The Princess Alexandra Hospital NHS
NHS Trust

Quality Accounts 2015-16

Building for excellence

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Introduction from the Chief Executive

Welcome to our annual review of the quality we believe that the Princess Alexandra Hospital Trust has delivered over the last year and also to outline the ambitions for further improving the care and better outcomes for patients over the coming year. You will see the high level of both patient experience and excellent clinical outcomes that we have achieved and the pride we take in our staff who are constantly living the values and despite all the pressures, give their best every day, every shift, every time.

We are pleased to say we were one of the very few organisations that delivered all of our cancer standards in the year and that patient feedback on the cancer care remains really positive. We also ended the year with just over 90% of all patients on waiting lists being seen in the 18 week target. This is a major achievement after introducing a whole new computer system and reviewing over 170,000 patient records.

By the end of June 2016 we hope to be at the national standard of 92% of all patients meeting the 18 week referral to treatment (RTT) target.

Our biggest challenge over the year and one which continues to be, is meeting the Emergency Department 4 hour standard. We now see almost 110,000 people in a year in the Emergency Department that was only built to accommodate 60,000.

We have also seen an increase in the number of over 75 year olds and above by more than 17% over the year whilst at the same time, the number of beds has gone down which has put huge pressure into the busiest parts of the hospital. Clinical Teams are working hard on developing a new 'clinical operating model' that will radically change the way we all work and will focus on the following 5 patient work streams:

i. Patient at Home
ii. Short stay patients
iii. Frailty
iv. Specialty Patients
v. Complex care

We will start to implement these changes through July to September 2016 to ensure a better patient flow and that patients get to the right place first time and then home again as soon as it is safe.

The Board and Senior Clinicians have been working on the future of the Hospital and looking how patient centred care is set to change over the next five years. True quality for service users is being able to access services closest to home and at the right time, so we are forging even stronger relationships with our Primary Care, Community and Social Care Colleagues. The future in utilising 'neighbourhood teams' with Hospital staff to provide seamless care for our population is exciting and evolving rapidly – the future for all our patients has to be about partners coming together and joining up services to enable better patient experience all round.

Our complaints continue to fall and the number of compliments increased. The scores on our Friends and Family Test (FFT) remains one of the highest in the region and the CQC rated us as the only Trust that was green (good) for care in every domain during their inspection in July 2015 this is something we are truly proud of and work continues to maintain and improve on for future inspections. In the likelihood that we do fail to give the high standard of care we aim for, we believe in being open and honest and carry the duty of candour above and beyond of what is expected. So we have listened when you tell us what is good and what can be done differently – remember this is our NHS and your voice is important.

We have a fantastic patient panel chaired by Ann Nutt and they will represent you and your voice if you find it hard to speak up, so please get involved and make your ideas and thoughts count to help make a difference.

Finally, I could not sign off without looking forward to a new future and the vision of a new hospital to help cope with the demands on our services and population growth .We have had fantastic support from our Local MP Robert Halfon and Malcolm Morley, Harlow Council, district councils alike and local commissioners to help press for significant monies to either refurbish, rebuild or even relocate to a new site. The Princess Alexandra Hospital is part of the fabric to Harlow and its surrounding area – it is the beating heart of the community to which we all hold dear. We hope to know very soon what plans lie ahead for our future and how we can truly have a hospital that is all what we need when we need it most.

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

Phil Morley
Chief Executive

Statement on quality from the CEO

The development of this Quality Account gives staff the ability to look at and think about the progress made to improve care for patients in 2015/16. It has also provided the Trust with a chance to decide on, and commit to, further improvements for patients that we will make in 2016/17.

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

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

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

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

Phil Morley
Chief Executive

Priorities for quality improvement 2016 - 2017

The Health Act 2009 and associated Regulations require all providers of NHS healthcare services in England to publish a quality account each year about the quality of NHS services they deliver.

The Trust has a process in place to ensure compliance with Chapter 2 of the Health Act 2009. The Chief Nurse is the Executive Lead for the Quality Accounts and is supported by the Head of Communications in the preparation of the accounts. The Chief Executive receives notification of any changes or revisions to guidance or regulation and any guidance issued by the Secretary of State relating to Chapter 2 of the Health Act 2009 (Duty of providers to publish a Quality Account) would immediately be identified and escalated to the Chief Nurse and Head of Communications. In addition, any new guidance is reviewed on publication and any revisions to the requirements is noted and addressed in the production of the Quality Accounts.

Each year we assess our performance against previous quality priorities and take account of national reports and emerging themes. This year we have again evaluated our focus for the coming year and have identified a number of quality indicators for 2016-17.

The Board has chosen three 'Big Dots', part of our 'Big Improvement Campaign' which encompass areas of concern, safety improvements, advice following our CQC inspection in 2015 and staff improvements as identified in the NHS national staff survey. These priorities are part of the Trust's overarching Quality Improvement Strategy which aims to improve outcomes for patients including our mortality rate which is measured at a national level.

The following indicators in the table below have been approved by the Board and will form the basis of all Trust-wide improvements across the year ahead.

Priorities for quality improvement 2016-2017				
1	**Patient Safety Priorities**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**
1.1	Improving the identification and treatment of patients with Acute Kidney Injury	To improve early recognition of Acute Kidney Injury to allow intervention and treatment	Patient have a diagnosis of AKI which facilitates monitoring under primary care Improved mortality 30 days after discharge from hospital with a diagnosis of AKI All patients leaving hospital with a diagnosis of AKI will receive information about their condition Improved reporting to GP's through electronic discharge summaries on	Audit of patient records to ensure that discharge summary contains the blood profile to alert primary care of AKI. This will be reported quarterly

			blood results, medication reviews and after hospital follow up requirements	
1.2	Improving the identification and treatment of patients with Sepsis	Standardisation and early recognition of sepsis and treatment with first dose antibiotics for both inpatient and those presenting in the emergency department	Patients with sepsis receive timely appropriate treatment in line with the national sepsis guidance Improvement trajectory to achieve 90% compliance with recognition of sepsis, antibiotic administration and review after 72 hours	Audit patient records to ensure that treatment concurs with the national sepsis guidance and that first dose antibiotics are delivered in 60 minutes of a formal diagnosis of sepsis. This will be reported quarterly
1.3	To improve Trust wide antibiotic stewardship	To improve antibiotic prescribing, to ensure rationale and duration are in accordance with best practice	To reduce antibiotic consumption per 1000 inpatient admissions	To reduce antibiotic consumption per 1000 inpatient admissions
2	**Clinical Outcome Priorities**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**
2.1	Continue to enhance the care people receive at end of life while in hospital and patients and appropriate next of kin are involved in end of life discussions	The discussion and completion of appropriate Do Not Attempt Cardiopulmonary Resuscitation orders End of Life plans of care in partnership with patients and their appropriate next of kin Early discharge to preferred place of care and reduce inappropriate readmission to hospital Palliative care Coding May 2016 1.85% (national average 3.34%)	Eliminate inappropriate resuscitation and demonstrate that patient return to their preferred place of care Discharge summaries will include record of discussions of advance care plans with patient (if possible), and those important to the patient Increased percentage of patients dying out of hospital (currently 48%) Palliative care coding will equal or exceed national average.	CQUIN milestones and other key performance indicators include: Improvements in the National Care of the Dying Audit Monthly audit of all cardiac arrest and mortality to ensure that patients has received appropriate end of life discussions and plans Review of discharge summaries Coding audit Monthly PS&Q meeting.
2.2	Continue to improve the care received in hospital by people living with dementia in accordance with the Alzheimer Society 2015 Annual Report	Early detection of dementia and onward referral to appropriate agencies Improvements in ward environment in accordance with recommendations from the Alzheimer Society Implementation the Dementia Champions and dementia volunteers for every patient facing area	Screening of all admitted patients aged over 65 (for their potential dementia risk) in line with the local and national CQUIN schemes Improved environment for dementia patients Continuation of dementia champions programme as part of the dementia training programme as required for the local and national dementia CQUIN Implementation of	Compliance with >90% patients screened and referred. Monthly submission to UNIFY Compliance with agreed standards for the environment for dementia patients At least one dementia champion in each clinical area

			dementia volunteers national programme	
2.3	Successful introduction of Hospital at Night to facilitate seamless and equitable care 24 hours a day for acutely unwell patients	This is a two year scheme to introduce and sustain a Hospital at Night team It will consist of a group of multi-professional individuals with an agreed range of skills and competencies to meet the immediate needs of patients and facilitate effective operational management of the Hospital at Night, optimising patient safety and minimising risk	Reduce avoidable cardiac arrests Reduction in the number of unplanned admission and readmission to ITU Reduce avoidable patient harm incidents occurring after 8pm and at weekends Reduction in the number of 'failure to rescue'/suboptimal care' incidents	Hospital at Night project team to monitor progress Compliance with local CQUIN milestones
3	**Patient Experience Priorities**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**
3.1	Improvements in transfers of care as detailed by 7 areas for improvement in the National Inpatient Survey (IPS)	Increased involvement in transfers of care of families, patients and carers Clearer contact information if you are unwell again and on key items such as medication side effects	The National Inpatient Survey 2016 and locally audited metrics supported by Clinical Friday and volunteers running surveys at ward level Improvement on two IPS indicators: • Was your admission date changed by the hospital? • From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	Board and committee reports Process improvement workshops Clinical Friday audit programme IPS results
3.2	Achieve at least 3 areas in the top 20% for ED and Inpatient Surveys for 2016	Improve Patient Experience survey results against 2015-16 and national comparison	Ensure all 77 Inpatient Survey indicators are at least in the middle 60% or above with at least three indicators in the top 20% of Trusts in England and Wales	Monthly Integrated Performance Review Real-time PALS/ patient feedback National survey results
3.3	Implement an effective electronic feedback system for patients with sampling rate of at least 20%	Pace of acknowledgement of complaints Quality of communication with complainants	99% of complaints are acknowledged within 3 working days At least 80% of complaints are responded to within a timeframe agreed with the	Complaints process monitoring at committee level and via the Patient led Complaints Reference group Annual and quarterly

			complainant At least 80% of complainants who provide a phone number and request a call, get a call within 3 working days of making a complaint	reporting. Satisfactions levels shown through survey
4	**Staff Experience Priorities**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**
4.1	Create a better working environment where staff morale is improved and all staff have received appropriate workplace training	Score the national average or above through staff survey	Progress will be monitored through monthly surveys focusing on these indicators: Increased number of staff appraisal/KSF reviews Less unreported experiences of physical violence Increased non-mandatory staff training, learning and development	National and local surveys
4.2	Ensure that the Trust's Vision and Values are embedded among the workforce	Increase number of staff being trained in Trust's Vision and Values	A rise in the number of staff receiving training from the current level of 61% to a minimum of 70%	Regular reports to the Board
4.3	To provide an improved working environment and career progression that will encourage staff to stay at the Trust long term	Staff retention	Reduce voluntary turnover to 10% or lower	Regular workforce reports to Performance and Finance Committee

Statements relating to quality of care provided

The Princess Alexandra NHS Hospital Trust (PAH) provides a range of services to a local population of around 350,000 living in west Essex and east Hertfordshire. The majority of services are provided from the main hospital site in Harlow, but local hospitals in Bishop's Stortford and Epping offer outpatient and diagnostic services too.

The Trust has 480 general and acute beds, employees approximately 2,500 whole time equivalent (WTE) staff and has an annual income of circa £196 million. It provides a full range of services, including; a 24/7 emergency department, an intensive care unit, a maternity unit and a level II neonatal intensive care unit (NICU).

The Trust has been working hard to mitigate the increased pressures on our Emergency Department, particularly over the past winter. The situation is a reflection of the national

picture which has seen emergency admissions increase by 47% in the last 15 years. In the past year PAH has seen 102,833 ED attendances with 28,782 patients being admitted.

In 2015-16 the Trust operated forty-six different services to meet the needs of its patients which are outlined below:

Directory of services			
Adult Critical Care	Diabetic Medicine	High Dependency Unit	Pathology
Audiology	Dietetics	Intensive Care unit	Patient Appliances
Breast Screening	Emergency Department	Interventional Radiology	Pre Op Assessments
Breast Surgery	Endocrinology	Maternity	Radiology
Cardiology	ENT	Medical Oncology	Respiratory Medicine
Chemotherapy	Family Planning	Neonatal Critical Care	Rheumatology
Child Development Centre	Gastroenterology	Neurology	Sexual Health Services (until 31.03.2016)
Clinical Haematology	General Medicine	Obstetrics	Special Care Baby Unit
Clinical Oncology	General Surgery	Ophthalmology	Trauma and Orthopaedics
Community Midwifery	Genito-Urinary Medicine (until 31.03.2016)	Oral Surgery	Urology
Day Surgery	Geriatric Medicine	Paediatric Diabetic Medicine	
Dermatology	Gynaecology	Paediatrics	

The Trust has a service level agreement in place with subcontract providers for the provision of services and has regular contact with them to agree levels, type and timescales for patient treatment. The Trust provides of 89% of its services within contracts and 11% is provided as non- contractual activity.

The Trust reviews all services and the data therein via Data Quality and Patient Safety and Quality groups as well as external review via Finance and Information Governance and SPQRG with main contractual commissioners.

Of the income generated by PAH health services, 100% is subject to review on a monthly basis and discussed at Health Boards and reported via Performance and Finance Committee.

Prescribed indicators

Below are the core indicators which NHS England has requested are included in the 2015 - 2016 Quality Accounts by all NHS Trusts.

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

12	Standardised Hospital Mortality Indicator	Oct 2014 to Sept 2015	National average	Highest score	Lowest score	The Princess Alexandra Hospital NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services , by these Improvement actions:
12a	(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and	103.3	100.0	111.7 North Tees	65.2 Whittington	PAH was 'as expected'. 18 Trusts had higher than expected. 15 Trusts had 'lower than expected' Continuation of Trust Morbidity and Mortality Strategy. Continued Reporting and Performance process with monthly Patient Quality and Safety review Panel chaired by the Chief Nurse, the Medical Director or the Chief Executive to hold individual health groups accountable for performance in their area.
	New HSMR	Feb 2015 to Jan 2016 84.65	97.13	108.6 Norfolk & Norwich	74.69 Cambridge	
12b	The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	Feb 2015 to Jan 2016 1.85 %	3.34 %	Data not available	Data not available	Further training for staff to understand and implement more robust clinical coding Better communication between coders and doctors and Advanced Practitioners. Continuation of escalation process for coding difficulties

Patient Reported Outcome Measures

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

PROMs measures health outcomes in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.

Data available – April 2015 to December 2015.

Participation and Coverage
There were 646 eligible hospital episodes and 460 pre-operative questionnaires returned – a headline participation rate of 71.2% (74.0%).

Of the 328 post-operative questionnaires sent out, 187 have been returned – a response rate of 57.0% (59.4%).

	England		The Princess Alexandra Hospital		
	April-Dec 2015	Adjusted Health Gain	April-Dec 2015	Adjusted Health Gain	Comments
Groin Hernia	%		%		
EQ-5D Index	50.8	0.087	46.9	0.051	Not an outlier
EQ-VAS	37.3	-0.8	33.3	-2.011	Not an outlier
Hip Replacement					
EQ-5D Index	90.1	0.449	93.3	0.46	not an outlier
EQ-VAS	66.1	12.035	56.3	9.292	not an outlier
Oxford Hip Score	97.8	21.926	97.1	20.583	not an outlier
Knee Replacement					
EQ-5D Index	82.2	0.331	73.4	0.292	not an outlier
EQ-VAS	55.4	5.506	49.4	1.431	negative outlier
Oxford Knee Score	94.3	16.654	93.8	16.281	not an outlier
Varicose Vein					
EQ-5D Index	53.9	0.1	64.7		insufficient records
EQ-VAS	41.1	-0.073	38.9		insufficient records
Aberdeen Varicose Vein Questionnaire	83.6	-8.949	83.3		insufficient records

Please note the use of different scales which reflect differences in the underlying measures and Adjusted Health Gain.

-- scores on the EQ-5D™ Index range from -0.594 (worst possible health) to 1.0 (full health)
-- scores on the EQ-VAS range from 0 (worst) to 100 (best)
-- scores on the Oxford Hip Score and the Oxford Knee Score range from 0 (worst) to 48 (best)
-- scores on the Aberdeen Varicose Vein Questionnaire range from 100 (worst) to 0 (best): a negative adjusted average health gain indicates improvement.

19. The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is having being provided by Dr Foster and as part of the Integrated Performance Report and audited Trust data.

19	**% of PAH patients re-admitted within 28 days** **Mar 2015 to Feb 2016**	**National Average**	**Highest Score**	**Lowest Score**	**The Princess Alexandra Hospital NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services , by these Improvement actions:**
Re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	7.83%	7.86%			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
The % of patients aged 0 – 14	8.04%		17.3% Hinching-brooke	3.93% North Bristol	
The % of patients aged 15 and over	7.69%		10.23% Sandwell	5.26% UCLH	

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	The Princess Alexandra Hospital NHS Trust average	National Average	Lowest Score	Highest Score	The Princess Alexandra Hospital NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services , by these Improvement actions:
	Data made available to the Trust by the Information Centre with regards to the Trust's responsiveness to the personal needs of its patients during the reporting period	6.5	7.2	3.6	9.4	Implementation of the transfers of care work stream Implementation of the Electronic Feedback System focussed on clinicians and overall quality of care Translation of learning from maternity services on call bells to the general side Focus on medical staff for additional training and support, supporting the clinical engagement efforts led by the CMO

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.	Jan to March 2016	Trust's nationally set target for this question	Our grading	Peer Highest score East of England	Peer Lowest score East of England	The Princess Alexandra Hospital NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services , by these Improvement actions:
	Percentage of staff who would recommend the trust as a provider to their family or friends in the Friends and Family Test.	72%	67%	Green	96%	59%	Better communications with all staff around survey to ensure more respondents

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

21.1	The percentage of patients who would recommend the trust as a provider of care to their family or friends.	2015 - 2016*	National Average	Peer group average in NHS England East	The Princess Alexandra Hospital NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services , by these Improvement actions:
	Friends and Family Test – patients	94.7%	95%	92.38% (based on 36 datasets)	Develop "Supporting Families in Difficulty" module, as Communication Level 2 module to enable better communication at point of care.

