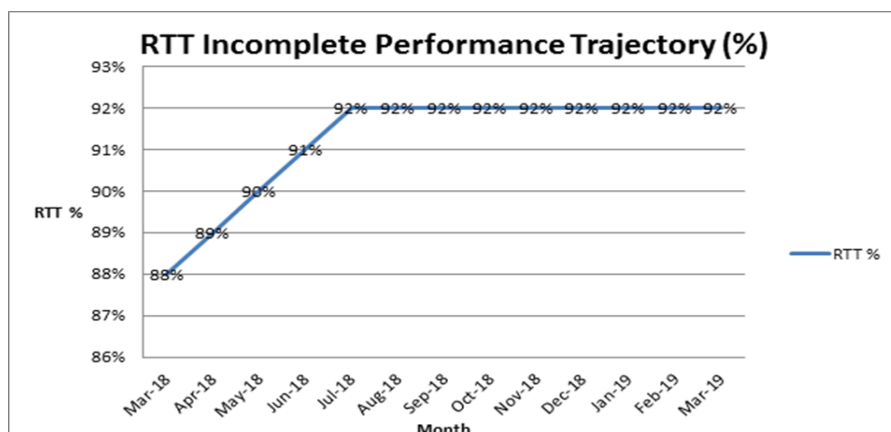
In January 2018 elective surgery was suspended across the whole of England due to the unprecedented pressure on the NHS emergency service. The impact of the suspension has been seen in a number of patients exceeding 18 weeks from referral to treatment, see graph 7. This resulted in the Trust not achieving the constitutional standard between January to March 2018.



Graph 7: RTT target expected performance improvement plan

Referral to Treatment (RTT)

We have now put in place a recovery plan; the detail of the expected improvement is detailed on graphs 7-8. Our aim is to return to our previous performance by the end of September 2018.



Graph 8: RTT target expected performance improvement plan

In year we have a small amount of patients who do not attend hospital for their outpatient appointment; this is detailed on Table 24.

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
6.73%	7.06%	6.72%	6.71%	6.72%	6.72%	6.53%	6.57%	7.90%	6.50%	6.14%	6.41%

Table 24: The percentage per month of patients that do not attend their outpatient appointment (DNA)

The Trust does need to cancel some operations if there are insufficient beds to allow us to care for the patients. The details of these are in Table 25. We do ensure that we do not cancel any clinically urgent operations.

Cancelled Operation Rate for 2017/18

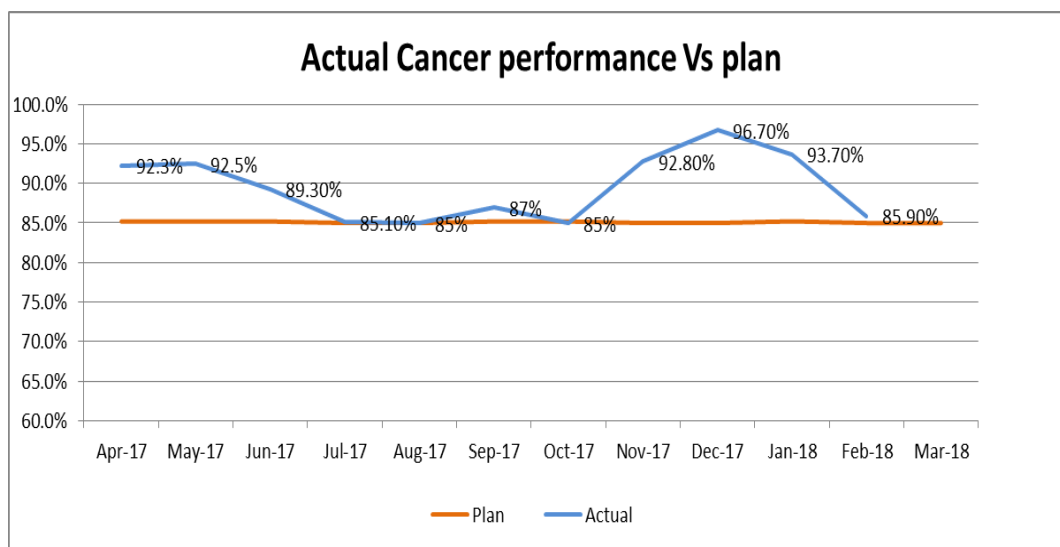
Cancelled Operations during 2017/18	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Cancelled Operations for Non Clinical reasons	34	54	30	27	51	40	56	40	30	16	18	41
Cancelled operations - breach of 28 day standard	0	0	0	0	0	0	0	0	0	2	3	5
Urgent operations cancelled	0	0	0	0	0	0	0	0	0	0	0	0
Urgent operations cancelled for a second or more time	0	0	0	0	0	0	0	0	0	0	0	0

Table 25: Cancelled operation rate for 2017/18

Cancer

Since 2016, the Trust has consistently achieved the cancer 62 day standards and is currently performing within the top 10% of all Trusts in England, see graph 9.

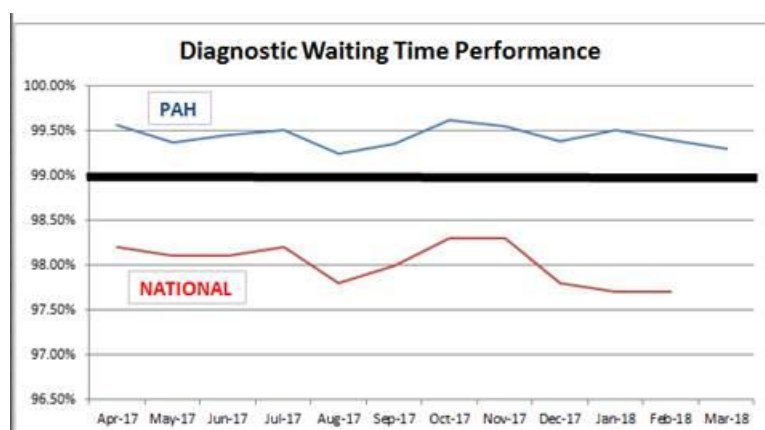
Workforce issues in the speciality of Urology have meant that the 62 day standard will not be achieved for March 2018. However as a result of the strong performance in January and February, it is still expect that the Trust will still achieve the 62 day standard for Q4 of 2017/18.



Graph 9: Cancer target performance expected during 2018/19

Diagnostic Performance

The Trust has achieved the 99% Diagnostic Wait target every month for the last 3 years. This means that over 99% of all patients waiting for diagnostic examinations have this completed inside 6 weeks of the referral being made, graph 10. We are proud of consistently maintaining this performance despite a 5% growth in demand, year on year.



Graph 10: Diagnostic waiting time performance

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, see graphs 9 and table 26.

Our Radiology and Pathology Services have well established standard operating procedures in order to adhere to the Trust Internal Professional standards set out under the previous 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. Over 95% of patients in the Emergency Department now have their blood test or radiology results inside 60 minutes of request.

The below table demonstrates the improvement in Cancer Waiting Time performance in Radiology showing the mean waiting times for cancer scans. The national turnaround times are still 10 days; however we push for our diagnostic tests to be performed in 7 days and are now working towards lowering this to 5 days.

Test	Target	2015-16	2016-17	2017-18
Magnetic Resonance Imaging (MRI)	<7 Days	8 Days	6.5 Days	6 Days
Computed Tomography (CT)	<7 Days	8.5 Days	6 Days	5 Days
Non-Obstetric Ultrasound (Non-Obs US)	<7 Days	9.5 Days	7 Days	6.5 Days

Table 26: Radiology performance for 2017-18

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 areas for improvement is centred on the monitoring and performance of examinations that cannot be completed at our hospital, so are sent externally to other providers. It is difficult for us to control the performance of other providers, yet we are still accountable for any breaches that occur for our patients. We believe that work could be done around improving service level agreements with external providers, thus 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. In order to ensure that scanning capacity does not exceed our ability to provide timely and responsive reporting, a review of the workforce requirement is being undertaken. Where a need for additional consultants is identified, this will be presented to the Executive Management Team to pursue recruitment and selection.

Cancer Service Improvement

We have steadily been reducing waiting times against the national standard of 85% of patients beginning treatment within 62 days of urgent GP referral. This culminated in the Trust being ranked No 1 out of 133 NHS Trusts in the December 2017 nationwide operational tracker - achieving an outstanding 97.6 per cent.

The improvement reflects the trust's emphasis on collaborative work across various departments. We have a dedicated team of Pathway Coordinators and trackers who oversee every patient on a suspected or confirmed cancer pathway. Their job is to liaise with surgeons, physicians, radiologists, histopathologists, oncologists, and x-ray departments, endoscopy departments among others, to ensure that appointments are made in a timely manner and that where possible the patient's prompt responsive care is expedited.

The trust has set an internal standard to see all patients for their first appointment under seven days - the national target is 14 days.

Pathology Improvements

During the summer of 2017 The Pathology department at The Princess Alexandra NHS Hospital Trust were the first NHS run lab in Essex to achieve UKAS accreditation across all departments. UKAS is the UK's National Accreditation Body, responsible for determining, in the public interest, the technical competence and integrity of organisations such as those offering diagnostic testing. Once accreditation is received

UKAS revisit to ensure that the laboratories are, at least, maintaining standards but preferably improving and developing its quality standards.

In December 2017 and February 2018 our lab was revisited. The whole department maintained accreditation and impressed the assessors with our staff's dedication, knowledge and commitment to delivering a quality service.

This means that at the time of maintaining accreditation we were the only lab in Essex to achieve and maintain. This is testament to the hard work of all the staff and our commitment our patients and their care.

Our Outstanding Maternity Service

Our outstanding Maternity and Gynaecology service supported the birth of 4028 babies in hospital or at home. Work on the new maternity theatre has started and this will give the labour ward two theatres, a 4 bedded post anaesthetic recovery area, all birthing rooms will now be ensuite, with doctors offices and other facilities. Most importantly, the new facilities will mean the majority of women within the maternity department who are required to have an operation will be able to have their procedure done without being transferred to the general operating theatres in the main hospital. Recruitment and retention of staff within Maternity has been really successful with a midwife to birth ratio of 1:29 which is the best it has been for the past five years.

As the result of a successful bid for money from Health Education England has enabled us to send 79 midwives, 5 Consultants, Nurse nurses, Nurses and Maternity Care Assistants on Resilience Training, Neonatal Life Support (NLS) course, PROMPT training which we will now be able to teach in-house, Childbirth Emergencies in the Community, CTG masterclass, Maternal Critical Care and Human factors.

Maternity Voices Partnership (MVP) formally Maternity Services Liaison Committee has been relaunched in 2018 and is attended by women who have recently given birth or due to give birth within our maternity department. The chair is a local national childbirth antenatal teacher. At the partnership we ask our women to tell those present their experience. Since the relaunch three women have told their birth stories, detailing all the positives and highlighting areas that could have been better. The maternity team will take these actions forward. We will use this partnership to help shape our improvements going forward.