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	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	National Target Q3 2015-16	April – Dec 2015 Highest Score	April – Dec 2015 Lowest Score	The Princess Alexandra Hospital NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services , by these Improvement
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	98.27%	99.11%	98.28%	98.26%	95.9%	100% Bridgewater Community NHS Trust	78.5% Hull & East Yorkshire Hospitals Trust	Continue failsafe check lists at ward level. Continue updated VTE risk assessment proformas. Patient leaflets available in clinical areas. Patient Safety Thermometer includes whether prophylaxis given. Process for poor compliance shared with all ward and departments. Continue Anticoagulation Nurses undertaking teaching at ward level and for all new doctors.

24. The Princess Alexandra Hospital NHS Trust considers that this data is as being reported by Dr Foster, HSCIC, Public Health England and it is part of the Integrated Performance Report and audited Trust data.

24	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period	No. of cases April – Nov 2015	PAHT Target No. of cases*	Rate per 100,000 bed days	Trust Apportioned 2015-2016 **Highest Score	Trust Apportioned 2015-16 **Lowest Score	The Princess Alexandra Hospital NHS Trust intends to take the following actions to improve this indicator, and so the quality of its services , by these Improvement actions:
	C-Diff - cases on national surveillance database	20		14.14	**0	**139	Continue responsible use of antibiotics Continue thorough cleaning and monthly cleaning and hygiene code audits Continue hydrogen peroxide decontamination Continue excellent standards of hand hygiene
	C-Diff - cases attributable to PAH (total less successful appeals)	6	10	4.24			

*** Latest benchmark data available from NHS Choices**

**There are no comparable average figures for C diff case numbers for Trusts, as it depends on the patient population (e.g. elderly patients have more C diff than children in a paediatric hospital or women in an obstetrics and gynaecology hospital etc.), the use of antibiotics (an acute hospital with an A&E department will use more than a hospital which has more elective patients or no A&E for example).

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 severe harm or death.	Number of Serious Incidents and incidents resulting in death 1 April - 30 Sep 2015	Serious Incident National Average 1 April - 30 Sep 2015	Serious Incident Trust Average 1 April - 30 Sep 2015	Incidents resulting in death. National average 1 April - 30 Sep 2015	Incidents resulting in death. PAH average 1 April - 30 Sep 2015	Incident reporting rate 1 April - 30 Sep 2015
		7 Severe Incidents 3 Deaths	0.3%	0.2%	0.1%	0.1%	47.63 incidents per 1,000 bed days

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

Statement on Relevance of Data Quality

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

- An Electronic Patient Record (EPR) system to replace the Trust's existing technology was implemented during July 2014.
- Regular reporting on data quality issues to the Information Governance Steering Group via the Trust's weekly Operational EPR Group, the Performance and Finance Committee and Board of Directors.
- Continue clinical validation of medical records coding to ensure accuracy of data for national and local benchmarking.
- The use of data quality risk registers to manage data quality risks/issues and monitor the actions the Trust takes to mitigate those risks.
- Development of the weekly Data Quality dashboard to support monitoring and operational resolution of data quality issues.

Data quality, metrics and processes

NHS Number and General Medical Practice Code Validity

The Princess Alexandra Hospital NHS Trust submitted records during 2015/16 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:

Which included the patient's valid NHS number was:

- 99.5% for admitted care
- 99.6% for outpatient care
- 97.9% for accident and emergency care

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

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

Information Governance Toolkit attainment levels

The Trust's Information Governance Assessment Report overall score for 2015-16 (V13) was 81%, and was graded green and therefore compliant.

It has been the first time in five years where the Trust has been able to publish a full satisfactory level 2 score.

This vast improvement from the 2014-2015 (V12) red graded publication score of 68% was due to the high level of progress made in relation to the Trust's Information Asset Management project work plan.

The plan of which had been approved by the Health and Social Care Information Centre (HSCIC) in September 2015 as having been adequately documented to improve scores and/or mitigate risks.

Clinical Coding Audit

PAH was not subject to a payment by results Clinical Coding audit in 2015/16. However, an Internal Information Governance Coding Audit was undertaken to ensure that our coded data was compliant with the highest information Governance requirements. The audit covered a sample of 200 episodes across all specialities.

The accuracy rates reported at the time for diagnosis and procedure coding were:

PAH Attainment Level for Information Governance Purposes		
Subject Area:	**(%)**	**Level**
Primary diagnosis	95%	Level 3
Secondary diagnosis	97%	Level 3
Primary procedure	95%	Level 3
Secondary procedure	98%	Level 3

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

The Princess Alexandra Hospital will be taking the following actions to improve Clinical Coding data Quality:

- The continuation of a training package and audit cycle that underpins high quality coding, within the Coding Department.
- On-going engagement with clinicians and Health Groups in the validation of coded activity, ensuring accuracy between coding classifications and clinical care provided
- The Development of an e-learning module to enhance awareness of coding amongst Clinicians. It will cover all aspects surrounding the importance of coding and will contain an assessment to gauge the level of understanding. This module will be incorporated within the Mandatory training profile for all doctors to ensure that it is competed by all.

Participation in clinical audits

During 2015/16 there were 40 National Clinical Audits as identified by the Healthcare Quality Improvement Partnership (HQIP) and four National Confidential Enquiries that covered the NHS services that the Trust provides. These are represented in Tables **1** and **2**.

During that period, the Trust participated in 85% of the HQIP National Clinical Audits and 75% of the National Confidential Enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Table 1: Summary of HQIP National Clinical Audits that the Trust was eligible to participate in

Audit Title	Participated?	No. of Cases Indicated or Required	No. of Cases Submitted	% Cases	Comments / Improvements made as a result of findings from this or previous participation in National Audits
Cancer, Cardiology & Clinical Support Services					
Patient Blood Management in Scheduled Surgery	Yes	Data on all consecutive cases of patients who have undergone one of the index operations and received transfusion pre operatively and/or intraoperatively and/or post operatively. Cases will be collected from patients who were operated on during the period 1st February to 30th April 2015 up to a maximum of 45 cases	18	100%	Patient Blood Management PBM working group formed in response to NBTC PBM recommendations

Audit of the use of blood in Haematology 2016	Yes	Patients seen in January 2016 with a malignant haematology, and include up to 40 patients receiving a red blood cell transfusion (up to 20 in inpatients and 20 in outpatients). A similar number of patients receiving platelets will be audited	17	100%	Results not yet available To be presented at HTC 28.07.16
Audit of the use of blood in Lower GI Bleeding	No				
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes				
Cardiac Rhythm Management (CRM)	Yes				
National Heart Failure Audit	Yes	70% of all cases or minimum of 100 datasets	102		
Lung cancer (NLCA)	Yes	All cases		100%	
Bowel cancer (NBOCAP)	Yes		154	100%	
National Prostate Cancer Audit	Yes		224	100%	
Family and Women's Services					
Child health clinical outcome review programme	Yes	All cases		100%	
Diabetes (Paediatric) (NPDA)	Yes				Awaiting publication of results
Neonatal Intensive and Special Care (NNAP)	Yes				Data submitted - report due to be published Oct / Nov 16.
Paediatric Asthma	Yes		15	100%	Presentation planned for July 16
Diabetes (Adult) Pregnancy in Diabetes Audit	Yes				Guidelines being reviewed and updated - to be completed by Q2
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	All cases			Closure date for submission of data is Oct 16. Improvements include: Development of (Cosmic) template for under 24 weekers to facilitate improved data collection and analysis. Implementation expected Q2. From Oct 15: Use of Clinician to enter data

Medicine Health Care Group					
Emergency Use of Oxygen (BTS)	Yes		15	100%	
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	All cases	373	100%	(1) Average time-to-theatre within the recommended 36 hours (2) Over 90% are seen by Orthogeriatrician within 72 hours of admission (3) 98% get falls and bone health assessments (4) 98% get cognitive assessments (5) Decrease in the incidence of hospital acquired pressure sores (6) 99% are seen by a physiotherapist the day after their surgery (7) Below average mortality (8) Fast track policy and escalation bed policy to expedite transfer from A&E to the ward are in place (9) Increase in the number of patients receiving cemented hip hemiarthroplasties (10) Increase in the number of patients receiving total hip replacements (11) Increase in the number of patients receiving nerve blocks in theatre (12) Increase in the number of patients receiving spinal anaesthesia (13) High return-home-from-home rates at 30 days
Inflammatory Bowel Disease (IBD) programme	No				We did not contribute to the National IBD audit for 2015-2016 as we did not have the staff available. This was a specialist biologics audit and not mandatory. We did however arrange a visit to our service from the national IBD audit team in 2015. The Exec team have subsequently supported a second IBD Nurse post and development of the specialist pharmacist role and we are hoping they will be in post within the next 6 months.
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	All cases		100%	Trauma Committee in place where audit results and action plan reviewed. Improvements include • Working with Radiology Team to improve process for provision of results • Use of posters to raise awareness of network protocol for the transfer of patients • Agreement with the network that all trauma patients with acute spinal injuries are transferred out to the MTC at Addenbrookes

National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Secondary care workstream)	Yes				• Increase and improve access to specialist respiratory care during weekdays- Partly achieved • and at weekends – not achieved • Increase smoking cessation services- community led. • Increase dietetic services- not achieved.. • Continue to improve the level of palliative care services- partly achieved. • Better access to specialist respiratory care- achieved. • Better access to specialist respiratory beds- partly achieved.
Oesophago-gastric cancer (NAOGC)	Yes		59	100%	
Rheumatoid and Early Inflammatory Arthritis	No				Principal Auditor could not register despite contact with the British Society for Rheumatology
Sentinel Stroke National Audit Programme (SSNAP) Post Acute Organisational Audit	No				Last participation in 2014 – this is a 2 yearly audit therefore no requirement to participate in this year
Sentinel Stroke National Audit Programme (SSNAP) Clinical Audit	Yes	78 per quarter	target met	100%	Audit results have been monitored monthly via local reporting systems with Stroke Steering Group in order to implement improvements. However, stroke services have now been temporarily suspended with aim to reintroduce in 6 months. At this time the service will be different and the audit requirements will also change.
UK Parkinson's Audit (previously known as National Parkinson's Audit)	No				
Vital signs in Children	Yes		100		Report published 31.5.16. Initial review indicates that there is much good practice demonstrated in this audit. Full review of the findings being carried and will include consideration of the five recommendations made.
VTE risk in lower limb immobilisation	Yes		123		Report published 31.5.16. Full review of the findings being carried and will include consideration of the five recommendations made.
Procedural Sedation in Adults	Yes		50		Report published 31.5.16. Full review of the findings being carried and will include consideration of the six recommendations made. Work has already started with the review and development of improved local guidance
Diabetes (Adult) Diabetes Inpatient Audit	Yes		50		Action Plan in place to address recommendations
Diabetes (Adult) National Diabetes Adults	Yes				Action Plan in place to address recommendations

Surgery & Critical Care Health Care Group					
Case Mix Programme (CMP)	Yes	All cases	649	100%	3 monthly reports show us to be performing favourably compared to our peers. The Trust needs to ensure that discharges from critical care back to the ward is timely; however this is currently hampered by lack of beds. This has been escalated to the Board.
Elective surgery (National PROMs Programme) HIPS	Yes	Cases where patient wants to participate		100%	
Elective surgery (National PROMs Programme) KNEES	Yes	Cases where patient wants to participate		100%	
Elective surgery (National PROMs Programme) VEINS	Yes	Cases where patient wants to participate		100%	
Elective surgery (National PROMs Programme) HERNIA	Yes	Cases where patient wants to participate		100%	
National Cardiac Arrest Audit (NCAA)	Yes				
National Complicated Diverticulitis Audit (CAD)	No				
National Emergency Laparotomy Audit (NELA)	Yes				NELA advised: Princess Alexandra Hospital is taking part in the NELA Patient Audit, and has been since the start of the audit in January 2014. Year 3 of the Patient Audit began in December 2015, but it doesn't appear that Princess Alexandra Hospital has submitted any cases since September 2015.
National Joint Registry (NJR)	Yes			100%	
National Vascular Registry	Yes				

Table 2: Summary of 2015/16 NCEPOD studies that the Trust was eligible to participate in

Subject	Participated	Cases indicated or required	Cases submitted	100% Cases submitted
Mental Health	Yes	5	5	100%
Acute Pancreatitis	No	3	0	0%
Sepsis	Yes	5	5	100%
Gastrointestinal Haemorrhage	Yes	5	5	100%

During the same period and as part of the Trusts quality improvement programme, there were 118 local audits registered across all four Health Care Groups. The Trust process requires the audit findings to be reviewed for compliance against the standards being measured against and for an action plan to be developed and monitored for implementation Examples of improvements can be seen in Table **3**.

Table 3: Examples of improvements made to the quality of healthcare following local audit:

Audit	Action / Improvement
Management of 3rd and 4th Degree perineal tears	Modified data collection tool to support management - Done
Gallbladder Cancer and Dysplasia	Creation of a Standard Operating Procedure to establish a consistent protocol for sampling and reporting gallbladder samples - Done

Quality improvement highlights of 2015-2016

There has been significant success in 2015-16 with several developments for the Trust that build on last year's achievements, and there are also some areas where there is still some work to be done.

The statistical markers for mortality have been lower than expected for the reporting period of 2015-16. The ranking of the Trust regionally and nationally remains in a favourable position. Hospital Standard Mortality Ratios (HSMR) was statistically 'lower than expected' which has been 'as expected' or 'lower than expected' for over a year. The Trust's HSMR has fallen for the last 4 years from higher than expected 2011/12 to as expected in 2013/14 to now lower than expected; nationally the ranking of PAH for HSMR has moved to the upper decile.

There has been a 12% increase in incident reporting during 2015-16 compared with 2014-15, with a reduction in severity of incidents reported. The Trust is recognised as being in the top quartile nationally for incident reporting. Our aim remains to increase the overall level of reporting as it is an indicator of an open, transparent and effective safety culture as it helps us to identify where things are not working as they should, and allows us with the opportunity to investigate incidents to find root causes so that learning and improvements can take place thereby decreasing the severity of reported incidents.

The goal for the Trust continues to be zero-tolerance of hospital-acquired, avoidable pressure ulcers. The percentage of pressure ulcers deemed 'avoidable' following scrutiny panel was 48% and the number of 'unavoidable' was 52%. The number of patients with 'avoidable' pressure ulcers has reduced from 2014/15 but themes around inconsistent documentation prevail, rather than poor or inadequate care. Trust staff continue to work hard to reduce avoidable harm, through the tissue viability ward champions and the highly challenging scrutiny panel approach adopted by the Trust in 2013.

Dementia care has again been a key focus in 2015-16 and we've seen significant developments in training, improving awareness and gaining volunteers. Overall 15 dementia champions were trained with 11 more in training. 86% of our staff have undertaken dementia awareness training and two dementia fellows have been recruited and an additional £50,000 grant has been awarded to employ more dementia volunteers. To continue our focus on patients, carers and families as partners, we have involved our dementia volunteer in all of the clinical training, which has been a significant success in raising dementia awareness.

The Trust is also taking part in a national research study looking at attitudes to dementia and we have become an active participant in the local and National Dementia Alliance initiatives.

A new assessment and intervention plan has been rolled out across the Trust to aid in the prevention of falls. Training has been delivered to junior doctors, student doctors and therapies and a study day to improve awareness took place in November with dementia friendly falls leaflets being distributed which sit alongside the community information folders we are providing for at risk patients. We are working to recruit rehabilitation assistants to work on engaging and exercising with patients, start referring patients for vision assessments, and make better use of community services.

Research, development and clinical trials are of fundamental importance to measure the efficacy and safety of new, innovative medicines and treatments. The Trust aimed to recruit 370 patients into the National Institute for Health Research (NIHR) portfolio of clinical trials

during 2015-16, but have managed to exceed that target by 203, bringing the current number of participants in clinical trials to 573.

The Patient Experience and Engagement Team have had another successful year; a reduction in complaints, reporting the lowest level ever at 292 for 2015/16. We have robust tracking and monitoring of all complaints and the Patient Panel lead the Complaints Reference Group to monitor the quality of responses to our patients and families. There has been an upgrade to the PALS service to every ward area, and two new voluntary organisations, Family Mosaic and Action For Family Carers are working with the Trust. The volunteer service also won £50k from NESTA to fund the introduction of younger people into volunteering.

One of the most significant successes was the National Maternity Survey 2015 with four domains in the top 20% in the country and no areas highlighted in the bottom 20%; this which equates to being in the top 20% of high performing maternity units nationally. The Trust are also proud to be the second most improved maternity unit out of 64 Trusts nationally (Picker Europe Survey) and 9th best overall in the country, while also having achieved an 'outstanding' for Caring in the CQC inspection in July 2015.

Our patient panel too have been extremely active, The Annual Patient Panel Conference was well received and after hosting a seminar on Emergency Department changes, the next event is to be on End of Life care on 11 May 2016. The Chair of the Panel was also nominated for and won the regional East of England Leadership Awards and now goes on to compete at the national Leadership Award for the title of National Patient Champion 2016.

In 2015-16 the Practice Development Team recruited new members of staff with a wide range of skills. The team are there to design and deliver a comprehensive induction programme for the arrival of new nurses, to prepare them for working at the Trust and ensure they receive a comprehensive induction. They have also been reviewing our preceptorship programme for newly qualified nurses to improve compliance of nursing documentation, competency acquisition and to work closely across the Trust with wards, clinical areas and nurse specialists to improve the quality of care for patients.

The Tissue Viability Nurses (TVNs) have continued a downward trajectory of hospital acquired pressure ulcers in 2015-16. In conjunction with Nutrition, there are now over 150 trained Agents for Nutrition and Tissue Viability (ANTs) who continue to and provide specialist training. The Tissue Viability Newsletter has been a great way to share learning from incidents and it also keeps staff up to date about the department.

We have improved Learning Disability and Autism awareness by delivering informative presentations on induction and on the Vulnerable Patient Study Day. A Learning Disability Assistant joined in April 2015 and has trained Learning Disability champions who have also had bespoke Epilepsy Awareness Training. The Learning Disability Steering Board continues to meet quarterly and a new non-executive lead for Learning Disability will chair the meetings from 2016.

The following sections will give more detail about the outcome of the work the Trust has have been doing, what the next steps are to improve on this year's successes, the challenges we must overcome and our aims for 2016-17.

How we did last year against our priorities for quality improvement 2015-2016

Each year we assess our performance against previous quality priorities and take account of national reports and emerging themes. Last year we evaluated our focus for the coming year and identified a number of quality indicators for 2015/16.

Below is full information about how we did on each indicator, listing our specific targets.

How we did against each quality improvement priority 2015-2016

Priorities for quality improvement 2015-2016					
1	**Patient Safety Priorities**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**	**How we did**
1.1	Deliver harm-free care	Compliance with best practice	Eradication of Never Events	Datix Monthly report Integrated Performance Report (IPR) Serious Clinical Incident Group (SCIG) External commissioner reporting	2 Never Events were reported in 2015/16 Sustained use of NHS Safety Thermometer and this included for paediatrics and maternity Reduction of Serious Incidents sustained throughout the year and evidence of increased incident reporting to ensure the Trust is in the top quartile nationally A total of 9366 incidents were reports; 75% resulted in no harm, 20% in minor harm The incidence of death, severe & moderate harm incidents equates to 5% of all incidents
1.2	Successful implementation of Sepsis 6 Bundle	Timely clinical care of patients with Sepsis	Successful implementation of Sepsis 6 Bundle	Through Patient Safety Quality Committee, quarterly reporting and Sign up to Safety reporting.	The Trust has successfully implemented the Sepsis 6 Care Bundle; and made progress against the National CQUIN which focused upon 2 specific measures; the percentage of eligible patients screened for Sepsis in the Emergency Department (ED) and

					the percentage who received antibiotic administration within 1 hours of presentation in ED Monthly audits of compliance have been reported on a quarterly basis to Commissioners throughout the year
1.3	Sign Up To Safety	Improvement in key areas identified in our Sign Up To Safety pledge Long list derived from pledge Shortlist arrived at through consultation sessions with staff	Achievement of outcomes set out in improvement plan for each of the priority areas	Through Patient Safety Quality Committee, quarterly reporting and Sign up to Safety reporting	Sign Up To Safety campaign widely publicised throughout the Trust through communications and events. The launch was in April 2016, with events occurring throughout the week, and was well received by staff and patients alike with 55 people attending the main launch and many more attending the information stands throughout the week. The three focal areas were; • Acute Kidney Injury • Sepsis 6 care bundle • End of Life Care These are known as the Big Three Dot items and are endorsed by the Trust Board for 2016/17
2	**Clinical Outcome Priorities**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**	**How we did**
2.1	Continue to enhance the care people receive at end of life and involve patients and appropriate next of kin in plans of care for end of life	Improve the discussion with patients and next of kin in Do Not Attempt Cardiopulmonary Resuscitation orders Agreed plans of are for end life care with patients Expedite early discharge to	Eliminate inappropriate resuscitation or clinical intervention Improve palliative care clinical coding to above the national average	CQUIN milestones	End of life care was a Trust Big Dot quality initiative and was launched as part of our Sign Up To Safety campaign A third clinical nurse specialist was appointed Participated in the national care of the dying audit (report

		preferred place of care			available April 2016) We have implemented a new patient care packages The number of patients coded as being cared for by the End of Life care team has risen by 33%
2.2	Continue to improve the care received by people living with dementia	Early detection and onward referral Improvements in ward environment Roll-out of Dementia Champions	Screening of all admitted patients aged over 65 (for their potential dementia risk) in line with the local and national CQUIN schemes Improved environment for dementia patients Continuation of dementia champions programme as part of the dementia training programme as required for the local and national dementia CQUIN Implementation of dementia volunteers national programme	Compliance with >90% patients screened and referred. Monthly submission to UNIFY Compliance with agreed standards for the environment for dementia patients At least one dementia champion in each clinical area	Partially achieved There have been issues with recording data due to EPR and clinical engagement, however validated results for Feb 2016 show that 92.79% of patients aged 65 or over admitted as an emergency asked the case question, 100% of patients answered positively and 96.97% having had a positive diagnostic assessment where referred in line with local pathways 87% of staff within the Trust have attended Dementia Training
2.3	Successful introduction of Hospital at Night to facilitate seamless and equitable care 24 hours a day	This is a two year scheme to introduce and sustain a Hospital at Night team, consisting of a group of multi-professional individuals with an agreed range of skills and competencies to meet the immediate needs of patients and facilitate effective operational management of the Hospital at Night, optimising patient safety and minimising risk	Reduce avoidable cardiac arrests Reduction in the number of unplanned admission and readmission to ITU Reduce avoidable patient harm incidents occurring after 8pm and at weekends Reduction in the number of 'failure to rescue'/suboptimal care' incidents	Hospital at Night project team to monitor progress Compliance with local CQUIN milestones	Not achieved The Hospital at Night scheme has not been introduced yet, so no data is available.

3	Patient Experience Priorities	What we are trying to improve	What success will look like	How we will monitor progress	How we did
3.1	Greater visibility of Patient Experience information at ward level on complaints and compliments	Information and transparency for patients about our performance at ward and Health Group level	Delivering bespoke plans in place developed in partnership with patients and reported back on the 22 Know How We Are Doing Boards	Board and committee reports Process Improvement workshops. Clinical Friday audit programme	Achieved The Trust continues to publish detailed information about Patient Experience in reports with synopses shared across the region Delivered improvement workshops with Healthcare Groups and Trust wide teams, e.g. Transfers of Care and Always Events Clinical Friday events about patient experience and the data is feeding into a refreshed strategy to be published in 2016-17
3.2	Evidence of outstanding levels of patient satisfaction in the top 20% of Trusts in England	Improve Patient Experience survey results against 2014-15 and national comparison	Ensure all 77 Inpatient Survey indicators are at least in the middle 60% or above with at least three indicators in the top 20% of Trusts in England and Wales Our evaluation is that we have improved overall. • Only 8 reds left vs. twenty reds 5 years ago vs. ten last year. • Transfers of care, only 3 reds, after last year's 6. • Ratings of doctors have improved with 2 of 3 areas now as good as other hospitals nationally. • A&E, Hospital and Ward, Nursing, Operations and Procedures, nursing have zero concerns. However, much work remains to be done: • We have not improved as fast	Monthly Integrated Performance Review Real-time PALS/ patient feedback. National survey results	Partially achieved Maternity Services and Day Surgery have achieved results in the top 20% of Trusts nationally We have reduced areas in the red from 10 to 8, and have halved concerns around discharges of patients from 6 to 3.

			as we wanted or expected to • Two admission issues have emerged; Call bells and being asked about quality have become an issue, also previously not visible. We will work hard to eliminate these as issues over the next year.		
3.3	Excellent communication skills demonstrated by medical and nursing staff	Improved patient experience through communication which is respectful and empathic	90% compliance with training on Level 2 communications skills for all clinical staff	Staff training statistics Complaints and compliments thematic analyses Real-time feedback	Partially achieved. Compliments are the highest they have ever been, complaints are the lowest ever recorded at the Trust from 665 in 2011-12 to 292 in 2015-16 with positive knock on effects for overall quality and cost A level 2 course has not yet been created, however compliance with Values Standards and Behaviours Training is at 80%
3.4	Outstanding complaints handling process improvements	Top ranked complaints handling processes nationally	95% of complaints are acknowledged within three working days. 95% responded to within an agreed deadline	Complaints process monitoring at committee level Annual and quarterly reporting Satisfaction levels shown through survey.	Partially achieved Over 95% of complaints are acknowledged within 3 working days. However, 95% of complaints were not responded to within an agreed timeline This has improved significantly this year, going from 53 to only 28 out of time by the end of the year 292 cases were received in the year as a whole
4	**Staff Experience Priorities**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**	**How we did**
4.1	To create a better working environment	Score the national average or above through	Progress will be monitored through monthly surveys	National and local surveys	Partially achieved Equality & Diversity

	where staff morale is improved and where all staff have received appropriate workplace training such as equality and diversity training	staff survey			training delivered was 37% in 2015 and increased to 73% by March 2016
4.2	Ensure that the Trust's Vision and Values are embedded among the workforce and are being adhered to	Increase number of staff being trained in Trust's Vision and Values	A rise in the number of staff receiving training from the current level of 61% to a minimum of 70%	Regular reports to the Board	Achieved In January 2015, 65% of staff had attended training. In January 2016 79% of staff have had training in the Trusts Values and Behaviours
4.3	To provide a working environment with career progression that encourages staff to stay at the Trust long term; providing a stable, happy workforce, leading to better patient care and experience	Staff retention	Reduce voluntary turnover to 10% or lower	Regular workforce reports to Performance and Finance Committee	Not Achieved Turnover – Feb 2014 to Jan 2015 – 14% Voluntary Turnover – Feb 2015 – Jan 2016 – 15.1%

Commitment to Safer Staffing

The Trust currently achieves an average compliance with planned nurse staffing levels for registered nurses of 70% day time and 75% night time and for care support staff 90% daytime and 95% night time.

The Trust Board receives a monthly report highlighting the actual versus planned staffing levels which includes the impact of staffing levels on the meeting of patient care needs. On average around 11% of all shifts are reported as having not met the workload or dependency needs of all patients. This information is then triangulated with key quality metrics and patient experience feedback to ascertain the impact of staffing levels upon the root cause of any incidents.

To mitigate the risk to patients and staff when nurse levels fall below plan, the Trust completes 3 times per day dependency and acuity assessments utilising Safe Care. This information is used to realign staff from areas of lower risk to areas of greater risk.

An overview of all inpatient areas in terms of staffing numbers and skill-mix aligned to patient dependency and acuity is discussed three times per day in the operational hub; overseen by

the Associate Directors of Nursing and midwifery and escalated to the Chief Nurse or Deputy Chief Nurse.

A number of alternative roles have been introduced to ensure that clinical staff are able to concentrate their time upon direct patient contact cuties. Each ward has a clerical administrator to support the ward manager as well as a ward clerk. The ward assistant role has been developed; complimentary to the domestics and healthcare support workers, the ward assistant can undertake a wide range of patient related activities.

Case Study One – Recruitment, Retention and Development

Recruitment and Retention

Recruiting to many key posts in the Trust can be challenging due to the geographical location of the Trust. The proximity to London and the increased pay available from London Trusts is an ever present issue.

The challenges are particularly acute for nurses and midwives. However, we have many advantages – our standards of care, our outstanding commitment to professional development and our deserved reputation as a friendly and supportive place to work.

Recruitment Team

The recruitment team have gone through a recent restructure, and the team is fully established and trained to provide support for the managers. Recruitment managers are supported by the recruitment team to ensure they bring the right candidates to the Trust. A nurse recruitment manager has been recruited to provide additional focus to this work, as we seek to reduce our reliance on agency staff and provide continuity of care to patients.

In 2015-16, the team managed about 10 recruitment events which were held in the Trust for different Health Groups. For 2016-17, the recruitment team has planned recruitment events

for the Surgery and Medical Health Group once every 6 weeks. The focus for these events is to recruit Staff Nurse Band 5 as well as carers into the organisation.

Other recruitment events continue to be held across the Trust; Pharmacy, Family and Women Health Group, and return to practice will all be held during the course of the year.

Candidates that attend these events have the opportunity to meet with Senior Staff and even the Chief Nurse and Deputy Chief Nurse. Candidates are given the opportunity to have a tour of the hospital, meet staff and ask questions. At the end of the event, suitable candidates can leave with job offer on the same day if they meet the criteria for the post they have applied for.

Recruitment campaign

The Trust has continues its aggressive approach to nurse and midwife recruitment. The Trust is currently working on Home to Harlow campaign; this is a concept to encourage staff that have left the Trust for one reason or another, to come back to the Trust. The campaign also explains why working locally matters. The target is those nurses and midwives who commute into London each day. It also highlights the quality of life benefits of working at their local friendly hospital.

Online Recruitment

Although adverts are placed on NHS jobs, the Trust uses many online job boards for its adverts. Facebook and Twitter are also used to post adverts to encourage much wider view. In 2016 the Trust launched a You Tube recruitment video campaign to target specific staff groups for specific job roles and which includes a personal introduction and invitation by the Chief Nurse and has recently added a LinkedIn recruitment account.

Overseas Recruitment

In addition to the UK Recruitment Events, the Trust actively recruits overseas to support UK recruitment activities. The Trust works in partnership with specialist overseas recruitment agencies to recruit from EU, India and the Philippines. Skype interviews with senior Trust Nurses are held once the agency has met with the candidates and verified their documents.

The nurse recruitment strategy recognises that use of overseas nurses deals with a medium term skill shortage. Our aspiration is to build a long term local workforce through improved local recruitment and excellent career paths to attract, train and retain nurses, supported by our long term workforce development strategy.

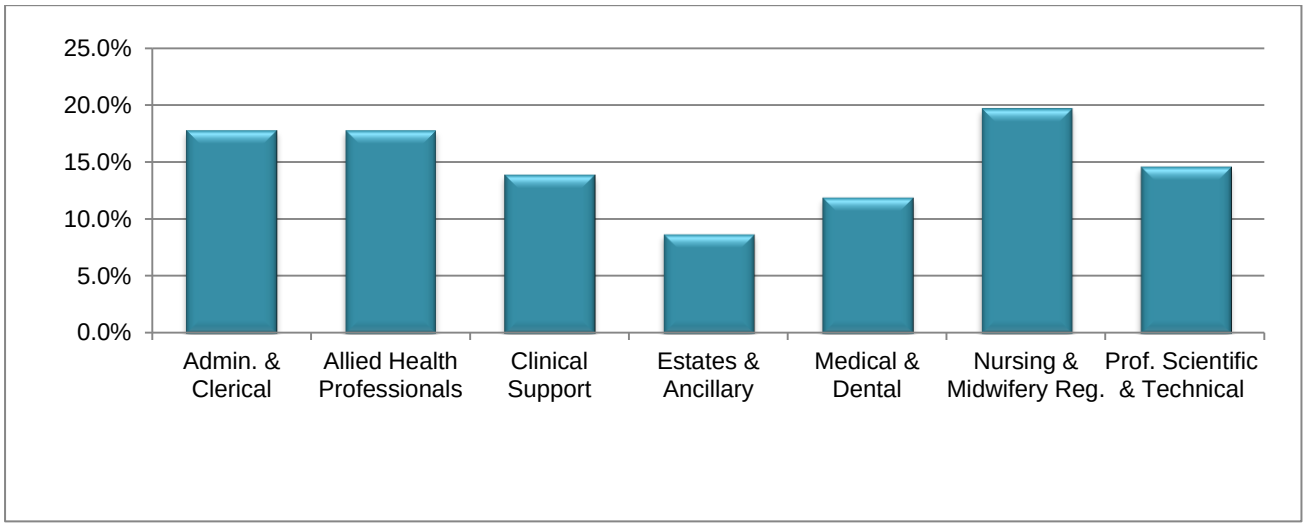
Return to practice Nurse Programme

The Trust is running three recruitment campaigns for candidates who have not practiced nursing in a while. This is run in collaboration with the Health Education England. Candidates are paid a bursary while they complete their programme or they are appointed into substantive Band 3 posts. Once they complete their return to practice (RTP) programme they are able to move into a substantive Band 5 nursing role.

Voluntary turnover

The voluntary turnover rate started to creep up in Q4 of 2015-16 compared to the slight decrease seen in Q3. The recruitment and retention committee continue to explore improvements to the Trusts on boarding process and other options to retain staff.

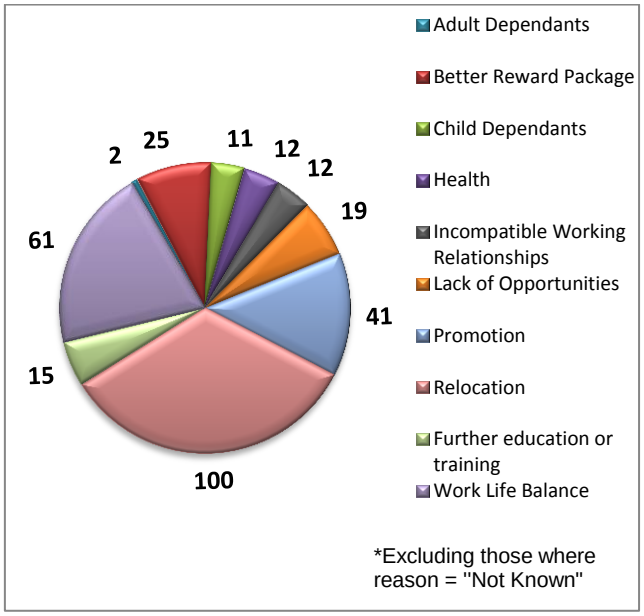
Voluntary turnover rates by staff group as at 31st Mar 2016



Voluntary turnover staff rates remain high for Nursing and Midwifery staff and Allied Health Professionals (AHPS). AHPs are a relatively small staff group who experienced an unexpected spike in turnover. There are no reported problems with recruiting new Physiotherapists and OTs.