We have four Professional Midwifery Advocate (PMA) and this is a new way of working. The role of the PMA is to be involved in the deployment of the A-EQUIP model of midwifery supervision, supporting and developing the advocacy role of midwives, supporting and guiding midwives through actions that will benefit women and their families. To provide providing support and feedback to develop, progress and strengthen the capabilities of the midwifery workforce.

We are proud our stillbirth rate remains exceptionally low at 1.45 per 1,000 births. This is compared to the national rate of 4.2 per 1,000 births.

The work continues with our Smoking Cessation Midwife and Safe Sleeping Campaign throughout this coming year. The safe sleeping campaign is aimed at ensuring all babies have a safe sleeping environment to reduce the risk of sudden infant death. Following delivery and before discharge our midwives will discuss with all mums the A, B, and C actions of safe sleeping. This includes ALWAYS put baby to sleep on their BACK in a CLEAR cot (no bumpers, toys, pillows). The safer sleeping advice with regard to smoking and alcohol and co-sleeping are to never to go to sleep on a sofa with the baby. This is to reducing the risks of sudden infant death which sadly causes the death of 300 babies every year.

Our Children's Service

Children's Services have had an exciting and challenging year with many positive changes in the last year. We were successful in the recruitment of three new Paediatric Consultants and 15 new registered nurses.

Dolphin Ward

Our Matron worked on the ward during this year covering the ward managers maternity leave, this has brought about significant change, staff have grown in confidence and morale has improved. We were proud of the way the team performed and the enthusiasm with which they approached the CQC inspection and they have been empowered as a team. In February 2018, we appointed an acting Band 7 Ward Manager and are creating an official deputy post to the ward manager.

The retirement of our Practice Development Nurse (PDN) created the opportunity to review roles and we have since created a combined role of PDN and Oncology Nurse Specialist which has enhanced our service.

Staffing vacancies has continued to be a challenge, but through the flexible and facilitative support of the executive team we secured some high quality agency staff to work on the ward. This has strengthened access to experienced skilled nurses and improved the number of nurses working on Dolphin (our children's) ward. We are delighted with our recent recruitment activities and in the last 12 months we have recruited 12 new staff nurses some of whom are yet to join us, but all will be in post by September. We have had only 2 staff resignations, 3 staff have internal promotions and 2 of these staff moved to our Paediatric Ambulatory Care, photo 10.

Staff morale and engagement has significantly improved on the ward and this is reflected in the falling levels of short term sickness, staff feedback, patient feedback and formal feedback from internal quality reviews and inspections. We have also recruited into all our Healthcare Support worker vacancies and are fully staffed. We have developed the role of ward assistant to manage stock control, equipment, portering tasks and non-clinical tasks

We have a bespoke Paediatric Nurse Development programme for newly qualified staff and are undertaking a competency review for all grades. Staff training days will further support team building and regular clinical updating. We now have two registered nurses that completed the High dependency care course (to look after the sicker children) on the ward and this will enhance the service.



Picture 10: Dolphin and paediatric team

Paediatric Emergency Department

We have opened our Emergency department for 24 hour a day since July 2017 and in December 2017 moved into a brand new larger department designed specifically for children. This has resulted in improvements in patient experience and a reduction of clinical incidents associated with the care of children out of hours, pictures 11-12.

We now have a Paediatric Advanced Nurse Practitioner, who is registered to prescribe medicines. We see this role as pivotal to our vision of having a consistent and comprehensive expert led paediatric emergency service.



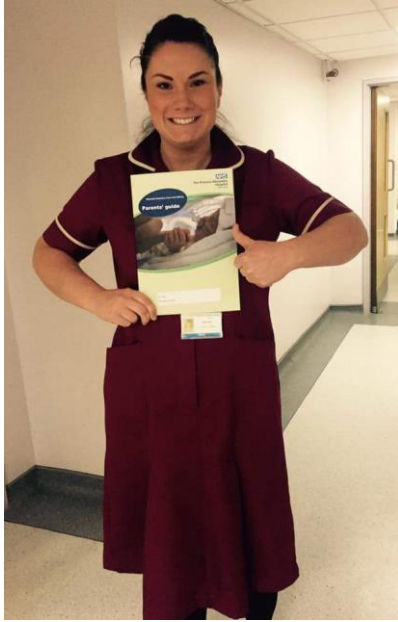
Picture 11-12: Paediatric Emergency Department

Neonatal Intensive Care Unit (NICU)

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

The unit has not been as busy as the previous year with lower occupancy levels this may in part be due to the lower than expected number of deliveries we have had in our Maternity Unit and more babies receiving transitional care within the post-natal wards.

We have completely refreshed and refurbished our parent facilities which are now more welcoming and sympathetically decorated. We have also devised a new parent handbook which has been very well received by families, see picture 13.



Picture 13: Katie Barke, Practice Development Nurse on NICU, showing the parent booklet

Paediatric Outpatients

We have recruited an Allergy Nurse Specialist who is now managing the Outpatient Team as well as running nurse led services for our children, she has presented at National Conference this year and has supported the team in getting the Outpatient area reorganised and it is now more children friendly.

Pharmacy – Improving medicine safety

Medicines are the most common intervention in medical care. The costs of medicines amount to around 10% of NHS expenditure.

Achievements Within the last 12 months

Extended ward pharmacy service - pilot on 4 wards having additional pharmacist, pharmacy technician and assistant during weekdays resulted in:

- Improving medicines reconciliation rates - for one ward from 36% to 100%
- Improving daily review of inpatient charts,
- Improving the discharge prescription (TTA) provision,
- Managing all ward stock requests and putting away the weekly medicines
- Assisting with the daily controlled drug checks and fridge temperature monitoring.

Specialist Pharmacist support - The Pharmacy department have introduced specialist roles in critical care, gastroenterology and rheumatology to support patient care. Pharmacist presence on the daily consultant ward rounds in critical care provided expert advice on medications, ensuring correct choice and dose in critically ill patients, in addition to bedside teaching of staff regarding medication matters.

Medication safety

The most recent report from NHS Improvement, for incidents occurring between 1 April and 30 September 2017 showed that:

- The proportion of reported incidents that were for medication was 13.3%. This is above the average for other acute (non-specialist) Trusts in England which had 10.7%.
- It is considered a good thing to have a high level of reporting with a low level of harm. In fact we are very pleased that this was an increase from the figure of 8.5% for the same period the previous year.

Our Trust proportion of harm incidents was less than the national average for an acute (non-specialist) Trust.

• This indicates that PAH has made a huge improvement in the rate of reporting of medication incidents. Each incident reported provides an opportunity for sharing lessons learned locally, and outside the organisation, in order to improve medication practice. The following have been achieved as part of the medication safety programme:

- Delivery of training on medicines to cover safe prescribing, antibiotic management and anticoagulant management, to medical staff.
- Prescribing assessments completed by junior doctors and new non-medical prescribers.
- Audits on appropriate usage and storage of medicines across the organisation
- Inclusion of a 'Medication Safety – Tip of the Week' in the Trust bulletin every week.
- A meeting between senior pharmacist and senior nurses each week to discuss medication incidents which had occurred during the previous week, and to agree on actions which should take place to reduce the risks of the incidents occurring again.
- A summary of prescribing incidents is presented to medical staff at Grand Round and to specialist teams.
- All relevant and appropriate actions have been taken in response to national Patient Safety Alerts.
- Two e-learning packages were made with the aim of improving patient safety and patient experience. These packages explore the problems of missed doses and of delays in preparation of discharge medication.
- The setting up of a multidisciplinary anticoagulant steering group to ensure that the use of anticoagulants is optimised and the risks in the systems involved are minimised

Antibiotic stewardship.

Antimicrobial Stewardship (AMS) is an overarching system of strategies to improve the use of antibiotics to benefit patient outcomes from infection.

The following has been achieved as part of antibiotic stewardship program:

- Implementation of NICE guideline NG15 by ward pharmacists by using the Intravenous Antibiotic Review Stickers.
- Improvements in fulfilling NICE requirements and quality standards for Antimicrobial Stewardship.
- Improved management of antibiotic therapy and identification/implementation of cost savings initiatives, particularly during the shortage of supply of some antibiotics.
- Antimicrobial ward rounds are being undertaken by the Consultant Microbiologist and the Antimicrobial Pharmacist with the aim of promoting appropriate, safe and cost-effective antibiotic prescribing and optimal infection control practices.
- An Antimicrobial Stewardship Group was established in December 2017 as per NICE guidelines (NG15), taking into account the resources needed to support Antimicrobial Stewardship across all care settings. The Committee is responsible for:

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

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

Actions Planned for the next 12-36 months

- **Medicines Optimisation** - This will include implementation of the hospital pharmacy transformation plan, pharmacy workforce plan and a plan to develop integrated Pharmacy services.

- **Capital, Equipment and IT** - Working with the Lister Hospital to explore options for aseptic pharmacy services. Upgrades of the automated dispensing system and out-of-date equipment have also been ring fenced for investment by the Trust.
- Further work needs to be undertaken in the following areas: promote temperature monitoring in medication storage areas to meet MHRA standards. Investment may be required.

Review of Pharmacy Service Provision and Performance

The following is to be undertaken as part of the Pharmacy service review and performance management:-

- To undertake a service user satisfaction survey.
- To continue to improve the number of drugs to take home (TTAs) within 2 hours.
- Further use of dispensing carts at ward level to improve the timeliness, patient experience and safety of patient discharge.
- To recruit to an Emergency Department (ED) pharmacist post.
- To recruit a neurology pharmacist
- To develop a Homecare Pharmacy Team
- To extend the amount of time that pharmacy staff spend on patient facing tasks
- Expansion of self-administration of medicines (SAM).

Education and Training

- To introduce mandatory medicines management training for all clinical staff to ensure safe prescribing and administration of medicines to reduce harm to all patients.
- To review and update the Pharmacy Department Education and Training Strategy.

Infection prevention and control

The safety of patients, their families, visitors and our staff is a top priority for the Trust. 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 2017/18 our pursuit of excellence in control of healthcare acquired infection standards has meant that PAH remains in the top quartile nationally, demonstrating low rates of infection in four key alert organisms. Two of these have annual trajectories which if not met incur financial penalties for the Trust; Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* (*C difficile*).

IP&C remains 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'.

Trust Performance

There are four key alert organisms that the Trust is required to report performance on, and these are published by Public Health England (PHE) as part of a national mandatory surveillance programme. The Trust apportioned numbers of MRSA, Meticillin Sensitive *Staphylococcus Aureus* (MSSA), *Escherichia Coli* (*E.coli*) and *C difficile* cases, are published nationally by the 15th day of the following month. 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 penalties were attached.

From April 2017, there has been an NHS ambition to halve the numbers of healthcare associated Gram-negative blood stream infections (BSIs) by 2021. This is now a joint IPC target between CCGs and Trusts. The target is led by the CCG, as the majority of GNBSIs are in patients who present unwell to hospital. Nevertheless this is a programme that requires close working between our CCGs and the Trust IPCT.