Estates and Ancillary staff have the lowest voluntary turnover rate (8.7%). While 87 registered nurses left the organisation due to one of the below reasons of which 151 registered nurses to voluntary resignation compared to 153 the last financial year.
Voluntary resignation reasons are shown in chart below with relocation is the most common reason cited for voluntary resignation.

Voluntary resignation reasons April 2015- March 2016

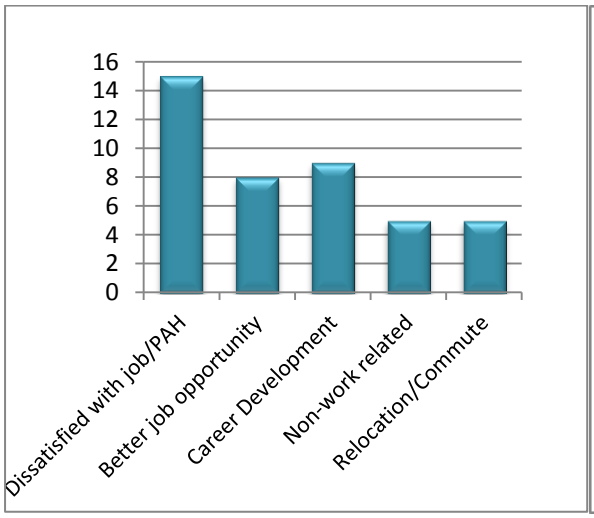


Exit questionnaires feedback

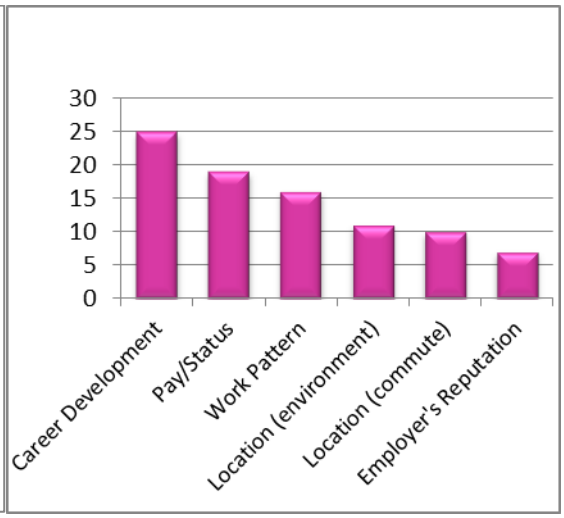
A new electronic exit questionnaire was introduced in June 2015 and has seen improved response rates. 'Dissatisfaction with job/PAH' was most-common reason given for leaving (which correlates with findings from staff engagement survey). Leavers rated both Job Role and Colleagues as Good, and 'Our Staff' were cited as the most-positive feature of this Trust.

'Career Development potential' cited as the most favourable aspect of new job they were moving to, whilst not a single leaver cited 'career development' as most positive feature of PAH. This has resulted in a major change to our HR strategy. The Trust Board has recently approved a Development and Deployment strategy which puts careeer development and internal promotion at the heart of employment value proposition. This change will not be achieved over night, but a new appriaisal scheme, the introduction of leadership training and a talent management strategy are just three of the initiatves being will persued in 2016-17.

Reason for leaving PAH



Favourable aspect of new Job



Our new people strategy sets out five simple objectives going forward:

To Deliver Highly efficient recruitment, candidate acquisition, selection and on boarding processes for all staff

To Deliver Fair and appropriate treatment of all individuals who work on behalf of the trust

To Deliver Improved staff engagement

To Deliver A suitably skilled and flexible workforce now and in the future

To Deliver The ability to plan the future workforce effectively

Staff Engagement

The number of staff recommending the Trust to their friends and family has seen successive increases over the past three quarters to 61%, although this is still disappointing.

However, the number of staff recommending the NHS as a place to work is only 3% higher that the number who would recommend the Trust itself – which indicates that employees' dissatisfaction is linked predominantly to the sector in which they are working rather than to this organisation specifically.

Organisational Development

A leadership development programme was launched in September 2015 with the aim of ensuring the Trust and its staff are fit for the future by developing our staff from within. The three year development strategy focused initially on the Achieving Breakthrough programme, a framework for all staff to use to enhance and practice their leadership, the Great Leaders programme, and developing leadership attributes with 360 reviews.

In 2016-17 the programme will roll out wider delivering a core programme for managers and defining team approaches and dashboards. The following years will support talent and delivery with structured coaching and action learning and finally in the realisation of an Improvement Academy with our partners.

Research, Development and Clinical Trials

At the beginning of 2015/16 it was agreed with North Thames Clinical Research Network that Trust would recruit a target of 370 patients into National Institute for Health Research (NIHR) portfolio adopted trials. In November 2015 the Trust reached the agreed target and continued to recruit across all Health Groups during the remainder of the financial year.

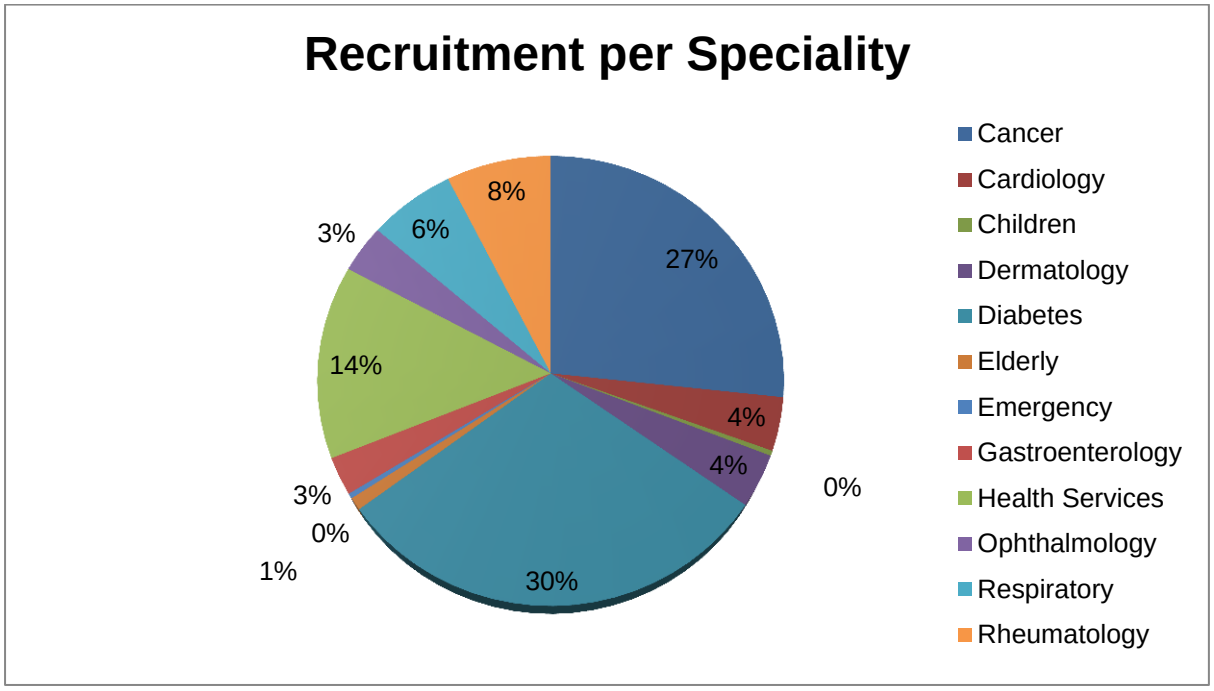
As of 31 March 2016, the Trust have recruited 547 patents into clinical trials, however complete close is 21.04.2016, to date we have recruited a further 13 patients bringing the grand total to 573.

The number of patients receiving relevant health services provided or sub-contracted by The Princess Alexandra Hospital NHS Trust in 2015-16 that were recruited during that period to participate in research approved by a research ethics committee 547.

Recruitment per Speciality

Speciality	Recruitment
Cancer	146
Cardiology	21
Children	2
Dermatology	21
Diabetes	165
Elderly	5
Emergency	2
Gastroenterology	15
Health Services	76
Ophthalmology	19
Respiratory	34
Rheumatology	41

Recruitment by Speciality



Good news stories

The Princess Alexandra Hospital were:

- PAHT randomized the first UK patient for the Pharmacyclis PCYC-1130 UK study, which is a global study.
- A Research Nurse joined the team in May 2015
- Successful International Clinical Trials Day on 21 May 2015, where stands and presentations were:

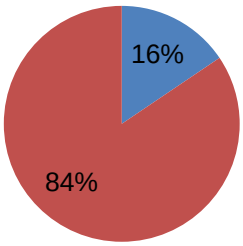
    1. First Clinical Trial/GCP/Research Governance/Approval process
    2. Muscoskeletal with a patient story (patient in attendance).
    3. Cancer – Patient in attendance
    4. Research Nurse Stand – demonstrations of equipment used in the CLEOPATRA and EAST studies
    5. Targeted Therapies Stand
    6. Quintiles/Anglia Ruskin University Clinical Trials Unit
    7. North Thames Clinical Research Network
    8. Recruitment data and successes of trials at PAHT
    9. HEE (Health Enterprise East) Stand.

- Funding received from the NIHR for a Research Nurse to take on Rheumatology studies after appointing Nikki Staines as Lead Research Nurse.
- £25,000 received of Research Capability Funding for approving and delivering on nation high level objectives for 7 commercial studies in the last year
- Appointed Research Health Care Assistant further to winning a bid from the NIHR for a post that would not normally be associated with research.
- A Research Nurse joined the team on 2 November 2015 as the Trust – Ranked 3rd across North Thames for the BADBIR Study.
- A Research and Innovation Facilitator joined the team in December 2015.

- The Princess Alexandra Hospital NHS Trust had the lowest mean number of days between VRA (Valid Research Application) and First Patient at 19.0 days, and also the lowest mean duration between NHS Permission and First Patient at 15.9 days in the UK.
- The Trust are leaders for Quintiles (Commercial Company) Regionally.
- An Administration Assistant joined the Breast Research Team in St Margaret's.
- Research became a department in its own right after a restructure and sits under corporate services.
- Confirmation from the NIHR that all contracts can be renewed for the next financial year.
- The Trust became research active in 3 new specialities (Respiratory, Sexual Health & Urology).

Approved Studies

Approved Studies 2015/16	
Commercial	**Academic**
7 or 16 %	38 or 84%



R&D Approvals (Research Studies)

Study Name	Brief Description	Speciality	Commercial or Academic
AB12005	A prospective, multicentre, double-randomised, double-blind, 2-parallel groups, phase 3 study to compare as first line therapy efficacy and safety of masitinib in combination with gemcitabine, to gemcitabine in combination with placebo, followed as second line treatment by masitinib in combination with Florfiri.3 versus placebo in combination with Florfiri.3 in treatment of patients with non resectable locally advanced or metastatic pancreatic cancer.	Cancer	Commercial
Add-Aspirin	A phase III double-blind placebo-controlled randomised trial assessing the effects of aspirin on disease recurrence and survival after primary therapy in common non-metastatic solid tumours.	Cancer	Portfolio Non-Commercial
Address 2	An incident and high risk type 1 diabetes research cohort - After Diagnosis Diabetes Research Support System	Diabetes	Portfolio Non-Commercial
After the LCP	After the Liverpool Care Pathway – What next for people with dementia?	Elderly	Portfolio Non-Commercial
Airways 2	Cluster randomised trial of the clinical and cost effectiveness of the i-gel supraglottic airway device versus tracheal intubation in the initial airway management of out of hospital cardiac arrest	Emergency	Portfolio Non-Commercial
Clarity	Clinical Efficacy and Mechanistic Evaluation of Aflibercept for Proliferative Diabetic Retinopathy	Ophthalmology	Commercial
CL2-78989-012	A randomised, double-blind, placebo-controlled proof of concept study of the efficacy and the safety of gevokizumab in the treatment of patients with giant cell arteritis	Rheumatology	Portfolio Non-Commercial
Everrest	A 6 year prospective study to define the clinical and biological characteristics of pregnancies affected by severe early onset Foetal Growth Restriction – **The study is lead out of UCLH and the Trust doesn't receive any recruits for this.**	Maternity	Portfolio Non-Commercial
Embarc	The European Bronchiectasis Registry	Respiratory	Portfolio Non-Commercial
EndCap	Enhanced Neoplasia Detection and Cancer Prevention in Chronic Colitis. A Multicentre test accuracy study.	Gastroenterology	Portfolio Non-Commercial
Engage	Exploring decision-making in breast cancer prevention.	Cancer	Portfolio Non-Commercial
Eylea	Evaluation of Physician and Patient Knowledge of Safety and Safe Use Information for Aflibercept in Europe: An Observational Post authorisation Study	Ophthalmology	Portfolio Non-Commercial
Health Watch Essex	Hospital Discharge in Essex: A Study of Patient Experience & Discharge Processes	Health Services	Portfolio Non-Commercial
Leavo	A Multicentre Phase III Double-masked Randomised Controlled Non-Inferiority Trial comparing the clinical and cost effectiveness of intravitreal therapy with ranibizumab (Lucentis) vs aflibercept (Eylea) vs bevacizumab (Avastin) for Macular Oedema due to Central Retinal Vein Occlusion (CRVO).	Ophthalmology	Portfolio Non-Commercial
MMY007	A Phase 3, Randomised, Controlled, Open-label Study of VELCADE (Bortezomib Melphalan-Prednisone (VMP) Compared to Daratumumab in Combination with VMP (D-VMP), in Subjects with Previously Untreated Multiple Myeloma who are Ineligible for High-dose Therapy	Cancer	Commercial

Part	A randomised controlled trial of Partial prostate Ablation versus Radical prostatectomy (PART) in intermediate risk unilateral clinically localised prostate cancer.	Cancer	Portfolio Non-Commercial
PGRx	Outcome Research	Surgery	Portfolio Non-Commercial
Precision	A randomized control trial of magnetic resonance imaging-targeted biopsy compared to standard trans-rectal ultrasound guided biopsy for the diagnosis of prostate cancer in men without prior biopsy	Surgery	Portfolio Non-Commercial
PCYC	A Randomized, Multicenter, Open-label, Phase 3 Study of the Bruton's Tyrosine Kinase Inhibitor Ibrutinib in Combination with Obinutuzumab versus Chlorambucil in Combination with Obinutuzumab in Subjects with Treatment-naive Chronic Lymphocytic Leukaemia or Small Lymphocytic Lymphoma	Cancer	Commercial
Platform	Planning treatment for oesophago-gastric cancer: a randomised maintenance therapy trial.	Cancer	Commercial
Reach	A pragmatic cluster population-level randomised controlled trial of a community-level intervention to increase early uptake of antenatal care - Pregnancy Programme	Maternity	Portfolio Non-Commercial
Respiratory Care Bundles	An evaluation of the effectiveness of 'care bundles' as a means of improving hospital care and reducing hospital readmission for patients with chronic obstructive pulmonary disease (COPD)	Respiratory	Portfolio Non-Commercial
Schwartz	Organisational Case Studies: Phase 2 of a Longitudinal National Evaluation of Schwartz Center Rounds: an intervention to enhance compassion in the relationships between staff and patients though providing support for staff and promoting their wellbeing.	Health Services	Portfolio Non-Commercial
Spirit 2	Multicenter, Randomized, Double-Blind, Placebo-Controlled 24-Week Study Followed by Long-Term Evaluation of Efficacy and Safety of Ixekizumab (LY2439821) in Biologic Disease-Modifying Antirheumatic Drug-Experienced Patients with Active Psoriatic Arthritis	Rheumatology	Commercial
Spirit 3	A Phase 3, Multicenter Study with a 36-Week Open-Label Period Followed by a Randomized Double-Blind Withdrawal Period from Week 36 to Week 104 to Evaluate the Long Term Efficacy and Safety of Ixekizumab (LY2439821) 80 mg Every 2 Weeks in Biologic Disease-Modifying Antirheumatic Drug–Naive Patients with Active Psoriatic Arthritis	Rheumatology	Commercial
Star	StereoTactic radiotherapy for wet Age-Related macular Degeneration. A randomised, double-masked, sham-controlled, clinical trial comparing low-voltage X-ray irradiation with as needed bevacizumab, to as needed bevacizumab monotherapy	Ophthalmology	Portfolio Non-Commercial
Time	Day time Intervention at Night: Evaluation of Major Outcomes and Vascular Events	Cardiology	Portfolio Non-Commercial
Tamoxifen Questionnaire	Investigating how women with breast cancer view Tamoxifen: A mixed-methods study	Cancer	Portfolio Non-Commercial
Understanding Elective Colorectal Practice	Understanding elective colorectal practice - a national questionnaire study. Imperial Patient Safety Translational Research Centre	Cancer	Portfolio Non-Commercial

R&D Approvals (Masters)

Study Name	Brief Description	Commercial or Academic
6 Minute Walk Test	A comparison of the standardised 6-minute walk test with a non-standardised walk test in ambulatory oxygen assessments for patients' post-acute exacerbation of chronic respiratory disease on discharge from hospital	Non- Portfolio Non-Commercial
Cascade	Case-finding in hospitals: Impacts on care for people with dementia	Non- Portfolio Non-Commercial
Exploring The Effects Of An Exercise Programme Breast Cancer	Exploring the effects of an exercise programme on women with breast cancer.	Non- Portfolio Non-Commercial
INTHO	The Impact of New Technology on Healthcare Organisations.	Non- Portfolio Non-Commercial
Junior Midwife	Do junior midwives feel disenchanted with their role as a protector of normal birth when working on an obstetric led unit?	Non- Portfolio Non-Commercial
Management Of Acute Adult Emergencies	Human Factors in Management of Acute Adult Emergencies.	Non- Portfolio Non-Commercial
Nurses Speaking Up	The experience of newly-qualified nurses in challenging unsafe practice.	Non- Portfolio Non-Commercial
Porters And Domestics	A qualitative study exploring the views of domestic staff and porters when supporting patients with dementia in the acute hospital.	Non- Portfolio Non-Commercial
Retention In Critical Care Nurses In NHS	A proposal to explore the factors influencing the retention of critical care nurses in National Health Service (NHS).	Non- Portfolio Non-Commercial
Staff Engagement	Staff Engagement in the Medical Healthcare Group.	Non- Portfolio Non-Commercial

CQUINs

The Trust achieved 85% of the milestones associated with the CQUIN schemes in 2015/16. The 2015/16 CQUIN scheme was available to all providers which chose the enhanced alternative – the Enhanced Tariff Option (ETO) for the full year 2015/16. The value of the scheme was up to 2.5% of Actual Annual Contract Value, as defined in the 2015/16 NHS Standard Contract.

The national CQUIN goals reflected the financial challenges facing the NHS in 2015/16 and were set to incentivise quality and efficiency. The aim was to reward transformation across care pathways that cut across different providers.

One area of focus was Urgent Emergency Care (UEC). The aim of the national UEC CQUIN was to focus upon reducing the proportion of avoidable emergency admissions to hospital. The Trust worked closely with commissioners but was unable to come to an agreement on the scheme. Following arbitration it was decided that the Trust would not undertake the UEC CQUIN and access to the associated financial value was removed. This equated to £719,549. Consequently the overall income target associated with 2015/16 CQUIN schemes was £3.06 million. Details of the agreed CQUIN schemes for 2015/16 are provided in the table below.

Monthly monitoring both within the Trust and with the commissioners has taken place to assess progress against each of the milestones. The final achievement for 2015/16 is 82%.

CQUIN schemes 2015/16

Scheme	Full year income potential £
National: Acute Kidney Injury (AKI)	359,774
National: Sepsis	359,774
National: Dementia	359,774
Local: Integrated workforce	593,628
Local: Motivational interviewing	449,718
Local: Hospital at Night	431,729
Local: Transfer of care at end of life	323,797
Specialist Commissioning schemes	181,650
Total potential value	**£3,059,844**

CQUIN 2016/17

The CQUIN scheme for 2016/17 is intended to deliver clinical quality improvements and drive transformational change; the design has been influenced by the ambitions of the Five Year Forward View (FYFV). The National schemes to be undertaken by the Trust are:

- NHS staff health and wellbeing
- Timely identification and treatment of Sepsis
- Cancer 62 Day Waits
- Antimicrobial Resistance and Antimicrobial Stewardship

With a focus to finance transformation and sustainability priorities, discussions with commissioners and partner providers have identified the following locally developed schemes to be pursued by the Trust:

- Integrated workforce across the local healthcare system
- Introduction of system wide “virtual” MDT meetings for care homes in Essex
- Introduction of Ask 3 Questions to support patients with informed decision making about the care and treatment options
- Cancer pathway linked to 2 week and 32 day standards in line with national cancer strategy
- Stroke pathway; effective identification and management of suspected stroke

Care Quality Commission (CQC) rating and clinical effectiveness

The Trust is registered with the Care Quality Commission (CQC) and its current status is ‘registered without condition’. The CQC has not taken enforcement action against the Trust during 2015/16.

In July 2015 the CQC carried out a periodic (rather than a special review)full inspection of the Trust services which included a review of data, CQC led user group meetings and two full days on site where areas were inspected and staff / patients and visitors were interviewed. A full report of the visit is available on the Trust website with the quality improvement plan which has been updated monthly since the report was released in November 2015.

In preparation for the visit, staff attended briefing sessions and mock CQC inspections were carried out. During the visit and following publication of the findings, the Trust took action to address concerns raised, this included tightening the security arrangements for people leaving the maternity unit and having a ‘tested’ Child Abduction Policy in place. Details of all improvement actions are available on the Trust website.

When rating the Trust the CQC looked at the services it provides and considered the 5 questions it asks of all services, is it Safe, Caring, Effective, Responsive and Well-led? Overall the CQC rated the Trust as Requires Improvement, but gave Good for Caring across all services with the exception of Maternity and Gynaecology which was rated as Outstanding for Caring.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	☆ Outstanding	Good	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Inadequate	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Requires improvement	Inadequate

At the time of writing, the Trust is preparing for the 2016 CQC Inspection, scheduled to start on 28 June 2016.

During 2015/16 the Trust continued to monitor compliance against NICE guidance and Quality Standards utilising the process endorsed by the CCG and NICE.

As part of an on-going programme of review, it was identified that the Trust needed to further strengthen the recording and monitoring of activity against NICE, Quality Standards and National Audits. To facilitate and support this, software was introduced which is now being embedded across the organisation.

Further review of quality performance 2015 - 2016

Transformation

The Transformation programme is designed to deliver the overall improvements over a three to five year period and to be explicitly aligned to the Trust's strategic goals and priorities.

The initiatives associated with each of the work streams are subjected to the Trust's established quality impact risk assessments process led by the Chief Medical Officer and the Chief Nurse, who ensure the highest standards of quality including safety, effectiveness and patient experience are maintained.

The objectives of the Transformation programme are to deliver the following outcomes:

- Excellent safety and outcomes for patients: benchmarked against the best
- Excellent patient and carers experience: delivering personalised care
- Excellent operational performance: meeting regulatory and national operating standards
- Excellent value: improving efficiency, productivity and reducing costs
- Excellent morale, staff engagement and organisational health: ensuring we are fit for the future

The guiding principles are:

- Improving patient safety and quality
- Early involvement of clinicians in the decision making process
- Clinical leadership of key projects
- Combine better health outcomes with productivity
- Sustainability
- System alignment

Key work streams underlying achievement of efficiency savings target

The total efficiency savings target was achieved for this year of £11.4m (2015/16) and for the next year is £12.0m (2016/17).

The Transformation programme comprises these principal work streams as follows:

Key Work streams	Objective and Scope	Quality Improvement and Outcome
Length of stay and bed capacity	Reduce operational pressures, reduce use of escalation beds, and facilitate penalty reductions. To deliver a clinically sustainable and financially viable non-elective pathway to ensure we can increase and manage our bed capacity more effectively; reducing backlogs across and along the pathway and reducing the financial penalties incurred.	• Right Care, Right Time, Right Place • Improved patient outcomes • Reduction of length of stay • Improved patient experience
Theatres Productivity	Reduce surgery cancellations, improve timings and capacity. Improve in-session and capacity utilisation to reduce wastage and ensure that theatres have the capacity to treat an increased number of patients, reducing waiting times and saving avoidable additional costs.	• improved patient experience and theatre utilisation • Improved team performance and staff well being • Improved access – Delivery of 18 week standard and to reduce cancelled operations.
Outpatients Productivity	Improve clinic utilisation, attendances and non-attendance rates. Increased capacity to see more patients more efficiently and reduce waiting times and avoidable additional costs.	• Improved clinic utilisation • Deliver 18 week standard • Improved booking and scheduling process • Improved patient satisfaction • Reduction in clinic cancellations • Improved patient safety through timely distribution of clinic letters, more appropriate procedure locations • Reduction in unnecessary follow up appointments to improve access for patients • Reduction in costs of unnecessary additional clinics
Medical Productivity	Match workforce capacity and demand closely. Introduce electronic roster system.	More efficient management of clinical rotas to ensure better patient care and investment in frontline services
Temporary Staff - Direct Engagement	Changing contracting arrangements for agency staff to reduce costs.	The savings can be invested in improving quality of care
Procurement and Supply Chain Opportunities	Initiatives to transition from a transactional reactionary buying operation to a strategic procurement function.	Better procurement to reduce wastage. Savings can be invested in improving quality of care.
Other Income Opportunities including Contract and Commercial	Including working with CCG colleagues to repatriate activity back into area and maximising the use of Best Practice Tariffs.	Repatriation of services locally will enhance patient access and experience. The Best Practice Tariffs Programme indicates that the policy is delivering real improvements in the quality of care that patients receive. We will further expand this to cover: • Promoting better management of long term conditions to reduce the risk of avoidable hospital admissions. • Delivering care in appropriate settings.

Key Work streams	Objective and Scope	Quality Improvement and Outcome
Optimised Pharmacy	To reduce amount of waste and to reduce variation with the dispensing of clinical pharmacy services.	Reduce or eliminate drug errors. Contain or reduce costs of patients treating patients at inpatients
Strategic Options	Developing and executing strategic changes that will put the Trust in a clinically, operationally and financially sustainable position	Ensuring we continue to provide long-term sustainable high quality services for the local population New service developments to provide better care to patients at a local level

Achievement of 2015/16 efficiency savings target

All Health Care Groups developed recovery plans, to pull back the under-achievement in the first half of the year. This included fast tracking additional CIP plans where feasible and concentrating on those schemes that will deliver recurrent savings across the organisation such as:

- The Trust developed four Big Ticket items – Non Elective Pathway, Outpatients, Theatres & RTT and Pharmacy.
- Corporate action to support delivery of the CIP and move towards the revised stretch target of £15m such as
    - Clinical workshops, sharing best practice from other Trusts and undertaking "deep dives" in areas where internal information would suggest opportunities for improvement, based on best practice benchmarks
    - Workforce: increased challenge on all non-clinical posts; review of interim positions with a view to terminating all bar essential posts; increased recruitment activity; weekly agency templates.
    - Finance: increased challenge as per letter to TDA (11/09/15) on expenditure of £3.1m including: technical changes to depreciation (FYE: £2.5m); and other stretch action targets totalling £0.6m such as: developing Direct Engagement; negotiating the 2014/15 year end settlement with NHS England and increasing the number of staff on the bank with NHSP.
    - Budget reviews and rapid cost reduction schemes
    - Executive led deep dives into all health groups.
- Plans to reduce temporary staffing costs in line with revised guidance from Monitor

Delivering 2016/17 efficiency savings target

The savings target for 2016/17 is allocated as follows: 5% for each health group and 11.8% for corporate areas. The focus is to identify recurrent schemes that will deliver clinical effectiveness, efficiencies and productivity.

The Transformation programme for 2016/17 and future years comprises work streams within the principal quadrants as follows:

- Clinical Effectiveness (40%)
- Efficiency & Productivity (30%)
- Cost Reduction (20%)
- Income (10%)

Each quadrant will deliver the following objectives and outcomes:

Quadrant	Objective and Scope	Quality Improvement and Outcome
Income	• Recording of care • Pharmacy (joint venture/ shop/ wholesale licensing) • Delayed Transfers of Care • Cardiology	• Right Care, Right Time, Right Place • Improved patient outcomes • Reduction of length of stay • Improved patient experience
Clinical Effectiveness	• Safer Patient Flow • Job Planning • Biosimilar Drugs • Pathology Test requests & review	• As above
Efficiency & Productivity	• Cost Control • Outpatients • Front Door • Theatre Consumables • Audiology	• As above
Cost Reduction	• Non Pay Review • Staff vacancies • Procurement • Cytology • Breast Unit	• As above

Information, Communication and Technology

Summary

With the increasing pressure on NHS services and reductions in available funding Princess Alexandra Hospital Trust has experienced its most challenging year to date. The ICT department continues to play a vital role in improving service efficiency, delivering new and innovative technology solutions whilst driving down its operational costs.

The Trust is now 2 years into a 10 year strategy to deliver Electronic Patient Records (EPR) which is core to realising the government's ambition for a paperless NHS. The on-going development programme is currently focused on five key schemes:-

EPR System - A modern EPR system based on Swedish solution provider Cambio's COSMIC EPR system.

Electronic Medicine's Management - Implementation of a suite of functionality based on established provider JAC

Integrated Care Records Portal - Based on the successful Graphnet CareCentric solution the Trust is developing a shared records portal which will provide a single point of access to all provider care records

Modern Laboratory Information System (LIMS) - The Trust is upgrading its established Technidata LIMS system to accommodate enhancements to Order Communications systems (OCS) and integration with its EPR solution.

Electronic Early Warning System (EWS) – Based on the established NerveCentre software suite, the new EWS system will provide significant enhancements to patient care by replacing paper care records with an electronic tablet based system to ensure all vital sign observations are captured electronically and escalated where abnormal for the patient.

The programme is based in the main on market leading technology but has not been without its challenges both in terms of proving technology but also service transformation. System testing and configuration has taken longer than planned leading to delays and cost over runs however the Trust remains committed to its modernisation goals and it is envisioned that these schemes will provide the foundation for the Trust vision of a future paperless hospital.

Lessons have been learnt from programme activity to date and the Trust will be restructuring its ICT team during 2016/17 to further optimise its capacity to bring in subsequent phases of its ICT programme on time and on budget.

Despite these issues new innovations are progressing at a pace and the Trust made good progress on its EPR strategy during 2015/16 as well as many significant other achievements

ICT Programme achievements for 2015/16

The Trust IT Programme is based on five major initiatives:

1. Cosmic – EPR System
The proposed development programme for the Trusts EPR system, COSMIC, has continued to prove challenging with continuing significant issues with the Referral to Treatment (RTT) pathways and general process compliance throughout the hospital.

Whilst the RTT project has succeeded in improving data quality and resolving activity reporting, this has been achieved by significant workarounds and manual processes which have had a substantial impact on the Trusts capital programme in respect of resourcing the project.

The ICT team are engaged with the highest levels of authority within Cambio to ensure that progress continues in resolving outstanding issues with the COSMIC product and are now expecting the automated RTT functionality to be deployed as part of a new service pack release in May 2016. This will undergo a significant testing process before being released into the Live COSMIC environment and is expected to be a leading edge development and possible first of type within the NHS Acute sector.

The Trust is working in collaboration with Cambio and other strategic IT partners to find solutions to mitigate the impact of further delays

Despite these challenges the development of the product is progressing on several fronts:

Specific milestones achieved

- The Trust returned to national reporting of their diagnostic position in July 2015
- The Trust returned to national reporting of their RTT position in October 2015
- Electronic Discharge Summaries are delivered electronically to West Essex and East & North Herts CCG, and extended to Redbridge CCG in January 2016
- Clinic outcome process redesigned and implemented in December 2015
- DNA outcomes mandated as part of clinic outcome process
- Improvements in the recording of the maternity pathway
- Upgrade to ICD10 5th Edition
- Implementation of Medicode in Outpatient clinical coding function

- Continued to develop and implement enhanced reporting

2. ICR Graphnet Care Centric: The CareCentric Portal is now live and in early pilot testing with the regional Medical Interoperability Gateway (MIG) which provides access to Primary Care Records

3. E – Prescribing – JAC Medication Management: Phase one: Pharmacy stock control went Live in December 2015 following an 8 week implementation plan. The team were applauded by the Supplier for their commitment to the delivery timeline; Phase two: Chemo Therapy Management System (First of type in UK) taken into operational pilot phase

4. Electronic Observation System: Nerve Centre: The Trust was successful in its bid to secure funding directly from the Department of Health and the electronic observation solution was procured and deployed within a challenging timescale. The system is now integrated with Trust EPR and being tested ready for pilot on three adult wards in May 2016

5. Laboratory Information System (LIMS) upgrade from version 3 to 11; Histology upgrade completed, Cytology upgrade completed, Blood Bank upgrade completed

Other ICT strategic developments completed:

- Med iSOFT Ophthalmology system installation.
- Migration of Prism Cardiology system to Solus to facilitate central reporting requirements
- Pharmacy prescription tracker
- Single Sign- On, which will increase the amount of time to care for our clinicians
- Migration to new NHS Registration Authority system
- Upgrading to the Trusts Multitone paging system
- Cardio Echo Imaging into PACS
- Cath. Lab imaging into PACS
- Maternity Ultrasound Imaging into PACS
- Replication of the PACS Image Storage environment (SAN)
- Paperless Board
- Clinician's SharePoint Portal
- Upgrade to Trust Storage area network
- Provision of over 200 tablet devices to support near patient data viewing and recording
- Implementation of DAWN anticoagulation system
- Deployment of Mobile Iron enterprise mobile device management system
- New contract signed for the continuation of ORMIS & ScanTrack post July 2016
- Restructure and modernisation of the Information Services team
- Development and implementation of Qlikview self-service reporting tool
- Implementation of new Integrated Performance Reporting to the Trust Board

ICT Plans for 2016-2017

The Trust Board remain committed to investing in technology to support the delivery of the highest standards of care and efficiency in patient care and this is reflected by sustained high levels of investment even in the face of a challenging financial environment.