In the graphs below, the numbers of Trust apportioned and non-Trust apportioned cases for the four organisms are shown. The Trust apportioned cases (are referred to as 'post 48 hr; post 72 hr for C diff) is shown as red bars, with non-Trust apportioned (pre 48 hr; pre 72 hr for C diff) as yellow bars. This is part of a co-ordinated programme of real-time surveillance supported by our on-site Microbiology laboratory, which we see as 'information for action'. This approach has helped us control HCAs with improved results year on year, since we started the programme ten years ago.

MRSA Bacteraemia

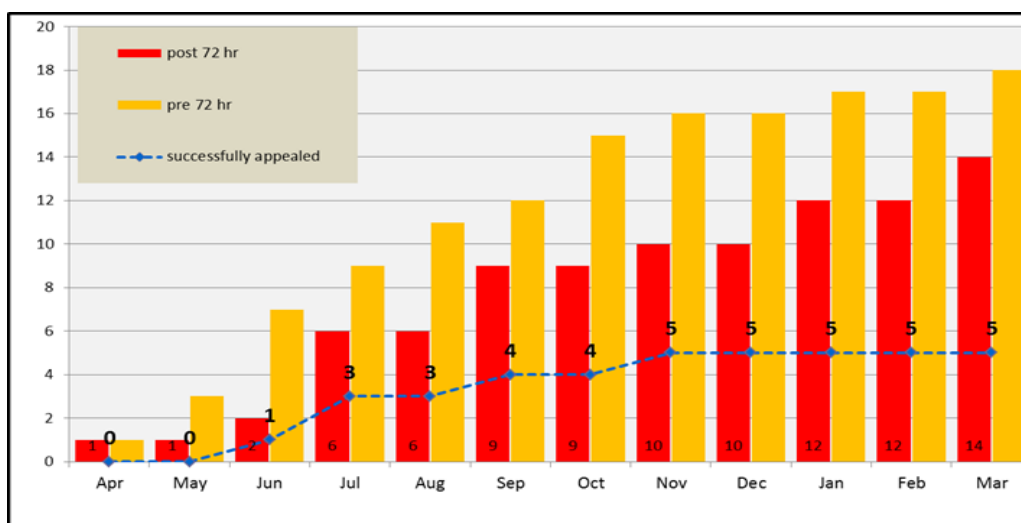
There is a trajectory of zero tolerance for MRSA blood infections (bacteraemia) across the NHS. We have had **no** cases of MRSA bacteraemia this financial year. Nationally, PAH NHS Trust ranks amongst the best performing Trusts in the country.

C.difficile

Once again, the Trust has done extremely well against the very tight *C.difficile* trajectory of ten cases annually for 2017-18. We remain in the top performing quarter of all Trusts nationally, doing better than last year. Although we ended the year on a total of 14 cases, only eight of these were considered to be Trust-attributable, graph 11. Six (6 of 14) of the cases were successfully appealed at the North Essex HCAI Scrutiny Panel, and two further cases (2 of 9) are awaiting appeal. Appeals are successful when there is demonstrable evidence that there were no lapses in care given to patients that contributed to the infection. This indicates that our infection control and prevention measures are safe and effective.

The PHE national database will however, still show the Trust as having had 14 cases this year. As a district general hospital with a large elderly population, a busy emergency department and many winter pressures, this is a remarkable achievement. It demonstrates true MDT (multi-disciplinary team) remained committed to infection prevention and control procedures throughout the year by:

- Antimicrobial stewardship by the medical and pharmacy staff
- Timely isolation by nursing staff and the bed management team, in order to reduce ward contamination with C diff spores.
- Hand hygiene by all clinical staff; this is monitored and re-enforced by cross over audits planned and managed by the IPCT and matrons
- Environmental cleaning including hydrogen peroxide decontamination by Facilities staff, an in-house team that have supported the C diff programme for over ten years.
- and use of personal protective equipment by all clinical staff



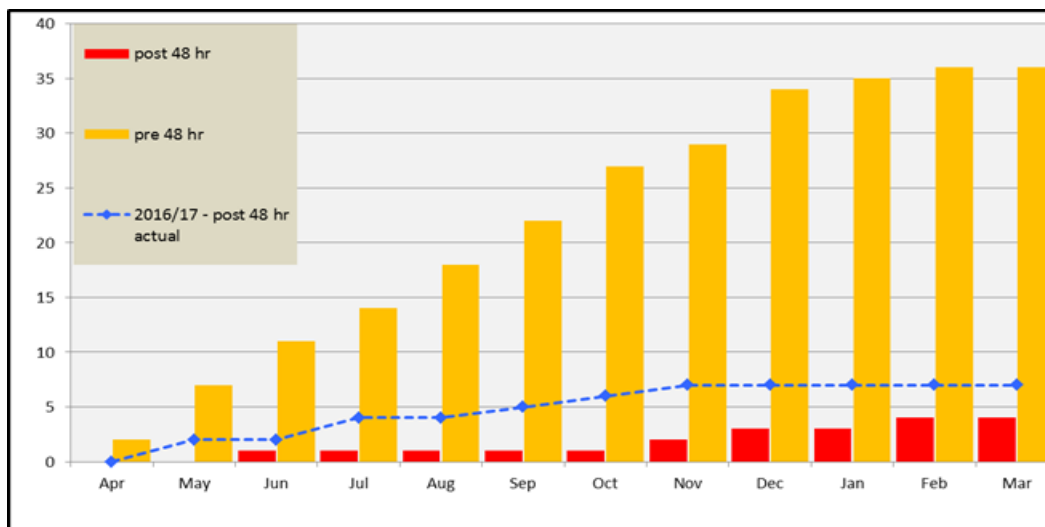
Graph 11: Cases of *C. difficile* cases at PAH NHS Trust for 1 April 2017 – 31 March 2018

PAH ranks as one of the best performing DGHs in the country for *C difficile* control. The Trust targets for 2018 - 2019 are one less than the case numbers we had in 2017-2018. Hence the PAH NHS Trust *C difficile* target for 2018 - 2019 is **nine** cases. Targets are set nationally by the Department of Health and are non-negotiable.

Meticillin Sensitive *Staphylococcus aureus* (MSSA)

The Trust is one of the top performing NHS organisations in the country in terms of our low Trust apportioned MSSA blood infections (bacteraemia). This year there have been just four Trust apportioned cases, as demonstrated in the table 12. Good asepsis in relation to IV lines has contributed to these low figures.

Cumulative MSSA bacteraemia cases 1 April 2017 – 31 March 2018

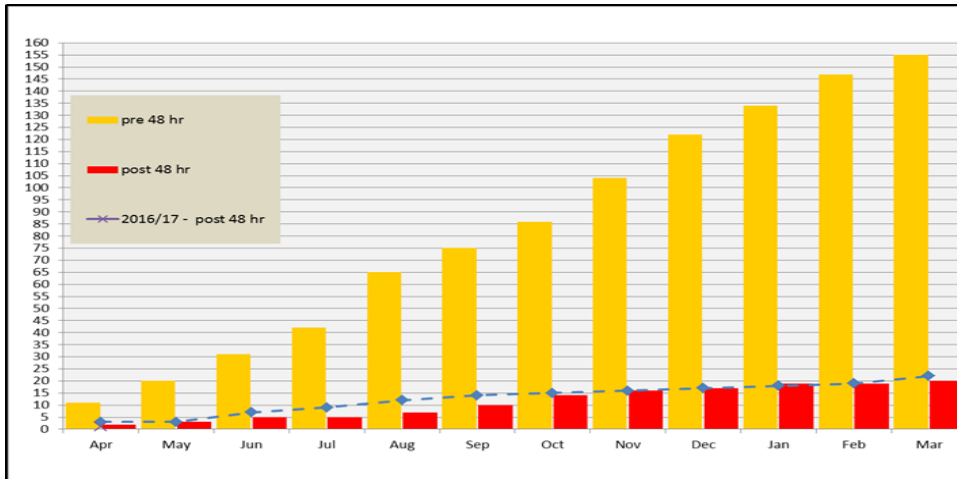


Graph 12: Cases of MSSA bacteraemia at PAH NHS Trust: 1 April 2017 – 31 March 2018

***Escherichia Coli* (E.coli)**

Numbers of Trust-apportioned *Escherichia coli* cases are low (red bars) and the Trust remains in a favourable position when compared with other hospitals nationally. During 2017-2018 we had 20 Trust-apportioned cases, see graph below, this compares to 22 cases last year, see graph 13. Root cause analysis (RCA) meetings have commenced this year for Trust apportioned GNBSIs, chaired by the Trust DIPC.

The largest proportion of *E. coli* bacteraemia is from the community (yellow bars). Progress needs to be made next year with RCA meetings led by the CCG for non-Trust apportioned GNBSIs. This will be a challenge as case numbers are high (155 cases in 2017/2018), and GPs, district nurses and other health care professionals caring for patients who present with GNBSIs are from different localities. Risk factors ranging from urinary tract infections, catheter associated infections and post-surgical infections may be found. Half of all community onset cases have had some healthcare interventions either from acute, primary or community care. We can only achieve reductions by working together across the whole health and social care sector. As soon as new CCG IPC arrangements are in place from April 2018, the PAH IPCT look forward to working with CCG colleagues to jointly develop an improvement plan. It is anticipated our CCGs will identify an Executive level lead, to be the main point of contact for control of GNBSIs.

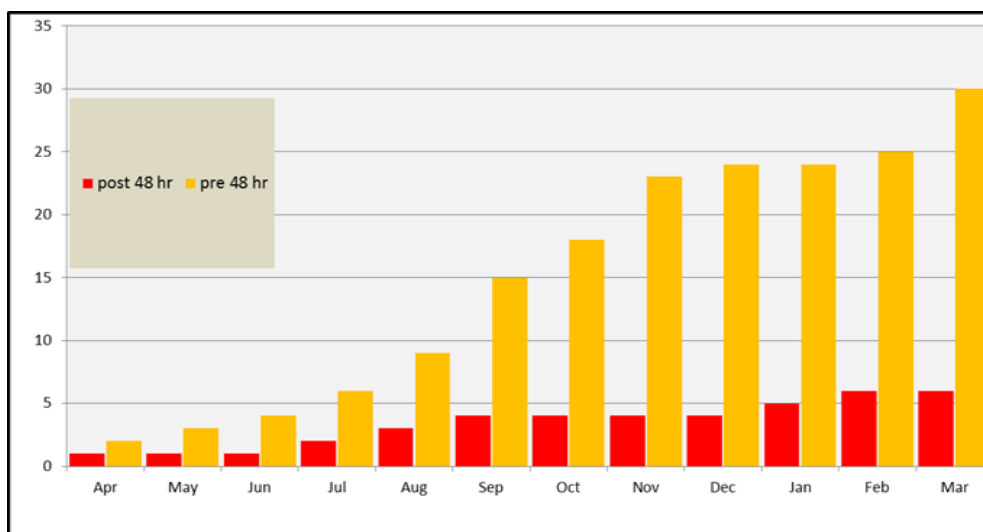


Graph 13: E-coli bacteraemia at PAH NHS Trust: 1 April 2017 – 31 March 2018

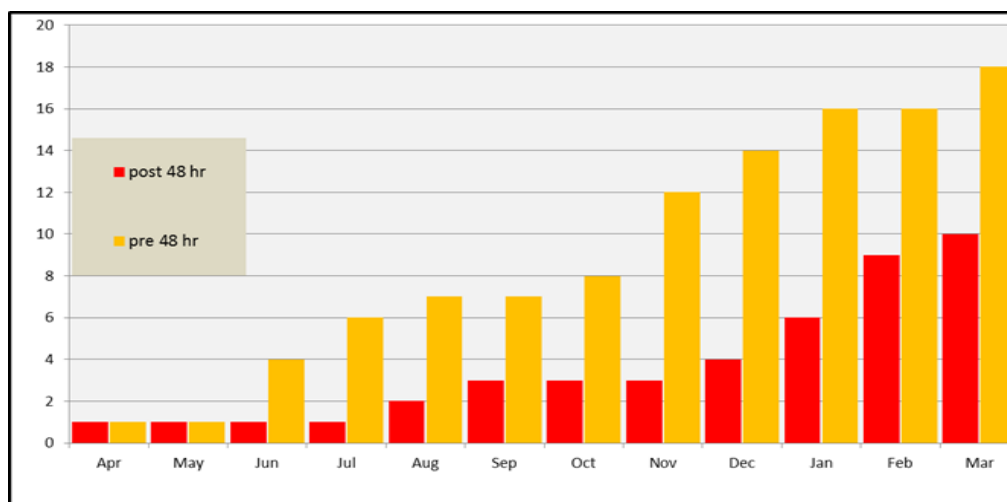
Klebsiella bacteraemia cases

For the first time this year, we have reported the numbers of Klebsiella species and Pseudomonas species in blood cultures. This is in order to start addressing the new NHS ambition from 2017-2018 to reduce Gram-negative blood infections by 50% by 2021.

A healthcare associated Gram-negative BSI is a laboratory-confirmed positive blood culture for a Gram-negative pathogen in patients who had received healthcare interventions either the community or hospital in the previous 28 days; our performance is detailed in graph 14



Graph 14: Klebsiella bacteraemia cases at PAH NHS Trust: 1 April 2017 – 31 March 2018



Graph 15: *Pseudomonas* bacteraemia cases at PAH NHS Trust: 1 April 2017 – 31 March 2018

Klebsiella spp. and *Pseudomonas aeruginosa* BSI case numbers are smaller than *E.coli* case numbers. IPCTs were therefore advised by NHS Improvement to start addressing *E.coli* infections, and to subsequently address the other two organisms, graph 14-15.

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 improved focus on these infections.

Infection Prevention and Control Incidents and Outbreaks

In line with national mandatory surveillance requirements, infection rates associated with orthopaedic surgery (hip and knee replacement called a prosthesis) are monitored. The data is used to identify improvements in surgical orthopaedic pathways and to reduce infection rates for patients even further.

Towards the end of 2016 and in early 2017, an increased number of infections were identified in patients that had undergone hip / knee joint replacements. These cases were fully investigated by the IPCT and orthopaedic teams. Several measures were implemented in the pre-operative (before), intra-operative (during) and post-operative (after) surgery. The actions implemented were:-

- use of a screening tool called 16s ribosomal RNA monitoring, undertaking intra-operative tissue samples just prior to wound closure in theatre
- the orthopaedic surgical prophylaxis regimen was reviewed and updated
- theatre discipline was tightened.
- post-operative ward procedures were also improved.

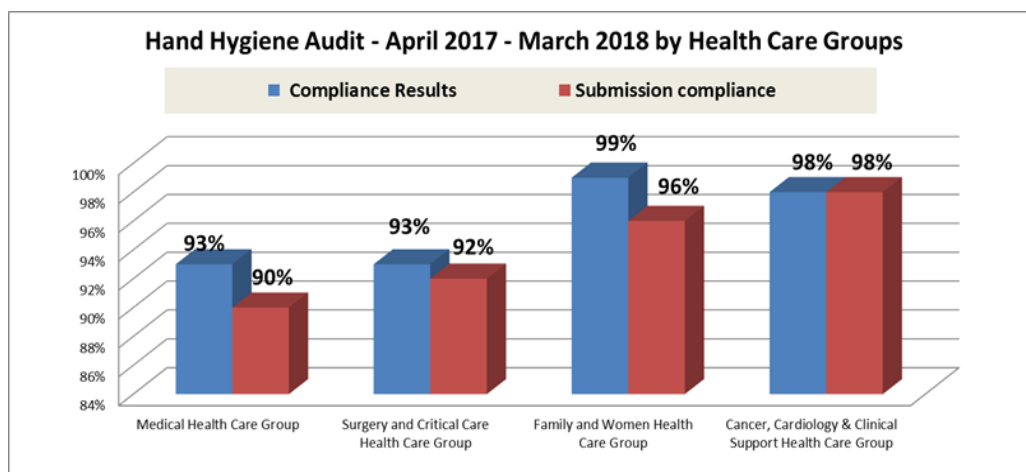
There have been no deep infections since these steps were put in place in mid-2017. Monitoring of interventions and surveillance continues as joint infections can occur up to 1-2 years post operatively.

This year we also introduced surveillance of elective caesarean sections. However, there is still further work being undertaken to ensure that all eligible women are being included.

Norovirus outbreaks occurred in the Trust between August 2017 and March 2018. Mostly these were isolated incidents; however in January- March 2018, there were several wards closed at the same time. The Trust has robust systems in place for the management of outbreaks with daily meetings for the duration, led by the IP&C Team and supported by the Chief Nurse or Deputy Chief Nurse. Testing of samples for norovirus in our Microbiology laboratory has helped manage norovirus outbreaks. There was a review of lessons learned, and improvements that could be made in the future in relation to communication and patient placement were identified.

Audit programme

The IP&C team facilitate a robust annual audit programme to ensure that clinical and environmental standards are met and maintained in relation to the prevention and control of infection. This includes hand hygiene audits, in which all clinical areas participate. An example is shown below.



Graph 16: Hand Hygiene compliance

The audits are undertaken by another ward/department (not self-audited) to ensure a peer review approach and validity. Overall, compliance is excellent and actual performance is reviewed monthly, with appropriate actions (such as feedback, training and escalation) taken as necessary, graph 16.

In addition to clinical audits, the Trust also has a programme in place to ensure standards of cleanliness are maintained throughout the hospital. The Facilities team are responsible for a programme of monthly environmental and cleanliness audits, which must adhere to certain standards. In critical care / high risk areas, for example, compliance must be over 98%. If this is not achieved initially, immediate actions are implemented to rectify the non-compliant issues and then the area is re-audited. The IP&C team also support this by undertaking a clinical and environmental audit in clinical areas, which monitor all aspects of care in relation to IP&C.

Conclusion

PAH has again maintained another year of excellent control of HCAs, and control of spread of resistant organisms. We have reduced our Trust apportioned HCAI case numbers year on year, with even lower numbers compared to last year. This is largely attributed to the continuing and sustained commitment by clinical and management staff to patient safety and IPC practices, and a 'Board to Ward' approach.

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.

During 2017/18 the Trust has completed:-

- A successful study day in November 2017 that was well attended by the new aspiring Falls Champions.
- Falls training has continued on Clinical Updates, preceptorship, EU Nurse Induction, FY1 Induction, Student Dr's, Vulnerable Adult Study Days, HCSW programme and ad-hoc for professional staff groups.
- Become integrated within the local community charities and contributes to the Falls service mapping exercises run by the CCG.
- Develop a Falls Care plan to address current NICE guidelines and actions that were identified following the Royal College of Physicians Audit in 2017.
- Purchase of modern flat lifting equipment to aid safe retrieval of fallen patients.
- Produced patient brochures that contain information around falls and well-being.
- Purchased materials to support staff in assessing Lying/standing BP
- Introduced a tool for assessment of new bed rails and low beds.
- Support the Dementia team by training staff participating in the Virtual Dementia Tour and assisting with their monthly audit analysis.
- Publicise the End PJ paralysis campaign to raise awareness of the issue of deconditioning on the wards

Our Falls for 2017/18 were the lowest for the last 4 years. Our falls rate is 5.3 falls per 1000 per occupied bed days (OBD). This continues to be lower than the national average which is 6.6 falls per 1000 occupied bed days, graph 17.

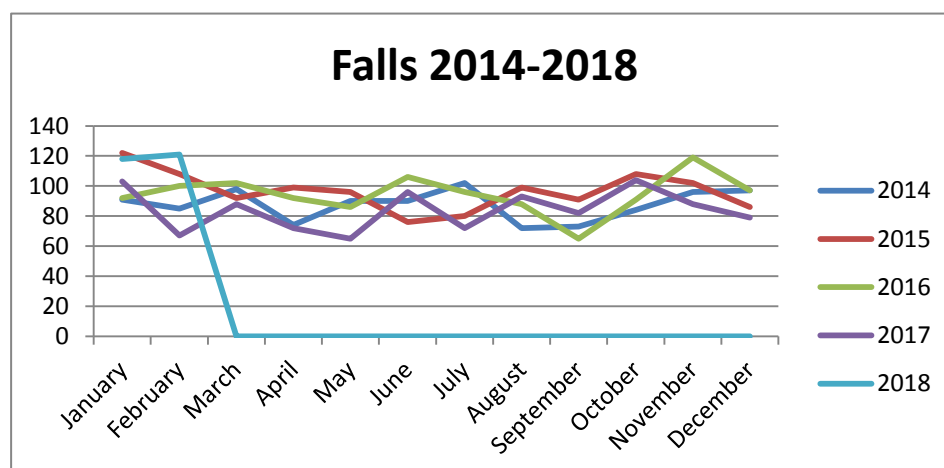
Overview:

The Trust is working with partners to pursue a longer term approach to falls prevention, acknowledging that prevention is more effective, efficient and financially sustainable than rehabilitation. Patients become weaker, confused, and more dependent then suffer tissue viability issues and falls. This is easily avoidable with regular low level activity but this is not prioritised on the wards, instead we attempt to keep patients 'safe' by restricting their independence. A complete rethink of this approach is urgently required and staff members need empowering to mobilise and engage actively with patients. This is where the proposed Associate therapy practitioners could start real change.

Falls by Severity 2017 (rated by Harm level):

- No Harm: 761
- Minor Harm: 232
- Moderate Harm: 17
- Severe Harm: 1

Comparison with previous year's falls occurrence is on the graph 17



Graph 17: Results of Royal College of Physicians National audit

Scrutiny Panel Decision on falls:

We take learning from incidents seriously. When a patient has moderate or severe harm from a fall we ask that the ward team to present the investigation findings to our Essential Care Scrutiny Panel, detailed in Table 27. The panel is chaired by either the Deputy Chief Nurse or the Matron for Quality and provides a chance to those staff involved to talk through their investigation findings, the care delivered which then in turn can aid the identification of any deficiencies, omissions and opportunities to learning, in addition to the ability to identify notable practice. This is a non-blame seeking endeavour which we believe provides valuable insights into how we can improve and ultimately reduce harm coming to patients in the future. The learning is also disseminated throughout the Trust via patient safety newsletters, meetings and reports.