Confirmed Capital Projects

Project	Description
EPR	Further development of the Trust Cosmic EPR system
Medicines Management	Completion of Further development of the Trusts JAC Pharmacy system will see Trust wide deployment of Chemo care management and Electronic Prescribing/Medicines Management
LIMS Pathology upgrade	Completion of the Trusts established Technidata LIMS system
Electronic Observations/ Early Warning System (EWS)	Trust wide deployment of the established Nerve Centre system
Integrated Care Record	Continuing development of the Graphnet CareCentric Clinician Portal
Single Sign on	Trust wide deployment of Impravata OneSign to all Clinical areas
Ormis Theatre System and Scantrack	Implementation of new Theatre and Instrument tracking functionality
Outpatient and ED Kiosks	Introduction of self-service check in kiosks to the Trust Outpatient and Emergency Department
Patient Wi-Fi	Provision of patient and guest Wi-Fi services to all areas
NHS Mail	Migration to the new NHSmail service
Enhanced IT disaster recovery facilities	Further enhancement to the Trusts IT disaster recovery facilities

Programme highlights for 2016/17

The Trust IT Strategy will continue to progress at pace with specific developments for the big 5 schemes as follows:-

Cosmic EPR will deliver: Automated Referral to Treatment management process, Extended Electronic Discharge Summaries for Day Surgery and Short Stay areas; NHS Spine Compliance (PDS)

Medicines Management – full deployment of electronic prescribing and medicines management leading to an integrated end to end solution

LIMS – Full implementation of the LIMS solution with integration capability

Electronic Observation/Early Warning System – Deployment across all appropriate ward areas then implementation of Doctor/Nurse Handover and Hospital at Night functionality

Integrated Care Record (Portal) – Deployment of technology into Primary Care

Further programme highlights for 2016-17:

Single Sign On: Trust wide deployment by of the summer
ORMIS & Scantrack: New contract signed to continue with ORMIS & Scantrack post July 2016, Upgrades to both systems will take place before July 2016, ORMIS to be extended to Maternity Theatres

PACS: Plan to consolidate diagnostic imaging technologies and image repository in progress, replacement solution for NPfIT PACS to be implemented before July 2017

Outpatient & ED Kiosks; Self check-in kiosks to be installed in Outpatients and ED

Trust & Guest Wi-Fi: Wi-Fi development plan in progress, enhanced Wi-Fi in all areas which will include guest Wi-Fi for patients and visitors.

NHS Mail; Trust email will be migrated to hosted NHS mail solution providing greater security and interoperability across NHS care providers

Disaster Recovery Site; A secondary disaster recovery site will be established for essential IT systems and services.

Winter planning

The Trust has been working hard to mitigate the increased pressures on our ED service, particularly over the past winter. Our own situation is a reflection of the national picture which has seen emergency admissions increase by 47% in the last 15 years. In the past year we have seen 102833 ED attendances with 28782 patients being admitted.

Below, we outline some of the challenges the Trust is facing and the specific steps we are taking to address these in collaboration with our local health partners.

Emergency Department context

The National Emergency Access Target (NEAT) requires the Emergency Department (ED) to treat, admit or discharge, 95% of attending patients within four hours. PAHT performance has fallen below this standard, and also the Trust's agreed trajectory for this financial year 2015/16. The key reasons can be seen within two areas; external pressures and internal pressures:

External pressures

- Primary care services in the local area have also struggled to deal with the increase in demand despite having robust plans in place
- An increase in ambulance conveyances
- Out-of-area ambulance conveyances to PAH where the nearest hospital is not considered to be PAH
- 15% of the Trusts adult ED attendances are over 75. This patient group has a higher rate of admission due to complex needs and exacerbation of longer term conditions
- Delayed transfers of care remain above 3.5% threshold

Internal pressures

- Mismatch of ED demand and capacity specifically relating to patients conveyed by ambulance resulting in delayed handovers and overcrowding in ED
- Increase in patient acuity as demonstrated through recent audits completed at PAHT
- Closure of Assessment areas due to building works and the opening of escalation beds, impacting on demand within ED
- Delays in patient discharges
- Delayed transfers of care
- Increased patient admissions to hospital
- Reduction in capacity of Ambulatory Care Unit due to building works
- Continued use of escalation capacity to maintain patient safety

Review of our Emergency Department

PAHT has recognised the pressures on the Emergency Department (ED) and has been working in close partnership with our Clinical Commissioning Groups (CCGs), National Trust Development Authority (NTDA) to provide a detailed review and recommendations to enhance our overall ED performance.

The Trust has implemented the Rapid Assessment and Treatment model (RAT) for all ambulance arrivals to support 'early senior review'.

To support the flow of patients through the emergency patient pathways, the system has invested in increased support staff with the introduction of patient journey navigators, senior floor-walkers.

The Trust is working in collaboration with health and social care teams to develop a model of care that will see patients who require a further period of assessment, taking place in their usual place of residence rather than in an acute setting. This will support improved accuracy of assessment as patients will not be affected by environmental factors, resulting; it is hoped in a reduction in associated delay.

The Trust held a 'break the cycle event in March working with system partners to implement the SAFER model, the red green day measure and also holding of a Multi-Agency Discharge Event [MADE].

The Trust runs a rolling recruitment programme for nurses and is actively recruiting for consultants within ED and our Emergency Assessment Unit (EAU).

Despite this level of increased pressure, we have continued to strive to deliver the best possible experience to patients who attend our hospital as an emergency. The clinical teams remain vigilant in taking every action possible to improve the service we provide our patients. With the support of a number of important stakeholders, the Trust has gained valuable insight into areas that can be improved.

With the benefit of strong clinical leadership and thanks to our dedicated teams, we are confident that the Trust can transform the delivery of urgent care and ensure sustainable, quality and safe care for all our patients.

Discharge and Transfer of Care planning

The Trust developed and refreshed the key recovery and action plans and launched the new programme "*Every minute matters*" to support a return to delivering better patient experience across the emergency pathway.

Effective Transfer planning should ensure that patients are transferred from the acute hospital when the acute phase of their clinical condition has been resolved. This requires careful planning and synchronisation of activities both internally in the Trust and externally by health and social partners to deliver a safe discharge. The transition of care from an acute setting is supported by the transfer of treatment information provided to GPs or other key stakeholders at the point of discharge and should be timely, accurate and relevant.

Any delays in transfer pose an increased risk to patient safety and impact directly on the availability of capacity to manage new patients requiring an acute episode of care. The increased pressures on acute hospital capacity means that there is an increased need to be able to effectively plan and discharge patients to their own home or other setting of care across the whole week and not just Monday to Friday to ensure that capacity is maintained within the whole system

The current arrangements which aim to steer patients through their clinical journey from admission through to discharge from hospital and beyond, can be less than seamless. Delays are often caused by the requirement to negotiate between different agencies and organisational entities, or the need to grapple with relatively complex discharge issues requiring effective working between different professional groups.

In 2015-16 the Trust engaged with system partners to undertake a number of key improvements, these included a running a multi-agency Transfer of Care Event. The out of this event will provide actions for the 2016/17 year to improve performance.

Patient Experience and Engagement

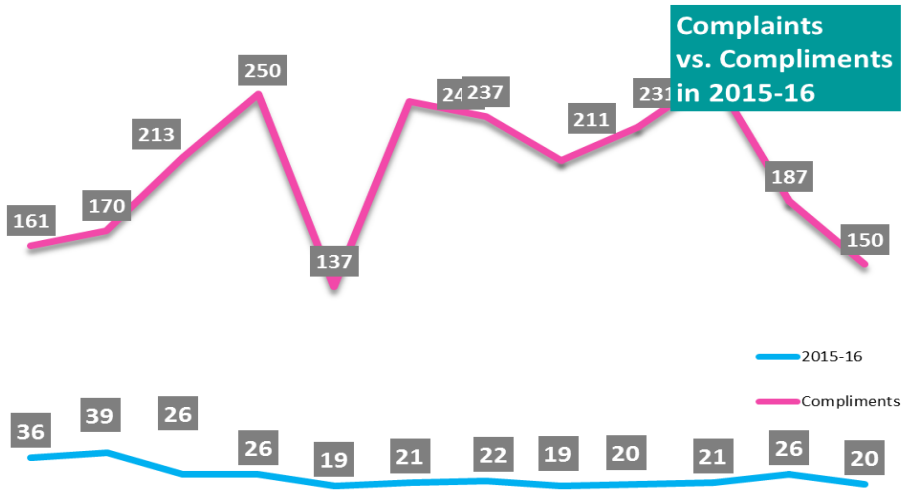
Highlights from 2015-16

- At the beginning of April 2015 we had 171 open formal complaints. At March 31 2016 we had 75 open formal complaints enabling clinical and safety teams to lead proactively rather than being reactive.
- Of 80 complaints referred to the Parliamentary Health Service Ombudsman in 2014-15, only 3 were considered not to have been completely resolved at the local level, the lowest level in the East of England and testament to a highly effective complaints process.
- Substantial learning is evident in many of the complaint responses we make, as well as clearer and more direct apologies when things do go wrong, consistent with our duty of candour.
- The total number of complaints has dropped from 665 five years ago to 292 in 2015-16, evidence of the further impact of point of care resolution.
- The Patient Panel hosts its third Annual Conference in May 2016 on end of life care, the event is sold out and speakers from around the country are to attend, real impacts on the knowledge and awareness of the local population in evidence.

This year promises to be an exciting one in patient experience and engagement at the Trust.

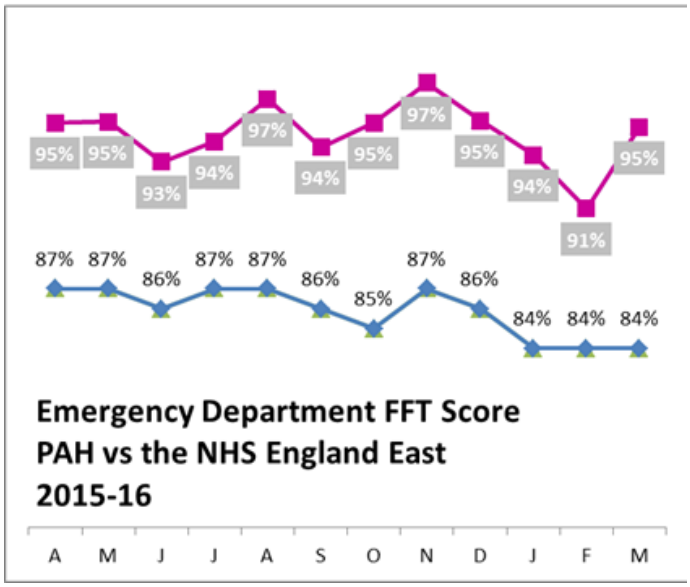
Medical staff will be participating in patient voices workshops, electronic feedback processes will be introduced for all feedback, including the Friends and Family Test, overall reduced complaints will, alongside a better resourced Patient Advice and Liaison Service (PALS) help us to shift more of our focus and resources towards proactive resolution and improving quality.

All Compliments vs. Complaints 2015-16

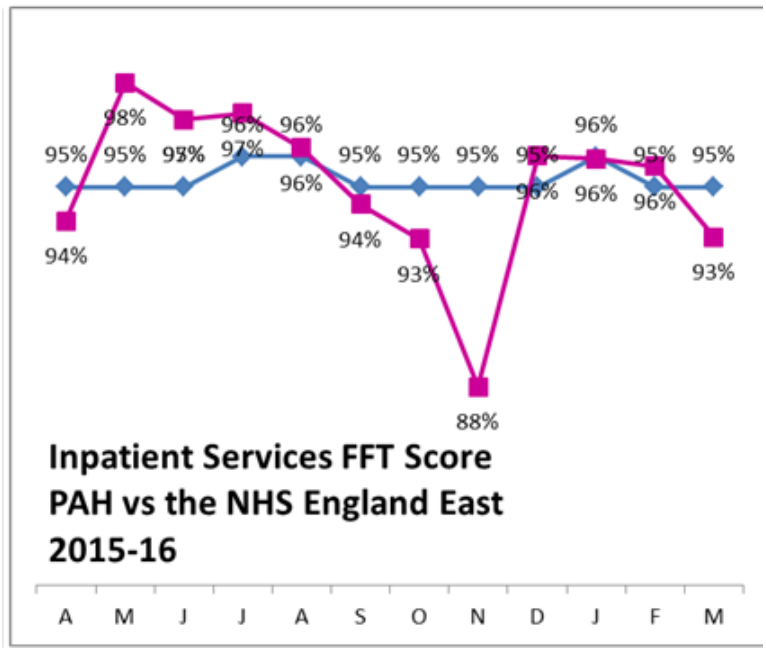


	A	M	J	J	A	S	O	N	D	J	F	M
2015-16	36	39	26	26	19	21	22	19	20	21	26	20
Compliments	161	170	213	250	137	246	237	211	231	261	187	150

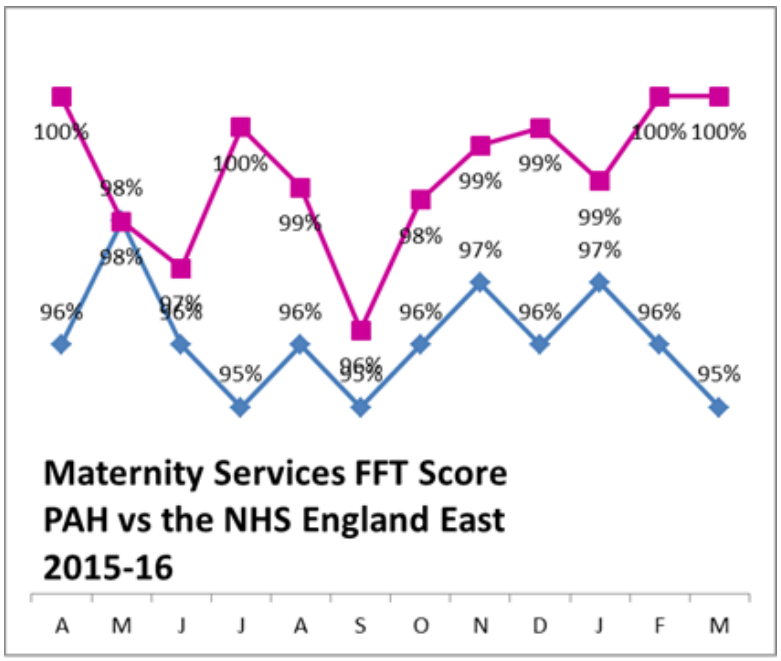
Emergency Department Friends and Family Test Score PAH vs. East of England NHS 2015-16



In Patient Friends and Family Test Score PAH vs. East of England NHS 2015-16



Maternity Services Friends and Family Test Score PAH vs. East of England NHS 2015-16



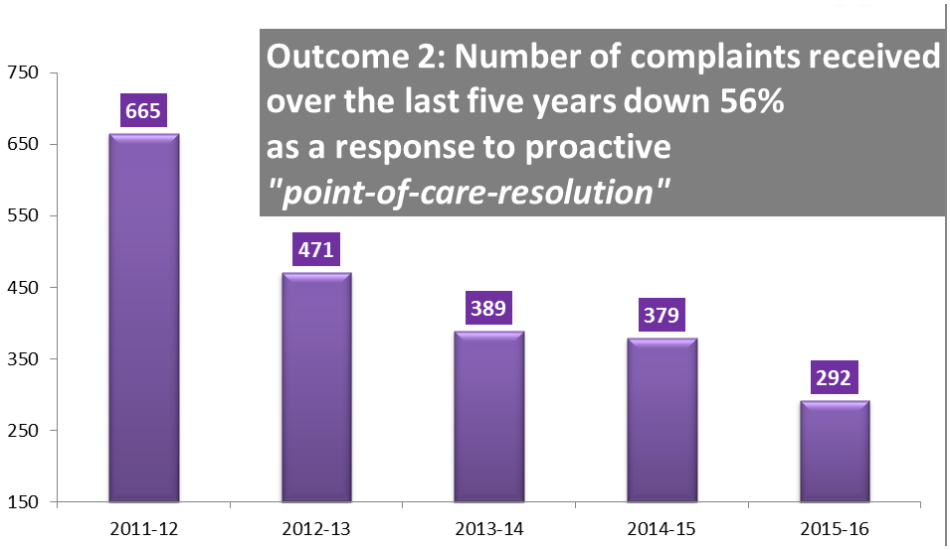
Outcome 1: Compliments:

The highest number of compliments ever received and logged - achieved in 2015-16, with 2454 logged for the year, a great achievement in a difficult year for the NHS and for the Trust.

A listening organisation

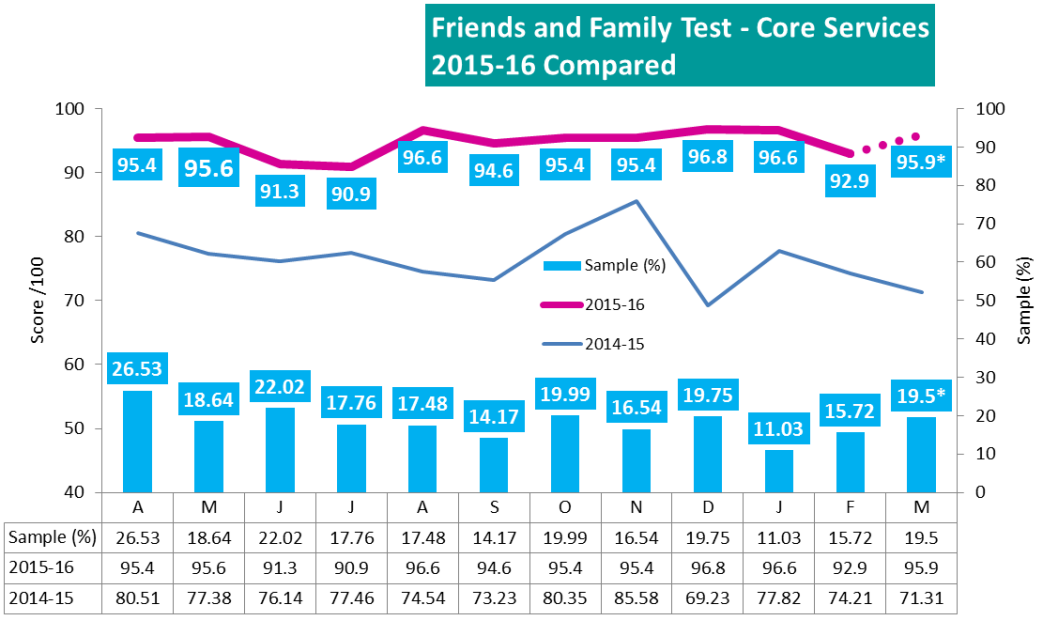
The Patient Engagement and Experience Team enable a listening organisation, and we can certainly demonstrate we have listened. The more significant questions remain for us, about how we enabled the Trust to do two things, to respond and then to improve.

During the 2015-16 reporting period changes were made to the method of calculating the score so the data for 2014-15 and 2015-16 are not comparable but have been shown here to highlight the downward trend.



Friends and family test

Thousands of patients have also voted in our Friends and Family Test, with 25,476 people voting to tell us about their quality of care of whom 23,818 would come back and recommend, that equates to 93.5% of our patients.



	A	M	J	J	A	S	O	N	D	J	F	M
Sample (%)	26.53	18.64	22.02	17.76	17.48	14.17	19.99	16.54	19.75	11.03	15.72	19.5
2015-16	95.4	95.6	91.3	90.9	96.6	94.6	95.4	95.4	96.8	96.6	92.9	95.9
2014-15	80.51	77.38	76.14	77.46	74.54	73.23	80.35	85.58	69.23	77.82	74.21	71.31

How do we listen?

We meet face to face with complainants, in 2015- 2016 this accounted for 106 of 237 cases closed where complainants chose to meet. We close all meetings with an opportunity to provide feedback, we also send all complainants a survey which assesses levels of satisfaction with the complaints process, we monitor feedback to the Ombudsman, which

showed most recently that in 2014-15 80 complainants contacted the Ombudsman, but only 3 complaints were upheld following a second stage review. We believe this is evidence of an exceptionally thorough local resolution process.

Outcome 3 - The Ombudsman:

Benchmarked against the best, the Trust compares well with the best performance in the East of England at the Ombudsman and comparable to the best in the country.

	Trust	Received	Accepted	Upheld	Not upheld	/10k Incident	Accept/10k	Clinical Epis	% upheld
117	Salford Royal NHS Foundation Trust	42	5	2	4	1.89	2.25	222291	4.8%
118	Lewisham and Greenwich NHS Trust	105	23	5	9	4.36	9.56	240627	4.8%
119	Leeds Teaching Hospitals NHS Trust	129	22	6	10	3.22	5.48	401206	4.7%
120	Peterborough and Stamford Hospitals NHS Foundation Trust	44	11	2	6	2.33	5.83	188791	4.5%
121	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	47	6	2	2	1.80	2.30	261169	4.3%
122	Homerton University Hospital NHS Foundation Trust	48	7	2	3	3.76	5.49	127556	4.2%
123	Northumbria Healthcare NHS Foundation Trust	49	15	2	11	2.27	6.96	215606	4.1%
124	Wrightington, Wigan and Leigh NHS Foundation Trust	25	14	1	8	1.41	7.92	176796	4.0%
125	The Walton Centre NHS Foundation Trust	25	5	1	2	4.49	8.97	55737	4.0%
126	Central Manchester University Hospitals NHS Foundation Trust	129	24	5	8	3.24	6.04	397540	3.9%
127	The Princess Alexandra Hospital NHS Trust	80	12	3	6	5.58	8.37	143383	3.8%
128	Kettering General Hospital NHS Foundation Trust	54	6	2	1	4.02	4.46	134472	3.7%
129	Harrogate and District NHS Foundation Trust	29	9	1	5	2.75	8.54	105399	3.4%
130	Moorfields Eye Hospital NHS Foundation Trust	31	2	1	1	2.52	1.62	123227	3.2%

In addition to this measure of performance and satisfaction the Trust monitors the number of complaint re-opened locally following an expression of dissatisfaction and this has been falling with 72 requests for cases to be re-opened in 12-13 to only 8 requests for a case to be re-opened in 2015-16. This is a reduction in re-opened cases from 2012-13 of 89%.

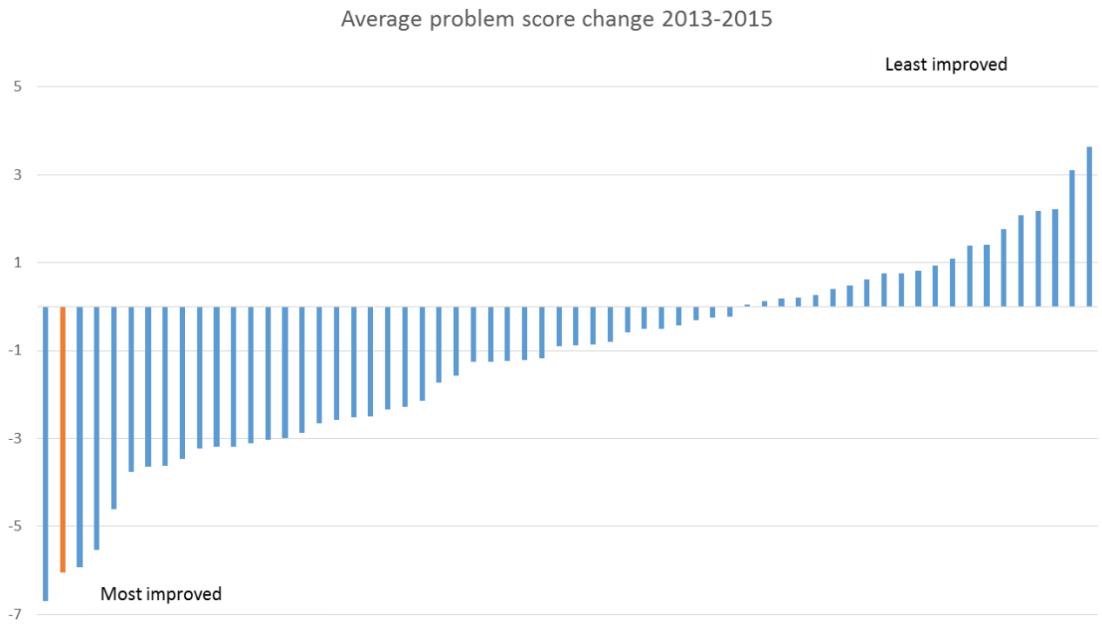
Improving Performance

Responding to our complaints and PALS cases in a timely way has also been a priority this year. With the introduction of Healthcare Group level performance data on the rate of closure of cases, the latest information shows that 79% of PALS cases are responded to in 48 hours, a significant improvement on the less than half where we had evidence in previous years. Some of these cases are managed by the PALS team directly and immediately resolved and many are answered with support by the Healthcare Groups.

The overall number of open complaints has fallen from 171 in mid-2015 to less than half of that, 75 cases at the end of the year. We are also now in a position where we have fewer complaints out of time than ever before, less than 33% and aim to reach zero by July 2016.

We have also seen one of the most promising National Patient Experience Surveys from Maternity in years, with no areas in the red and 4 areas in the green, by which we mean the top 20% nationally. The Family and Women's Healthcare Group and Trust can rightly be proud of a team who are the second fastest improving of 64 Trusts nationally, as measured by Picker Europe and the 9th best overall.

Combined with an assessment of outstanding for the Caring domain of the CQC assessment in July 2015, there are real reasons for optimism as the Trust believe the same green shoots of improvement are visible in the National Inpatient Survey 2015.



Outcome 4 - National Surveys:

"Proud of a team who are the second fastest improving of 64 Trusts nationally for Maternity Services!"

There are many things to look forward to, and 2016 promises to be an exciting year for enabling a responsive and improving organisation:

- electronic feedback systems to compliment new electronic patient observations
- our highly effective user groups and Patient Panel running their third regionally recognised conference in May
- a renewed attempt by many teams to respond to our patients, families and carers needs
- embracing quality improvement methods and tools such as Always Events.

The Patient Panel

The Patient Panel is now in its third year and continues to build on its reputation as a critical but constructive friend to the Trust. During the past year, the Panel continued to identify further projects and ways to communicate with patients and the local community to ensure that the patient voice is heard in all areas of the hospital, especially in the decision-making process. Respectful, Responsible, Caring and Committed are the values of the Trust, and part of the Panel's work is to ensure that staff adhere to these values. However, its role is not only to challenge, but also to highlight, the very good work done within the Trust.

In terms of improvement, volunteering and patient engagement through the Patient Panel has developed and spread rapidly with widespread interest across the patch in people wishing to work with our Patient Panel. The Patient Panel have welcomed and supported user groups in the organisation to further develop and the Trust have also established a thriving learning network, the South Essex Patient Experience Collaborative and held two meetings, with interest now from North London Trusts and across Essex.

Achievements in 2015 – 2016

Delays in the discharge process are still seen as a major issue, with all members of the Panel having had personal experience of this. The panel eagerly await the results of the research Healthwatch Essex carried out in three Essex hospitals, PAH being one of the pilot hospitals but were disappointed to not be approached to be involved in this research.

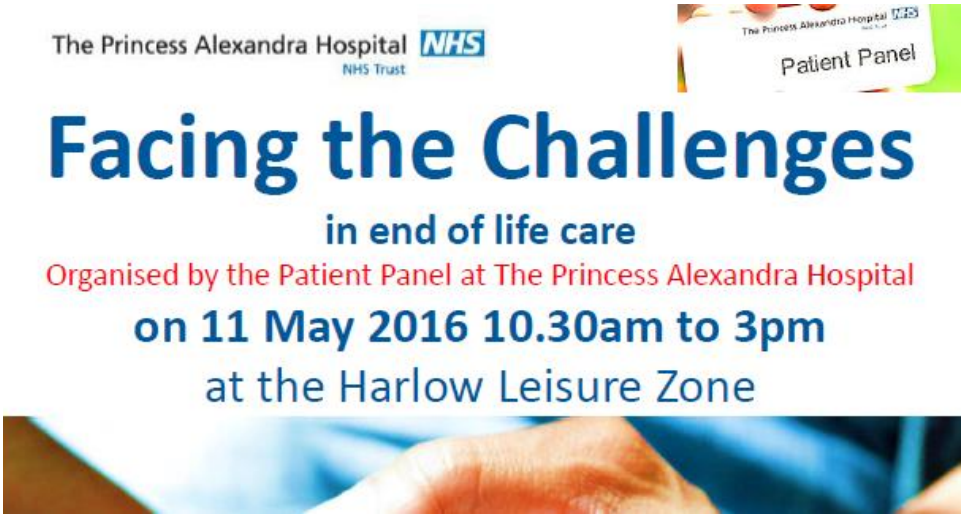
The Patient Panel continue to have a representative on the '100 Day Challenge' which is continuing to work in a collaborative way with other agencies particularly around integrated care.

Reporting

Currently there are Panel members sitting on over thirty committees, including acting as an independent person on the Panel looking at appeals over car parking charges and disputes. One member chairs the organ and tissue donation committee. A sub group reviews the handling of complaints and whether the complainant was satisfied with the way the complaint was handled. The feedback from members on these committees is fed back through the Chair to the Quality and Safety committee.

Nutrition and Hydration

This item has become a standard item on the agenda; a Patient Panel representative has spent a considerable amount of time visiting wards at mealtimes talking to patients and staff about the food that is served. Also she checks that staff is adhering to the "protective mealtimes" which enable patients to enjoy their food without being disturbed with trips to X-ray, Pathology or by doctors rounds, for example. The Panel looks forward to seeing the finished report.



The Panel held its third annual conference in May 2016 at the Harlow Leisure zone which was attended by more than 80 members of the public as well as many representatives from voluntary, educational and statutory organisations. Due to its popularity, it was unable to accommodate all those that wished to attend. The conference raised a number of key issues on End of Life Care and we were fortunate enough to have the CEO from the National Palliative Care Council as a keynote speaker, and also a speaker about the support for families and carers.

This conference has raised the profile of the Panel as well as the hospital and look forward to working with a number of voluntary organisations in the future.

The Panel also took part in a report prepared by the Health, Overview and Scrutiny Committee (HOSC) and highlighted the nurse ambassadors that work with the Panel who continue to offer a presentation to the new intake of student nurses.

A seminar was held in May 2015 for the public, voluntary organisations and professionals on the changes that were happening in the Emergency Department. The staff prepared and delivered the information and was able to alleviate any concerns the public had.

The Patient Panel have tried unsuccessfully to get a regular bus service that runs from the station to the town and then to the hospital. This is despite lobbying the local County Councillor; however talks are on-going with local taxi companies about designated pick up points.

Volunteers

Over the last year a Dementia specific training day has been developed to accommodate volunteers wishing to support patients with Dementia. This training day is facilitated by PAH staff with the support of voluntary organisations and current volunteers. As of the end of April, there will also be an individual section covering learning difficulties as part of the volunteer induction which currently covers the topics of manual handling, fire awareness, infection control, safeguarding adults, safeguarding children, information governance, and Trust values, standards and behaviours.

During the year relationships have been developed with schools and colleges in the local area and out towards Hertfordshire and aim to work alongside them to recruit a good calibre of volunteers and to help us ensure that volunteering within the Trust works as a two-way beneficial process. We continue to work alongside other voluntary organisations and have been collaborating with West Essex CCG on a number of projects.

Funding was granted this year to help support recruitment of volunteers between the ages of 16 and 24. There have been some struggles due to staff sickness but the aim is to pick this up in 2016-17 and continue to strive to attract new volunteers and to increase awareness amongst staff of how best to support volunteers within their departments. This year has also seen a couple of volunteers go into paid positions within the Trust.

Our volunteer Patient Panel continues to go from strength to strength with regular meetings and a wide ranging presence on many committees within the organisation. The Patient Panel will be holding their third conference on May 11 and are currently working on their second annual report. New members are still welcome as the patient panel are always looking for fresh ideas and opinions.

Cancer patient experience

A total of 148 Trusts took part in the 2015 National Cancer Patient Experience Survey which involved adults over the age of 16. The survey has now officially closed and all the data has been verified and integrity checked. The overall national response rate ended at 66% and the final response rate for Princess Alexandra Hospital is 68% which has shown an increase of 6% from the previous survey.

Work has now started on the data analysis and reporting, this year the results will be published as Official Statistics and the anticipated timetable for publication is as follows:

- Official Statistics Publication of the national results: 7 June 2016
- Official Statistics Publication of CCG and Trust level results: 5 July 2016
- Release of Comments Reports on the 100,000 comments made by cancer patients in the survey: mid-August 2016

A detailed presentation of the results will be requested from Quality Health to assist the Trust in understanding the data and further development of the service. The results will be circulated together with an action plan for 2016 – 2017.

The cancer patient experience remains high on the Trust's agenda and following the 2014 survey it was evident that better communication was a key concern for our patients. Extra training was made available for staff to develop in areas where improvement was required. These areas included Breaking Bad News and End of Life Care.

The Specialist Palliative care Team developed a care plan which supports health professionals in caring for people in the last few days and hours of life. The care plan also focuses on the needs and wishes of the dying person and those closest to them in both the planning and delivery of care wherever that may be and fundamentally places the patient and their family at the centre of decisions about their treatment and care.

The annual local surveys have continued and the results demonstrate that the majority of patients feel that they are treated with dignity and respect. Patients feel that they are involved in the decision making about their treatment and that their families are also included in the decision making process. Reassuringly most patients surveyed knew how to contact their keyworker and felt able to speak with them.

Question 5: I was treated with dignity, respect and privacy during my consultation

Tumour Group	Number responded	%
Breast	60	100%
Colorectal/Lower Gastrointestinal	8	100%
Lung	43	95%
Gynaecological	13	100%
Haematological	14	100%
Upper Gastrointestinal	15	91%
Urological	24	83%

Question 7: I felt involved in the treatment decisions regarding my care and I understood what was going to happen next.

Tumour Group	Number responded	%
Breast	60	98%
Colorectal/Lower Gastrointestinal	8	100%
Lung	43	95%
Gynaecological	13	93%
Haematological	14	86%
Upper Gastrointestinal	15	84%
Urological	24	79%

Question 8: My family and I were given the opportunity to ask questions about my condition and treatment during the consultation

Tumour Group	Number responded	%
Breast	60	56%
Colorectal/Lower Gastrointestinal	8	100%
Lung	43	98%
Gynaecological	13	92%
Haematological	14	100%
Upper Gastrointestinal	15	94%
Urological	24	96%

Question 12: I am able to speak to my local (PAH/SMH) Clinical Nurse Specialist/Keyworker when I need to.

Tumour Group	Number responded	%
Breast	60	56%
Colorectal/Lower Gastrointestinal	8	100%
Lung	43	98%
Gynaecological	13	92%
Haematological	14	100%
Upper Gastrointestinal	15	94%
Urological	24	79%

All patient surveys and action plans will be published in the tumour sites Annual Report 2015-16 and will be signed off at their Annual General Meetings.

Following the Cancer Patient Experience Survey 2014 the Acute Oncology and Malignancy of Unknown Origin have made significant service developments:

- **Implementation of the UK Oncology Nursing Society (UKONS) 24 hour triage tool –** developed to improve patient safety and care by ensuring that they receive a robust, reliable assessment every time they contact the helpline. The new tool has enhanced communication with acute teams, improved documentation and improved communication with treating Oncologist and CNS. Excellent patient feedback was received. This service has been audited with a plan to re audit in 2016.

- **Streamlining the referral process to the AOS/MUO team –** a new referral form is now available on the intranet, an AOS email for referrals has been set up with an urgent referral route via a bleep. New referrals are seen within 24 hours with structured patient assessment and documentation

- **Appointment of a second AOS consultant in January 2016 –** this appointment was in line with Peer Review requirements and has enhanced the service considerably. A recent Peer-review visit also highly commended the service provided at PAH.