Panel decision	Apr '17 – Jul '17	Aug '17 - Nov '17	Dec '17- Mar '18
Avoidable	5	1	1
Unavoidable	9	6	5

Table 27: Scrutiny Panel Outcomes for Falls for 2017-18

Our participation in the Royal College of Physicians National audit of inpatient falls last year shone a light on some areas that still require improvement. These were not a complete surprise to us, as we undertake internal audits. The results summarised in table 28:

	2015	2017	% Change
Delirium	20	0	-20
Continence CP	30	6	-24
BP	3.8	7	+3.2
Medication	21.4	23	+1.6
Vision	13.8	48	+34.2
Call bell	71.4	87	+15.6
Mobility aid	25	90	+65

Table 28: Results of Royal College of Physicians National audit

This feedback was valuable and provides the catalyst to our improvement work around falls for next year. The key areas to improve are the measurement of lying / standing blood pressure and screening for delirium and dementia on admission.

Improving pressure ulcer care

The Trust continues to strive to ensure high quality tissue viability care for all of our patients. We have 1.6 posts in our tissue viability clinical nurse specialist's team (TVN).

The team provides training for all registered nurses and Healthcare Support Workers (HCSW) on induction, at monthly pressure ulcer sessions run on the wards, and using the link nurse programme to enhance our staffs knowledge about tissue viability, nutrition and skills. This is run in collaboration with the Nutrition Practitioner. The team provides one to one training sessions at the bedside with individual nurses and students. We have trained 255 staff and the retention rate for this small group of staff is extremely high, with 78% remain employed within the trust.

We have had an overall reduction this year for pressure ulcers of 7.4% in comparison with the previous year.

2016/17: Total 121

2017/18: Total 102

In the event that a patient does sustain a pressure ulcer in our care, a rigorous process of investigation and scrutiny commence to ascertain the root cause and identify learning for the ward area concerned. We continue to learn from incidents and sharing learning through our Tissue Viability Newsletter and pressure ulcer teaching sessions.

The TVN's are also involved in work across the local area looking at reducing the high numbers of patients admitted with pressure ulcers. Education sessions for public and carer groups have been well received.

The TVN's are presenting a poster at The Tissue Viability Society Conference this year to showcase the work that has been done. Next steps in this work stream include rolling out the React to Red teaching programme for domiciliary carers in the community to educate them about skin care, pressure ulcers and when to refer on for help.

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 Champions:

The Dementia Champion's programme is aiming to have at least 2 champions in each clinical area. It is a 6 month programme to enhance the understanding of dementia so that our staff are able to lead on dementia improvements in their local area. The trust currently has 31 dementia champions with a further 9 to complete their course in May 2018.

The role of a dementia champion includes:

- Promote best practice skills, providing a link between theory and practice-
- Ensure 'This is me' document is completed,
- 'Forget me not' poster displayed above patient's bed,
- Carer's card issued and documented when necessary.
- Act as a named contact for staff working with people with dementia & their carers
- Provide professional information and signposting to staff working with people with dementia and their carers.

Dementia volunteers

The Trust now has 4 Dementia volunteers as of March 2018; this is a significant increase from 1 in 2017, with a continuous recruitment initiative in place for further Dementia volunteers.

The role of the dementia volunteer is varied but includes:

- 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 Nurse Specialist and Dementia Support Practitioner

In July 2016 the Trust appointed a Dementia Support Practitioner (DSP) on an initial 1 year secondment; this is now a permanent role. In January 2018 the Trusts appointed a Dementia Clinical Nurse Specialist.

These roles are responsible for:-

- Review patients in the wards and supporting staff with complex issues such as feeding, pain assessment, behaviour, end of life care
- Provide support for carers,
- The development of a carers group
- Implement bespoke training for security staff
- Raising the profile of the effect of delirium in dementia as part of a wider project
- Support with discharge planning and reducing length of stay
- Role modelling person centred care-working shifts alongside ward staff
- Reviewing the current training programme
- Develop the role within the wider MDT
- Participate in the dementia steering group that meets quarterly and is overseeing the revised strategy.

The Quality Mark

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

- Engaging patients, ward staff, hospital management and governors in assessing the quality of care provided
- Providing training to ward staff in Person, Interaction and Environment observations of care
- Producing a detailed local report that identifies achievement and areas for improvement, enabling targeted action planning
- Encouraging ward team reflection on their ability to provide elder-friendly care
- Awarding and recognising the achievement of elder-friendly wards
- Encouraging focus on a continuous improvement through iterative data collection.

Lister ward were awarded the Quality Mark in 2016, this is maintained until May 2019. Ray ward achieved the Quality Mark in 2018; further wards are working towards this achievement

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 2018, 87.27% of staff had completed this session.
- Virtual Dementia Tour (VDT) sessions on a monthly basis for all hospital staff. To date over 420 staff has attended a session. The sessions provide a positive experience for staff leading to many staff becoming dementia champions because of the VDT experience.

Bespoke training for the security team in response to some incidents within the Trust regarding security staffs role with patients with dementia. This commenced in March 2018.

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 2017 and February 2018 236 surveys were given to carers and 24 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.

Carers Group

A new initiative, a fortnightly group open to carers visiting PAH who come in to support patients with dementia, cognitive impairment or who just need a friendly ear.

The group currently meet in the restaurant, and are kindly supported by the restaurant staff. The groups aim is to ensure our carers know what we can support them with at PAH i.e. carers card/open visiting, overnight stay, reduced parking rates and refreshments. Advice also can be given about Dementia, its trajectory and support regarding discharge planning and nutrition

Delirium Project

The Dementia Team have recently been successful in their project bid for funding through the RD committee, the projects aim is to:

- Development and delivery of a communications and engagement strategy for delirium with the goal of raising awareness and profile, which in turn will seek to improve patient outcomes and experience.
- Develop a dashboard to track performance over time, so demonstrate both improvement and opportunities to learn. This can also be used to provide stakeholders (wards, clinical teams, etc.) with feedback on their progress.
- Review and improve pathway to define best practice approach and reduce 'unwarranted care variation', whilst increasing productivity and efficiency (e.g. reductions in LOS)
- Learning and development sessions to increase the delivery of a best practice approach.

Gibbered ward refurbishment

Gibbered ward successfully re-opened in September 2017 after being completely refurbished. Gibbered Ward will provide 24 hour care for patients with specialist needs in relation to care at end of life or those people affected by Dementia. The unit is staffed by a Multi- Disciplinary team who are trained to support patients and their family / carers.

Safeguarding

The Safeguarding Teams undertook a mapping exercise in 2017/18 to ensure each staff member was listed for the correct element of our training programme. This takes into account the differing roles of staff and the requirements against the national safeguarding legislation. . We have adapted our training programme in line with the changes to level 3 training requirement and we now provide an annual programme.

Safeguarding Adults

In July 2017 the Trust established a safeguarding scrutiny panel to meet on a monthly basis to review all safeguarding cases. This meeting is chaired by the Deputy Chief Nurse, and includes representation from both Herts and Essex social work teams. The panels main objectives are to ensure investigations are completed in a timely manner and following a robust process. Our Safeguarding Adults policy has been updated to reflect the investigation process which will follow the Trusts incident reporting process to ensure consistency in the report writing.

This process allows the Trust to identify and review learning and common themes from safeguarding cases. Representation from the healthcare groups and social service partners means that we are able to share learning across the health and social care system we serve, thereby improving partnership working with the local authorities. Our partners have the opportunity to express their views in a constructive and supportive manner and we are able to reflect together on possible improvements for the benefit of patients and their families and carers.

One of the key areas of concern, raised was information provided on the patient's discharge from hospital to other care providers in the community. This was particularly relevant when associated with patients who are leaving the hospital with an established pressure injury. To improve this situation, the Medical Health Care Group are currently piloting an initiative "Golden Envelope" in relation to ensuring all appropriate information is sent on discharge and discharge summaries have a nursing input.

Within the Trusts Safeguarding Adults level 2 training, we complete training for Mental Capacity Act. The safeguarding team also provide bespoke and practical training on the application of the Mental Capacity Act assessment process. The team follow up with clinical staff when they are in practice to ensure that the skills taught are being applied effectively for the benefit of our patients. In 2017/18, 176 staff attended the bespoke training. The compliance levels for safeguarding adults training are detailed in section 1.6.

The safeguarding adult's team continues to provide adequate training opportunities to ensure that every staff member can achieve their level 2 training compliance. The Trust is expecting to be compliant across all three levels of safeguarding training by November 2018.

Safeguarding Children's training

To follow on from the recent CQC inspection in December 2017, we have identified additional staff working in the operating theatres that require annual training. The increase in the number of staff requiring annual training has impacted upon our percentage of compliance negatively since December 2017.

The safeguarding team continues to provide adequate training opportunities in order to ensure that every staff member can achieve training compliance. The team can provide up to 1350 places for level 3 training and we currently have 620 staff required to attend. The Trust is expecting to be compliant across all three levels of safeguarding children's training by November 2018

The team have developed a robust process to follow up for staff who do not attend their training session. We recognise that that our high vacancy rate coupled with winter pressures across the hospital have impacted on the availability of staff to attend training. To counter for this challenge, the team have taken a responsive approach; undertaking additional specialist departmental training for up to 15 staff at a time in the local area.

We have struggled to achieve the supervisory requirements following the resignation of skilled staff members. The safeguarding team aim to implement a 'Hub and Spoke' supervisory strategy which requires more supervisors. The Named Nurse for Safeguarding Children is pursuing access to a 2 day supervisory course for new supervisors from an external provider.

Improving care for patients with learning disability and autism

Learning Disability (LD) Steering Group

The steering group continues to meet quarterly and a new non-executive Director is now the chair of the group. The steering group are in the process of co-producing a new work plan for 2018/2019. An initial focus group was held on 27th February 2018 with staff from the hospital, service users and family members to start this work. The previous improvement plan has now been 'closed' as all objectives are achieved. A report following on from the Steering Group will be presented to Patient Safety and Quality at each quarter.

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. The Learning Disability team continues to liaise closely with Community Learning Disability Teams both in West Essex and East Hertfordshire, commissioners and other external voluntary and non-voluntary organisations. A large proportion of the LD teams work in recent months has been engaging with GP services, PAH staff and residential services to

ensure that people with a learning disability are able to attend their hospital appointments with a successful outcome.

Training

The Trust remains committed to ensuring that all staff has 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 Clinical Update study day. This awareness training is also delivered on the Induction Programme for all new starters.

A further Learning Disability and Autism Champion programme was scheduled to commence during the latter half of 2017, however, due to unforeseeable circumstances, this was cancelled. It is expected that the programme will run mid-2018.

Learning from Incidents and Complaints

The Learning Disability team continue to review all complaints, incidents and deaths to ensure that any emerging themes are identified and that there have not been any instances of diagnostic overshadowing or instances where the level of care was variable solely due to the patient's learning disability and/or autism. The LD team see quite a high number of incident reports relating to patients who have a learning disability and/or autism. The numbers is, in part due to improved incident reporting by staff across the hospital.

The common themes that appear over the financial year include:

- Reports of pressure injuries, both upon admission and during hospital admissions. All grade 2 and above pressure injuries are presented at the Essential Care Scrutiny Panel, the LD team will attend if a patient with learning disabilities and/or autism is being discussed. This is, in the main part, to ensure that any gaps in knowledge across ward areas for learning disabilities and/or autism are picked up and acted upon with further training.
- Medication errors
- Deprivation of Liberty Safeguards being implemented
- Safeguarding referrals and social care referrals
- Falls
- Poor discharge

Patient Experience and Engagement



Graph 18: Performance of complaints and compliments

Highlights:

- Complaints have fallen by 65% in the last six years from 665 five years ago to 233 in 2017-18, with a balancing measure of 2923 PALS (Patient Advice and Liaison Service) cases received, graph 18.
- This means that the Trust received 240 more PALS concerns than last year which we were able to direct to our rapid-fire, early resolution service, that's 240 more problems solved than last year and 19 fewer complaints received.
- Compliments are critical to staff wellbeing and morale however during 2017-18 we received fewer compliments at 3826 than last year; this is not because our services are not well regarded, but we know it is due to under recording at local level as a result of staff unavailability.
- We have a plan to address this in 2018-19 connected with a new Electronic Feedback System.
- The Parliamentary and Health Service Ombudsman in 2017-18, reviewed 7 complaints not to have been completely resolved at the local level. Four of these were partially upheld and further responses from the Trust were sent to these complainants.
- The Trust appointed a Voluntary Services Manager in September 2017 who has been highly effective with the completion of a review of governance, a data cleanse and a refresh of all volunteers' inductions now complete
- We have also reached the milestone of 200 volunteers working for PAH (The Princess Alexandra Hospital) with the objective of recruiting another 100 volunteers by the end of 2018.
- The Patient Panel has continued to challenge hard and work with the Trust and believe they significantly contributed to the success of exiting Special Measures
- This work included hosting a patient led conference on the results of the National Cancer Patient Experience Survey 2017, which took place in March 2018.
- In June 2017 we also hosted the "I'm a patient, get me out of here" conference on the challenges around leaving hospital, the impact of which is in evidence in the early results of the National Inpatient Survey 2017.

Introduction: Services we provide to you

When we talk about Patient Experience and Engagement at The Princess Alexandra Hospital we mean three main services, these include:

Patient Experience: Patient Advice and Liaison Service (PALS)

Every year we signpost, provide support to, or resolve concerns for, numerous, patients, carers and families, in 2017-18, 2923 people were given this kind of support. You can contact PALS about this kind of problem and many others by email or by coming to the main entrance Monday to Friday between 10am and 4pm to meet one of the team. Our email is at pals@pah.nhs.uk.

Patient Experience: Complaints Service

We offer an effective and efficient complaints service and last year we resolved the majority of concerns by the deadline agreed between the hospital and the complainant.

The Complaints Service allows you to contact us with your concerns and ask us to investigate, often this can be where an incident has occurred or where several organisations are involved in providing care but this has been ineffective or uncoordinated. You can contact the Complaints service by email at complaints@pah.nhs.uk.

Patient Engagement: Voluntary Services

We have nearly 200 local people volunteering their free time at The Princess Alexandra Hospital, giving up hundreds of hours every week. Why not join? Catch us on twitter @PAHVolunteers or email volunteers@pah.nhs.uk.

Patient Engagement: Improvement Methods

All of this work is intended to help the hospital deliver continuous improvement. The hospital applies *systems thinking* to improve its services, these are discussed in the report "A promise to learn, a commitment to act" (Berwick, 2013). This means that rather than focusing solely on the area of complaint, such as in the Emergency Department, we look at the variety of contributory factors which led to the problem, such as a lack of bed capacity in the wider organisation.

Listening, responding and improving - Projects: What Matters to You

End of Life Care Volunteers: One of the areas where we have applied this approach is in end of life care, patients, the public and staff came together to participate in an End of Life Care improvement workshop using the World Café method.

This event which took place on Monday 3 October 2016 first discussed the idea of an end of life volunteer with the notes explaining the role as follows:



"The potential volunteer role could be a valuable addition to the service, and successful models elsewhere should be explored... the importance of screening, selection and training cannot be over-emphasised and a robust system of supervision and support is put in place by the Trust."

National Cancer Survey

On 29 March 2018, the Trust ran an event for the local community, led by the patient panel to gather views on how cancer patient experiences can be improved.

The National Cancer Patient Experience Survey 2017-18 results were very positive and provide evidence of a good service. There is always room for improvement and we are focusing on four specific areas:

- Side effects of care and treatment including late effects
- The financial impact of cancer and treatments
- The role of carers and how we can better support them
- Living with and beyond cancer

In order to ensure that the widest possible group of staff and local people heard and understood the areas for improvement an artist listened to the discussions taking place amongst the groups and illustrated their comments. Below are pictures 14 and 15 depicting two images taken from the discussion on the day.



Pictures 14 and 15 above demonstrate:

- **Caught up in processes.** Is a message for the local health system about how teams work together and the impact this has on patients and their families.
- **Highlight what is available:** cannot be underestimated, and better information was a key challenge to the local health system.

Next Steps: Reaching vulnerable groups and setting standards

We will continue to support our most vulnerable patients with the development of projects which connect with their needs, in particular:

1. **Learning Disabilities:** People with learning disabilities, their families and carers with the aim of working with LD services to develop a work plan for the next 3 years published on our website and shared with groups through outreach and easy read information we publish.
2. **Cancer:** Patients, families and carers receiving cancer care focussed on the National Cancer Patient Experience Survey results
3. **End of life:** Patients, families and carers receiving end of life care and reinforcing the support and assistance which can be offered to them including parking concessions, visiting times, food and drink and volunteer support
4. **Sensory Loss:** People experiencing sensory loss with the development of a community of practice to know as sensory ambassadors working with access experts ECL beginning by training 30 staff in supporting access, aiming for a disability friendly Charter Mark for the Trust.
5. **Inclusion:** Seeking out people with protected characteristics for involvement in patient groups, to ensure access to the complaints process and involvement in improvement.
6. **Standards:** We will set a patient experience minimum standard across all of our services so you know what to expect from your visit to hospital and will measure all of our services against this mark which will include the results of the National Patient Experience Surveys.

National Patient Experience Surveys

The Trust results of each of the National Patient Experience Surveys published in 2017-18.

The Trust's objective is that no area should be in the bottom 20% nationally for any question in any survey. At present, of the 244 questions asked across these four surveys, 13 are red rated (bottom 20%) in the Maternity, Cancer and Emergency Department Surveys. In the Inpatient Survey 17 are red rated (previously 20), making the majority of the remaining 214 amber or green, with a total of 30 questions red rated.

These relate to the following thematic areas (Inpatient Survey data grouped into themes for brevity and as some results mirror other Surveys):

Maternity 2017 (annual)

- Being left alone when it worried you
- Being involved in decisions about care and treatment

Cancer 2017 (annual)

- Explaining possible side effects of treatments in a clear way
- Doctors and nurses talking in front of you as if you were not there
- Enough privacy when discussing condition or treatment
- Being given a plan of care including pain control

Emergency Department 2016 (bi-annual)

- Privacy when speaking to receptionist
- Delays in hand over from ambulance service and more than 4 hours for treatment
- Doctors or nurses speaking about you as if you weren't there
- Staff available to provide emotional support
- Food and refreshments and home situation being taken into account

Inpatient Survey 2018

- Being admitted from emergency department and waiting for a bed
- Receiving answers to allow the involvement in care and decision making
- Nurse shortages
- Information about who to contact if worried after discharge
- Understanding medicines on discharge and receiving printed information.

The patient Experience team will be working on improvements in all of these results. If you would like to get involved, please contact Shahid.sardar@pah.nhs.uk.

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 229 complaints in 2017-18

Subjects of complaints

The most frequently occurring themes were medical care expectations, 63, communication with 45 and nursing 27.

Actions taken

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

You Said	We Did
Access to Chaplaincy Services is difficult and written patient information about this service is missing.	We wrote, consulted on, further developed and printed 3 new pieces of information, a calling card, a service information leaflet and a children's services leaflet in partnership with the Patient Panel who have positively evaluated the documents. In use from March 2018.
There is a lack of palliative care knowledge amongst ward staff, especially when senior staff are not available and for the adjustments which need to be made to meet the needs of the family and carers.	We trained all lead staff so they are now competent in the use of a new syringe driver pump. All staff has been updated on arrangements for families staying with patients who are nearing end of life. This includes a bed, to stay with the patient, free car parking, regular meetings with lead staff and the palliative care team to address issues and review scores.
Visually impaired patients lack support at ward level when calling for a nurse and need reasonable adjustments so that the call bell can be used and needs identified.	We designed and introduced a highly visible yellow band to enable staff to identify patients with sensory needs and where someone is visually impaired we will be introducing voice activated call bells which will provide a benefit for all patients with disabilities.
Patient and family communication with senior medical staff can sometimes be difficult and this has resulted in this case in a failed discharge.	We will introduce a set of Patient Experience Minimum Standards for all areas and wards including enabling all patients, families and carers to be able to meet a consultant at an agreed time.
Some patients can feel they are being pressured into having a local anaesthetic rather than a general. In this case the patient then became unwell and staff, with exception of the consultant, was unhelpful.	We established an additional Anaesthetic Clinic and developed a patient information leaflet, led by the Patient Panel to inform and assure patients about the options with regard to anaesthesia.
End of life care for patients with a learning disability is inconsistent with that for other patients, especially in the Emergency Department.	We recruited new learning disabilities champions in the Emergency Department and made environmental changes on Ray Ward where the quiet room was unsuited to patient and family needs.
A parent whose child received postnatal care using antibiotics didn't get the information and contact she expected following discharge.	We produced a booklet for parents outlining the reasons for antibiotic use, information about investigations and timescales in relation to results, with a contact number for postnatal staff to ensure communication between parents and consultant is maintained.
A mother raised concerns that her son was inappropriately restrained during a procedure.	We reviewed the competencies of staff in the Emergency Department and have now included therapeutic holding techniques and distraction for small children supported by Children's Services specialists.
A carer had concerns about a discharge to a care home without oxygen, feels that there was a lack of understanding of condition.	We wrote a new discharge checklist and patient information which has been very positively evaluated based on evidence from the National Inpatient Survey 2017. We are continuing to monitor its effectiveness.
A patient said that BSL (British Sign Language) interpreters are not identified as being needed prior to all pre-natal and post-natal appointments even if this has been explained a number of times.	We changed our Electronic Patient Records System to ensure all patients with a BSL interpreter requirement can be flagged on the system and these needs can be checked earlier to avoid patients being left unable to communicate.

Table 29: Summary of feedback from you said, we did

Our amazing Patient Panel

Our Patient Panel is a group of local people, critical friends to the hospital who contribute significantly to the organisation. The Patient Panel exists to ensure the voice of the patient is heard by decision makers and service delivery teams. To consider that age old question, “What is it like being on the receiving end of our care?”

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 Assessment of the Care Environment (PLACE)

The Patient Panel are crucial to the Patient Led Assessment of the Care Environment Assessment (PLACE) along with members from HealthWatch in Essex and Hertfordshire. This year the majority of the Panel took part in the assessment. The panel make recommendations for improvement and maintenance of flooring, lighting, public amenities.

Review of Existing Practice

The Panel members represent our patients and give input into drafts of patient information leaflets. They are there to ensure all our patients, families and carers will have their needs met through written information.

Panel members have taken part in the weekly quality inspection reviews which are unannounced visits to check on specific areas of practice and hospital work. They will talk to patients and carers to establish their views on care given. These help us to identify areas for improvement and recognise good practice.

Patient Panel members participate in over 30 hospital committees and on working groups including dementia, infection control, organ donation, sepsis, consultant awards and interview panels, with many more contributions too numerous to list here.

The Panel's Complaints Reference Group regularly monitors samples of closed complaints to ensure due process has been correctly followed and challenges and follows up to check that actions have been taken. This year the panel took part in the food tasting sessions for our new menus which are being introduced following the recent change in the catering arrangements. The Panel will be carrying out surveys of patients, staff and visitors.

Patient Panel Annual Conference

The fourth Patient Panel Annual Conference was held in June 2017 and looked at the discharge process with the title - “I’m a Patient, Get Me out of Here”. The conference was a great success. Students from Harlow College assisted the panel in the preparation of the conference and management on the day. They produced a short film to illustrate the discharge process. The team developed modified 'snakes and ladders' game, used to show problems and successes of discharging patients. This game received attention from NHS England with a view to using it for public awareness and education.

Harlow College students have again assisted by conducting a survey of GP's (who were on a training day). The aim is was to gauge the GP's understanding of the 'fast track' process for cancer patients in preparation for the 2018 Conference.

The Panel has supported a number of initiatives by members of staff by arranging, or helping to finance:

- the formation of an Addison's patient support group
- a Learning Disability Workshop
- a Deaf Awareness Day

- Another unexpected spin off from the work of the Panel includes being invited to speak to other hospitals in the Eastern Region about the approach of the Panel at PAH

Patient Panel Plans for 2018/19

The Trust and the Panel wants its membership to reflect the make-up of the local community and encourage wider participation in hospital affairs by minority groups. We are continuing to make contact with Muslim and Chinese communities. However, most of the Panel's work is undertaken at times when most people are at work or college, so we recognise our recruitment will be from a very small proportion of the population. Despite these difficulties, we endeavour to increase the membership of the Panel by 50% over the next year.

The Panel will make greater efforts to publicise its own activities and the good work of the Hospital by producing a Welcome Pack for new potential members.

The Patients Panel will nominate a member to attend each public Trust board as the first step in the process to developing our panel members so one can apply in the future to an advert for a Non-Executive Directors role.

If the Trust's outline business case for a new hospital is approved, the panel would like a member to be appointed to the planning steering group. This will demonstrate co-production at the highest level and reassure the local community that their views will be heard and considered, not only in the development and design of the new campus but also in the planning of public engagement and communication.

Optimising the hospital environment

In 2017/18 further work on the development of plans for our new hospital were undertaken, including testing the option for whether alternative funding streams to fast track the development of a new hospital could be supported. As a result of this work the Trust has successfully submitted a strategic outline plan to the Department of Health for consideration. Whilst work on developing plans for our new hospital are well underway we still have to ensure we improve where we can the existing buildings on the main hospital site

When the Trust developed its capital programme for 2017/18 it recognised the need for considerable improvements to address our patient and visitor experience, service capacity and organisational resilience across a range of diverse projects which included:-

Main Hospital Entrance – Patients will enjoy transformed access to services at Harlow's Princess Alexandra Hospital following a major upgrade. The installation of a new door was essential to enhance the patient experience on entering the building, to meet disability discrimination legislation and to improve the general environment of the 1960s built infirmary. We have transformed our coffee shop and have a small retail space in the Trust.



Costa Coffee Shop



Retail Outlet



Emergency Department

The Princess Alexandra Hospital NHS Trust secured additional capital funding from two successful bids to NHS England to support patient flow and safety in our main emergency department. As a result of this funding award we were able to carry out clinically-led extensive modifications to our Emergency Department which included alterations to the main reception for patients, a discharge lounge and were specifically targeted to improve the flow of patients through the emergency department and to reduce waiting times.





Paediatric Emergency Department

We were also able to commission and build a new paediatric emergency department as well as a paediatric ambulatory care unit. Since the completion of these projects there has been a demonstrable improvement in patient experience and a reduction in patient waiting times.



Outpatients Department Waiting Area, Main Corridors, Lift Lobby and Stairwell

This project was approved to positively impact on our patient experience. The Stairwell designed when the hospital opened was a spiral design which became unfit for purpose and required major development. The outpatient department was reconfigured to increase waiting area capacity and the wellbeing of our patients and visitors, attending the hospital. In addition the changes have had a positive impact on the patient flows, wayfinding, and in the case of the staircase refurbishment, improvements to safety and security.





Maternity Theatres Refurbishment

The Trust's annual birth numbers have grown dramatically since the build of the present theatre in the 1960s, and further growth and complexity of cases is anticipated as Harlow continues to expand. This project will ensure the Trust's maternity department can operate effectively and in the event of a complex birth, have the ability to operate in environments that conform to the highest healthcare standards.

Backlog Maintenance Schemes

Additionally, the Trust has made significant strides in engineering compliance by addressing a number of high risk backlog maintenance schemes, including; electrical remedial works, replacement generators, within our plantrooms, we have replaced valve systems, plate heat exchangers, motorised pump, heating and ventilation and building management system controls.

Statements from Stakeholders



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.

We would like to congratulate all staff at The Princess Alexandra Hospital NHS Trust for their hard work and dedication to achieve an improved CQC rating and to come out of special measures within 18 months. The changes in the governance approach and the inception of the Quality First team have had a positive effect.

In 2018/19 The Trust will continue to improve with the strategy Your Future Our hospital and concentrating on the five “P’s”, our:

- Patients
- People
- Performance
- Places
- Pounds

The specific priorities for 2018/19 are clearly identified; they are elements that require improvement from either a constitutional or CQC standards point of view and are needed to ensure quality care can be consistently provided to patients and their families.

The Trust has reported against last year’s quality priorities (2017/18) but it is not clear from the narrative whether these priorities were fully achieved or not. In some cases partial achievement is inferred but the reasons why have not been articulated.

The two new requirements for this year’s quality accounts are:

- Learning from deaths, this section is brief in the draft report and is being updated for the final version.
- A statement on how the Trust is implementing the 10 priority clinical standards for seven day hospital services, in the draft report this is a brief statement and does not refer to the clinical standards, we hope this will be revised in the final quality account

The Trust has identified many departments and speciality teams within which improvements have been made in the last year, notably the End of life team, the development of Gibberd ward as an end of life ward and the introduction of training for staff to become Butterfly volunteers. These volunteers can then provide one to one compassionate listening, comfort and companionship for patients who have been identified by the multidisciplinary team as being in the last few days and hours of life, particularly for those with few or no visitors who would otherwise be alone.

Both the Critical Care and Emergency Department teams have demonstrated the beneficial effect that can be achieved from the supportive environment that has been nurtured within the Trust. The

staff survey improvements and the training opportunities that have been taken up demonstrate how staffs are feeling.

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

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

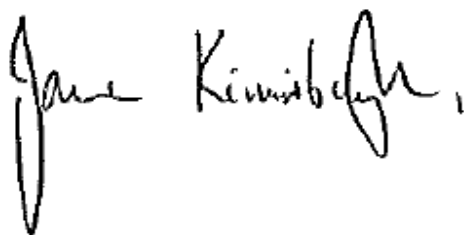
We are grateful that the Trust has included in the report the governance arrangements for producing the quality account, so it is clear to patients and families how this complex document is created. We are also grateful that a glossary of terms has been included.

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

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

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

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



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

May 2018

East and North Herts Clinical Commissioning Group's Response to the 2017/18 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 2017/18, based on the data submitted during the year as part of the on-going quality monitoring process.

During 2017/18 ENHCCG has met regularly with both the host commissioner, West Essex CCG (WECCG), and PAH to review progress in relation to the quality of services provided.

A key focus for PAH during 2017/18 has been to make the required improvements following the CQC's rating of 'inadequate' based on their inspection in 2016. The CCG recognises the effort and commitment of the Trust to improve services and ensure patients receive high quality care. This was evidenced during the Trust's further CQC inspection in December 2017, resulting in an overall outcome of 'requires improvement' and the Trust being removed from special measures. Whilst there is still work to do to make further improvements ENHCCG was pleased to see that the Trust has been rated as 'good' for the domains of effective, caring and well-led, and the Trust's maternity and gynaecology services were rated as 'outstanding'.

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

The Trust's 2018/19 Quality Priorities demonstrate the commitment to further improve the quality of care provided to patients and improve staff experience. ENHCCG is pleased to see that reducing mortality is a priority for PAH following the rise in SHMI throughout 2017/18. The CCG would like to see a clear focus on reviewing pathways and making improvements in areas where the mortality rate is higher than expected.

ENHCCG also notes the Trust's focus on its workforce, particularly in relation to staff wellbeing and recruitment and retention of registered nurses. Maintaining safe nurse staffing levels is essential, and whilst the CCG notes the work undertaken by the Trust, and the mitigating actions taken to ensure safe staffing levels are maintained, we would wish to see a reduced nurse vacancy rate over the coming year.

Whilst PAH has continued to perform well in relation to cancer services and referral to treatment times, performance in relation to the A&E 4 hour target has been disappointing. We do expect to see improvement in this area during 2018/19.

During 2017/18 PAH identified areas within the Trust where systems and processes were not as robust as they should be, resulting in a significant number of patients being identified that had not

received follow up care in a timely way. The CCG recognises the actions subsequently taken to address this issue and to check that no harm had come to patients as a result of delays. The CCG will be looking for further assurance during 2018/19 that systems are in place to prevent a recurrence of this issue.

Overall we acknowledge the quality work undertaken during 2017/18 resulting in an improved outcome from the latest CQC inspection; however ENHCCG wishes to see on-going drive and momentum to ensure these improvements are sustained and to deliver further improvements in the quality of services delivered to patients.

We look forward to working with and supporting PAH in further developing and monitoring the quality of services it provides for patients. We hope the Trust finds these comments helpful and we look forward to continuous improvement in 2018/19.



Beverley Flowers
Chief Executive
May 2018



Response to Princess Alexandra Hospital (PAH) Account 2017/18 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. We believe that health and social care organisations should use people's lived experience to improve services. Understanding what it is like for the patient, the service user and the carer to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it.

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

- What is impressive is PAH's significant achievement in getting out of special measures within 18 months, which shows both commitment and drive towards improvement delivered by its staff.
- HWE is also impressed with the work PAH has done around supporting people with sensory impairments and their commitment to meeting the Accessible Information Standard.
- It is encouraging to learn that PAH are actively using patients' stories to share the impact of care given from the perspective of the patient and their family – this is evident in bereavement and maternity. This helps to identify gaps and make improvements. Work is also being undertaken around end of life care.
- Communication and information given to patients at discharge has improved significantly and there has been a reduction in delayed transfer of care.
- It is promising that the Trust is actively working with external stakeholders involved in learning disability care to ensure that people with a learning disability are able to attend their hospital appointments with a successful outcome. The trust is also actively supporting carers, particularly those who care for someone with dementia.
- It is encouraging to learn that complaints have fallen and that the PALS early resolution services has been able to solve 240 more problems than last year.
- HWE is impressed that PAH have recruited 200 volunteers, and intends to recruit 100 more by the end of the year, and has also appointed a Voluntary Services Manager to support them.
- It is disappointing to learn that PAH has received fewer compliments than last year, and that this is probably a result of under recording, due to staff shortages.

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 David Sollis

Chief Executive Officer, Healthwatch Essex

16/5/18

healthwatch

Hertfordshire

Healthwatch Hertfordshire's response to Princess Alexandra Hospital NHS Trust (PAHT) Quality Account 2018

Healthwatch Hertfordshire welcomes the opportunity to comment on PAHT's Quality Account. A Healthwatch Hertfordshire (HwH) Board member participated in the Health Scrutiny Committee's session to question the trust on the Quality Account priorities in March 2018. HwH agrees with the recommendations, good practice and risks identified at this two day event (see Hertfordshire County Council Health Scrutiny Committee statement) .

In addition we would like to make the following comments:

- We would like to congratulate the Trust on moving out of special measures to 'requires improvement' in their recent Care Quality Commission (CQC) inspection with 'good' grades for the caring, well-led and effectiveness domains. The Quality Account reflects the ambition of PAHT to drive forward quality improvements and achieve a CQC 'outstanding' rating.
- Over the last year we have welcomed the increased involvement HwH has had with PAHT to represent Hertfordshire residents. This has ranged from our role on the Oversight Group, membership of the Trust's Patient Panel (HwH Board member) and joining volunteers in the PLACE (Patient Led Assessment of the Care Environment) audit of the hospital. Last October we conducted an Enter and View visit to several wards and we were pleased at the response the Trust gave to our recommendations.
- The Quality Account priorities for 2018/19 rightly focus on areas that have been identified as key for patient safety and experience. For example mortality, emergency department and cancer waiting time indicators. We look forward to seeing the progress made in these areas.
- Recent improvements have also been made to the estates and facilities of the hospital which will further enhance patient experience.
- We are pleased to see that the work on supporting patients living with dementia and their carers is continuing through a number of different initiatives with staff and volunteers.

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



Michael Downing, Chair (outgoing) Healthwatch Hertfordshire, May 2018



Seamus Quilty
County Councillor
Bushey South

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7 June 2018

Dear Lance McCarthy

On behalf of the Hertfordshire Health Scrutiny Committee (HSC) I welcome the opportunity to comment on the Princess Alexandra Hospital quality account and the engagement of the Trust with the committee.

PAH sits within the Hertfordshire and West Essex STP. This has led to a strengthening of the links between the Trust and the Hertfordshire HSC. Members have held in-depth discussion with PAH on a number of occasions. This has included consideration of the progress on the previous year's priorities and the implications for the Trust to maintain and further improve this year. PAH has been open in these discussions and responded to the concerns raised.

The Trust attended the Hertfordshire Health Scrutiny of Quality Accounts held over two days in March this year (15 & 29 March 2018) to outline the proposed priorities for 2018/19. The Trust provided a written response to the agreed questions in advance of the meeting. The scrutiny was attended by the Chief Executive and the Deputy Chief Executive & Chief Nurse.

The Committee was impressed with the Trust officers' open and candid responses to their questioning. They believe it shows a strong commitment to delivering and seeking to improve health services to the residents of Hertfordshire.

HSC appreciates the increasing contact with PAH. Participation in scrutiny is a valuable component of the engagement between the Trust and Hertfordshire County Council.

Members endorse the priorities as being appropriate to the needs of the users and carers.

Overall, members regarded the draft quality account priorities as sound.

A number of observations were also made during the scrutiny

- *The Committee recommends that PAH supports and remains focussed on maintaining the quality of care provided for current patients and that patient flow and demand management remains a priority, irrespective of any future plans for new facilities.*
- *Great work has been achieved under the current leadership at PAH; however, they raised the issue of contingency arrangements should strategic leaders leave the organisation. There is a risk that a change in leadership may compromise the improvements achieved.*
- *Concern was raised over capacity as there are too few beds to meet current demand. With projected future demographic changes and the increase in the population in the wider surrounding area increases the severity of that risk.*
- *The current number of vacancies for doctors and nurses within PAH and the difficulties in recruiting raises concern as to the impact this will have on patient outcomes.*
- *The reliability of IT systems at PAH was also noted as an issue of concern.*

Yours sincerely



Seamus Quilty
Chairman Health Scrutiny Committee

Thank you for giving the Health Overview Policy and Scrutiny Committee (HOPSC) the opportunity to comment on the PAH Draft Quality Accounts.

The HOPSC always seeks to provide critical friend challenge whilst being supportive to health providers. In particular, over the last year a HOPSC representative has participated in the Oversight Group you established to oversee quality improvement work arising from Care Quality Commission concerns.

The HOPSC receives a number of Quality Accounts each year from health providers and is unable to review them all in the short time span given us. This year the HOPSC has not specifically reviewed your Quality Accounts. However, we expect to work with PAH senior management in the coming months on a number of matters and look forward to constructive discussions.

Jill Reeves

Chairman

Health, Overview & Policy Scrutiny Committee

Member Hadleigh Division

Essex County Council

Statement from Princess Alexandra Hospital Patient Panel

The PAHT Patient Panel welcomes the opportunity to provide this statement on PAHT's Quality Accounts.

We confirm that we have reviewed the information contained within the Account and in our opinion it is accurate in relation to the services provided.

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

We have taken particular interest of the identified priorities for improvement and how this work will enable real focus on improving the quality and safety of health services for the population served.

The Patient Panel will be committed to working with the Trust to ensure a focus is kept on the Quality Indicators and regular progress will be monitored throughout 2017/18.

Ann Nutt

Chair of the Patient Panel

External Auditors Assurance Report

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

This report is produced in accordance with the terms of our engagement letter dated 25 April 2018 for the purpose of reporting to the Directors of The Princess Alexandra Hospital NHS Trust (the 'Trust') in connection with the Quality Account for the year ended 31 March 2018 ("the Quality Account").

This report is made solely to the Trust's Directors, as a body, in accordance with our engagement letter dated 25 April 2018. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018 to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

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

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

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

Scope and subject matter

The indicators for the year ended 31 March 2018 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 Ernst & Young LLP

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health 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 the other information sources detailed in the ‘NHS Quality Accounts Auditor Guidance 2014-15’. These are:

- Board minutes for the period April 2017 to June 2018;
- papers relating to quality reported to the Board over the period April 2017 to June 2018;
- feedback from the Commissioners dated May 2018;
- feedback from Local Healthwatch dated 16 May 2018, Healthwatch Essex and May 2018 Healthwatch Hertfordshire;
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated May 2018;
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the latest national patient survey dated June 2018;
- the latest national staff survey dated 6 March 2018;
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated 15 May 2018;
- the annual governance statement dated 24 May 2018;
- the Care Quality Commission Inspection Report dated 21 March 2018.

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

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

Assurance work performed

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

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

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

Inherent limitations

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

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

The nature, form and content required of Quality Accounts are determined by the Department of Health. 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 2018:

- 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.



Suresh Patel, Associate Partner
For and on behalf of Ernst & Young
Luton
26 June 2018

1. *The maintenance and integrity of The Princess Alexandra Hospital NHS Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Account since it was initially presented on the web site.*
2. *Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.*

Glossary of terms

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.

Ambulatory Care

Medical care provided on an outpatient basis, includes diagnosis, observation, consultation, and treatment

Appraisals

An act of assessing something or someone.

Appreciative Enquiry model

Seeks to engage stakeholders and uses existing strengths, achievements and successes and move individuals towards self-determining change

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 into standard, recognised codes that reflect the activity that happens to patients.

Clinical Commissioning Group (CCG)

NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Clinical Nurse Specialist (CNS)

A nurse who has advanced knowledge and competence in a particular area of nursing practice.

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.

Diagnostics

Tools used to help identify disease and illness

Diagnostic overshadowing

making an assumption that what is wrong with a patient is their LD not their medical condition

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 apologizing 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 management

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.

Escherichia Coli (E.coli) bacteraemia

Type of bacterial infection and a blood stream infection

Fit and Proper Persons Regulations

Providers of care must not appoint any person who has been responsible for, contributed to, facilitated any serious misconduct or mismanagement (whether lawful or not) in the carrying out of regulated activity

Friends and Family Test (FFT)

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

FY1

First year junior doctor

Gastroenterology

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

Genito-Urinary

The 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

Gram negative blood stream infections (GNBSIs)

Type of bacterial infection and a blood stream infection

Gynaecology

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

Haematology

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

Healthcare Associated Infections (HCAI)

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

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.

Klebsiella bacteraemia

Type of bacterial infection and a blood stream infection

Malignancy

The presence of a malignant tumor which is a 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

Medicines Reconciliation

Is the process of creating the most accurate list possible of all medications a patient is taking

Meticillin-Resistant Staphylococcus Aureus (MRSA) / Meticillin-Sensitive Staphylococcus Aureus (MRSA)

Types 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 of 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 services, as well as Independent providers that provide NHS-funded care. They offer providers support to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NICE

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

Norovirus

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

National Reporting and Learning System (NRLS)

A central database of patient safety incident reports set up in 2003

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

Public Health England

A government body with the role to protect and improve the nation's health and wellbeing and reduce health inequalities

Pulmonary Embolism (PE)

A sudden blockage in a lung artery.

Radiology

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

Rapid Assessment and Treatment (RAT)

A treatment model used in emergency care to provide an early senior assessment and early treatment

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.

SAFER

A resource used to implement the patient flow bundle. Ensuring 5 elements are undertaken to aid patients flow through a hospital. Ensuring: a senior review, all patients, Flow through hospital, early discharge and Review.

This should be completed in conjunction with Red2Green which is about identifying factors contributing towards a delay in discharge.

Sepsis and Septicaemia

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

Serious Incident Group (SIG)

A formal review of serious incidents which may need external reporting.

Serious Incidents (SIs)

An unexpected or unplanned event that caused harm or had the potential to cause harm to a patient, member of staff, student, visitor or contractor.

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

Standardised Mortality ratio (SMR) and Summary Hospital-level Mortality Indicator (SHMI)

Ratio between the actual number of patients who die following treatment at the trust and the number that would be expected to die, on the basis of average England figures given the characteristics of the patients treated there. SHMI

Senior House Officer (SHO)

junior doctor undergoing training within a certain speciality.

Transitional Care

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

Triage

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

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.

Venous Thromboembolism (VTE)

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

VTE Prophylaxis

The giving of a medicine or treatment to prevent a VTE

16S Ribosomal RNA

Used for studying and profiling bacteria to provide identification and classification