- **Review of the Metastatic Spinal Cord Compression (MSCC) policy –** stronger links has been formed with Queens Hospital, Romford and North Middlesex Hospital.

The AOS Team continue to work with these Trusts to develop the MSCC policy and pathway out to the tertiary centres

- **Neutropaenic Sepsis Policy –** There is currently a neutropaenic sepsis audit being carried out, the policy will be reviewed following results of the audit

In the National Annual Cancer Performance for 2015-16, the Trust achieved all targets except for the 31 day rare cancer:

Standard	Target	Achieved
2 WW	**93%**	**96.7%**
2 WW Breast Symptomatic	**93%**	**97.9%**
31 Day First	**96%**	**98.3%**
31 Day Subsequent Drug	**98%**	**99.0%**
31 Day Subsequent Surgery	**94%**	**98.9%**
62 Day	**85%**	**85.1%**
31 Day Rare	**85%**	**60.0%***
62 Day Screening	**90%**	**95.9%**
62 Day Cons/UP	**90%**	**93.0%**

***2 of the 5 cancers treated were outside of 31 days.**

To support cancer performance the Trust is monitoring diagnostics and have set internal targets of 85% of all CWT referrals being carried out within 7 days.

Overall Diagnostics Standard Performance (Routine/urgent/CWT)

Standard	YTD	Previous Month (**Mar 16**)	Latest Month (Apr 16)
> 99%	99.67%	*99.59%*	*99.67%*

CWT Waits Appointment offered within 7 days

Diagnostic	**Internal Target 85%**	**YTD Variance**	**RAG**	**April 2016**
Magnetic Resonance Imaging	85%	7.60%	G	92.60%
Computed Tomography	85%	4.50%	G	89.50%
Non-obstetric ultrasound	85%	6.60%	G	91.60%
Nuclear Medicine	85%	15.00%	G	100.00%
Plain film Radiology	85%	15.00%	G	100.00%

Improving Cancer pathways for patients
An increase in the percentage of patients, referred to PAH on a 2 week pathway, who have been diagnosed with cancer, and have a Decision to Treat* (DTT) within 31 days of referral* and who have a first definitive treatment within 62 days of referral in the following specialties:

- Lung
- Breast
- Skin

***Referral is the date that the referral is received by PAH.**
***Decision to treat as defined nationally (within the 31 day standard definition**

During 2015-16, the Trust has been working to deliver an enhanced prostate pathway for patients, including:

- Patients being able to have MRI on day of first their outpatient appointment to reduce length of time to biopsy
- Improvements have meant PAH have consistently met 62 day standard in this area since February 2016
- Recognition that there is work required to ensure sustainability

National Cancer Waiting Times System Report

Cancer Plan 62 Day Standard (Tumour) Urological (Excluding Testicular)					
Period	***Actual Total treated***	**Accountable Total treated**	**Accountable Total over target**	**PAH % meeting standard**	**National % meeting standard**
Q1	*51*	**47**	**10**	**78.72%**	**74.80%**
Q2	*49*	**44.5**	**7**	**84.27%**	**74.40%**
Q3	*46*	**43.5**	**7.5**	**82.76%**	**78.70%**
Q4	*44*	**43**	**4.5**	**89.50%**	**76.40%**
Total	*190*	**178**	**29**	**83.71%**	**76.10%**

The enhanced pathway has led to:

- The implementation of 7 day as a 'mean' for first outpatient appointment in all specialties
- Development of timed pathways
- Introduction of a weekly Network meeting to highlight issues and areas of concern with an aim to resolve them

There have been notable challenges in the past year; in particular capacity issues have been problematic in the following areas:

- Surgical Colorectal
- Dermatology
- Radiology (US FNA and CT Colonoscopy)
- Transperineal biopsy capacity and Template biopsy
- HIFU (High Intensity Focused Ultrasound)

However plans are in place for 2016/17 to further improve on the successes and overcome the challenges of 2015-16 which include:

- Review of timed pathways to reduce waits
- Review of demand and capacity (rolling programme quarterly)
- Development and roll out of specific cancer access policy
- 7 day for first OPA target to increase
- Development of recovery package which will see the implementation of:
    - End of treatment summaries
    - Stratified pathways to support earlier discharge
    - Health and wellbeing events
    - Holistic needs assessment
- Development of nurse led PICC service to facilitate earlier treatment
- Development of straight to test diagnostics for colorectal patients
- Working with London Cancer as part of the Cancer Vanguard to reduce waiting times with a particular focus on diagnostics

The National Cancer Patient Experience Survey 2015 is awaited and will ensure that the results of the survey are reflected in our work plan for 2016 -2017.

Case Study Two:
Pioneering new treatment at Princess Alexandra Hospital

For the past 30 years the standard treatment for prostate cancer confined to the prostate gland has been either surgery to remove the whole prostate or radiotherapy delivered to the whole prostate.

One in eight men, more than 4,000 men in the East of England are diagnosed with the illness every year and that's higher than the national average. More than a thousand men in the East of England die from it each year.

Traditionally prostate cancer is treated by removing the whole prostate gland but a new method targets only the cancerous cells with ultrasound.

The complications associated with whole gland therapy for the treatment of prostate cancer include possible incontinence, impotency, rectal injury and there is a longer recuperation.

	Radical prostatectomy	***Radical radiotherapy***	***Focal Therapy***
Rectal injury	*1-2% (fistula)*	*3% long term severe proctitis*	*<1%*
Impotence	40-60%	*25-60% (occurs over several years)*	5%
Incontinence	*50% early (10% long-term)*	*1% (severe long-term)*	1%

During the past few years minimally invasive treatments have been introduced which can be focused very accurately to treat only the area of cancer within the prostate and leave non-cancerous areas untreated – this leads to significantly decreased side-effects whilst maintaining equivalent cancer control.

One of these new cutting edge, innovative techniques is called focal HIFU – High Intensity Focused Ultrasound.

What is HIFU?

HIFU stands for High Intensity Focused Ultrasound and it is a non-invasive therapy that focuses sound waves to create heat in a similar to light traveling through a magnifying glass to create heat.

It raises the temperature of the target tissue to 90 degrees Celsius and destroys the targeted tissues where sound waves cross.

High-Intensity Focused Ultrasound (HIFU) pulses energy into an area about the size of a grain of rice creating a sharply delineated point of increased temperature, melting cell membrane lipids and denaturing proteins.

Focal HIFU treatment of prostate cancer involves a modified ultrasound probe inserted into the patient's back passage under general anaesthetic – the high intensity ultrasound waves are then focused onto the areas of cancer, heating the cancer cells to a temperature of 90-100 degrees Celsius and thus destroying them.

Princess Alexandra Hospital, Harlow is now only one of 5 hospitals in the UK offering this treatment on the NHS.

Advantages to patients of HIFU

- A Day surgery procedure – patient walks out of hospital same day
- No cuts or incisions made
- No blood loss
- Relatively painless
- Patient back to work within a few days
- Significantly decreased side-effects compared to traditional, standard treatments i.e. very low associated risk of urinary or erection problems
- Provides good cancer control
- Low morbidity
- Radiation free
- Can be repeated
- Can be used in radiotherapy failures

Of course there are some disadvantages:

- Possibly not long term (only 10-20 years outcome data)
- Probably not suitable for high risk prostate cancer

There are many benefits of establishing Focal HIFU at Princess Alexandra Hospital:

- Latest surgical innovations available for the local population
- Aids recruitment of consultants and junior doctors i.e. offer specialist services at the Trust to attract candidates
- Helps establish clinical trials and attract clinical trial staff e.g. clinical trials CNS, MSc students
- Help to establish a reputation as a robust urological cancer clinical trials unit
- Positive publicity for the Trust as it is now at the forefront in UK of diagnosing and treating prostate cancer

Prostate cancer is one of the last solid cancers in which we continue to treat the whole organ harbouring the cancer (radical prostatectomy or radical radiotherapy). HIFU allows us to accurately localise cancers, in the example of prostate cancer, we now have the tools to treat just the tumour and not the whole prostate where it is difficult to surgically remove only part of the prostate.

There is a need for an energy source that will result in cancer cell death and that can be accurately targeted/focused to affected areas and having the latest surgical innovations at the Trust is great benefit to the healthcare of our local population.

End of Life care

End of Life care is one of 3 quality improvement areas for 2016/17 for the Trust Board and as part of this End of Life Care is part of the national initiative Sign up to Safety. This was launched in April 2016 with presentations and a stand outside the canteen.

The Trust board is very supportive of End of Life Care and has members with a particular responsibility to champion this vital part of health care. The Chief Nurse and Chief Medical Officer are the executive leads and Pam Court is our non-executive lead.

Governance

The end of life steering group meets monthly with representation from internal and external stakeholders.

This group reports to the Patient Safety and Quality group monthly.

The Specialist Palliative Care Team report to the Safety and Quality committee quarterly and to the Trust Board yearly.

Education and Training

End-of-life training continues to be an essential part of mandatory training which is also supported by the Trust Board. All new clinical staff undergo a three hour-long training session during their induction. The foundation doctors joining the trust each August all undergo a two hour training/discussion on end of life care and the expectations from the trust that dying patients and their families receive the best care. Both sessions incorporate communication, symptom control, advance care planning and care of the dying patient in their anticipated last days of life.

End of life care training using the simulation manikin which was funded by a grant from the East of England Deanery has been very well evaluated and will continue with a half day twice a month. The training has been attended by acute, community and hospice staff and by doctors from all levels, trained and untrained nurses and allied health professionals. A poster was presented at the National Association of Palliative Care Educators conference in 2015.

The specialist palliative care team have collaborated with the practice development team to provide training for the preceptorship and the nurses recruited from abroad. Preceptorship nurses have a 3 hour open session where they provide the agenda for discussion on end of life care. Our overseas nurses receive several extra sessions focussing on differences between their home countries experiences and the UK with care, medications, procedures and communication.

Specialist palliative care team staffing and activity

Since September 2015 the team are supported by a 0.4 WTE consultant in palliative medicine. This is provided by a contract with St Clare hospice where 2 consultants provide 2 sessions per week.

Plans for 2016/17 are for a PAHT 1.0 WTE palliative medicine consultant in addition to the support already provided. A job description and business case is in the process of being worked up for presentation to the Trust Board who are aware and already supportive of the need for the post to be in place.

A third Macmillan palliative care CNS was appointed and commenced in post on the 29th February 2016. This post is was as a result of a successful bid to Macmillan Cancer Support (MCS) to fund the post for 2 years with the trust agreeing to continue the funding at the end of the 2 years. The post is full time and incorporates a project to improve end of life care for patients with dementia. A review of the national guidance to provide a 7 day 9 – 5 face to face service the team will provide a 6 day 9 – 5 face to face service from May 1 2016.

We are very grateful to MCS for their continued support to the team and to the trust.

The team continue to see a rise in referrals

Year	Number of new patient referrals	Number of re-referrals	Total referrals
14/15	478	35	513
15/16	525	55	580

The percentage of non-cancer referrals has also increase from 11% in 2012/13 to 34% in 2015/16.

2015 - 2016 CQUIN

The CQUIN for 15/16 involved the appointment of a discharge liaison nurse (DLN) for end of life care whose role also involved education and training at ward level to increase the numbers of patients identified as in their last year of life and ensuring appropriate care planning is in place to prevent inappropriate readmission to hospital.

An audit has shown an increase in referrals to the DLN and qualitative feedback from families has been very positive for the role and outcomes.

Embedding quality through patient champions

Improving Dementia care

The Princess Alexandra Hospital NHS Trust remains committed to improving the care of our patients living with dementia, those who have suspected dementia and their 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 addition, there are challenging milestones contained in the national and local Dementia acute care CQUIN which is continuing during 2015/16.

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

Training
The Trust remains committed to ensuring that its staff are suitably trained and experienced in dealing with patients with dementia and as such has set a challenging training plan. This will be described in detail in the CQUIN section of this report.

The third cohort of dementia champions will complete their training on the 22 June.

The programme has proved to be very successful and will continue during 2016 with a further cohort planned to commence in October/November.

Dementia CQUIN
The dementia CQUIN set the Trust continuing challenging milestones for 2015/16. The goal of the CQUIN is to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their medical conditions.

The CQUIN is divided into 3 main sections:

1. Find Assess Refer

- A) 90% of patients aged 65 years or older admitted as an emergency asked the case finding question.
- B) 90% of patients answering positively to the case finding question, having diagnostic assessment.
- C) 90% of patients having a positive diagnostic assessment referred in line with agreed local pathways.
-

There have been on-going issues in achieving and maintaining these objectives due to a number of technical problems within the COSMIC system and also due to clinical engagement.

However, following concerted efforts from staff across the organisation, the Trust was able to submit the following validated results for February 2016:

A) - 92.79%
B) - 100%
C) - 96.97%

Data for March 2016 will be validated at the end of April 2016.

2. Clinical Leadership/ Staff Training

- **Medical Staff** – The series of dementia sessions for junior doctors has continued. 65**%** of current medical staff have now attended one of these sessions. The sessions will continue during the next financial year.
- **Nursing and AHP staff** –The intensive training programme has continued and currently, over 94% of this staff group have attended one of these mandatory training sessions. The overall figure for the trust is 87%. It is disappointing that the Trust was not able to meet its self-determined target of over 95% staff having attended this training.
- Dementia awareness training forms part of all RN preceptorship programmes, EU nurses development programmes, the HCSW development programmes and the newly constituted Vulnerable Patient study day.
- The dementia e-learning programme is continuing to be widely promoted across the Trust.
- During February 2016, 7 staff completed the Virtual Dementia Tour Facilitators training. The training will be formally launched during National Dementia Awareness week in May 2016 and will be available to all staff. The aim is that this training will become part of mandatory training for all Trust staff.

3. Supporting carers

The Trust is required to survey carers of patients with dementia and report the results to the Board.

One of the changes to the dementia CQUIN for 2015/16 was for the Trust to work more closely with colleagues from the community Trust (SEPT) and the CCG on improving response rates for the carer's survey and producing action plans to address concerns raised by the carers. As part of this the Trust has worked with colleagues at SEPT to produce a simplified carer survey which is now being used by both Trusts.

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.

There have been considerable challenges in maintaining a high level of surveys being distributed and also a disappointing response rate. Since October 2015 there has been a re-focus on the way in which the surveys are being distributed and this has demonstrated an improvement in the amount being completed and returned.

April 2015	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2016	Feb	March
0	0	1	0	0	16	6	4	6	13	13	3

Although there will not be a formal CQUIN for dementia during 2016/17, the requirements of the current CQUIN are likely to be added to local contracts and KPIs. The Trust is committed

to continuing with all elements of the original CQUIN in order to improve patient experience and safety.

Dementia volunteers

The Trust has now held 3 training days for dementia volunteers. It is envisaged that recruits from these study days will be working in the clinical areas from April 2016.

Dementia Support practitioner

During March 2016, the Trust was successful in appointing a Dementia Support Practitioner on a year's fixed term secondment. This post will, in part, back fill maternity leave within the wider Nursing and Quality team and will ensure that the Trust can continue to improve patient experience and satisfy all national and local objectives.

National Audit of Dementia

The Trust has signed up to completing the National Audit of Dementia which commences in April 2016.

Alzheimer's Society report

In January 2016, the Alzheimer's Society published a report entitled: *Fix Dementia care: Hospitals*. This report outlined current issues with providing high quality care to people living with dementia whilst they are experiencing an in-patient episode in an acute hospital.

The Trust is committed to meeting the suggested recommendations contained within this report and will be producing an action plan to meet these. However, it has been decided that it would be practicable to have one overarching action plan designed to meet a variety of standards/recommendations rather than a number of individual ones. Therefore, during April 2016, the support practitioner will be devising an action plan to cover:

- National Dementia Strategy
- PM's challenge on dementia: 2020
- Dementia Action alliance – Dementia friendly hospitals self-assessment
- Alzheimer's Society – *Fix dementia care – hospitals* report.

Improving care for patients with learning disability and autism

Learning Disability (LD) Steering Group

The steering group continues to meets quarterly and is overseeing the implementation of the Improvement Plan. There has been appointment of a new Non-Executive Learning Disability Lead within the Trust who will chair the meetings from February 2016.

Working with External Stakeholders

In addition to the external members of the learning disability steering group, the Trust is actively working with other external stakeholders involved in learning disability care. Currently, the Learning Disability Nurse works closely with Community Learning Disability Teams both in West Essex and East Hertfordshire.

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 is covered in the Vulnerable Patients Study Days. This awareness training is also delivered on the Induction Programme for all new starters.

First cohort of Learning Disability Champions received some bespoke Epilepsy Awareness the Training from an external agency on the 10th December 2015. A second session is currently being arranged, as well as looking at sourcing communication training for staff.

As in the last quarter, the commencement of a second cohort of Learning Disability Champion Training has been challenging due to both current staffing levels and staff uptake/nomination for the role.

Incidents, Complaints and Compliments

Complaints involving LD/Autism

Month	Number of Complaints
December	0
January	0
February	2
March	0

Incidents involving LD/Autism

Month	Number of Incidents
December	9
January	14
February	7
March	10

Learning from Incidents and Complaints:
The Learning Disability Liaison Nurse continues to await response from Ward Managers where complaints have been high to ensure relevant teaching is disseminated to all staff. Themes of complaints continue to be discussed during generic training.

The Learning Disability Liaison Nurse continues to attend any relevant Scrutiny Panels and Serious Clinical Incident Group meetings to ensure any areas for learning are identified following incidents or complaints.

Falls

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

- A full time Falls Prevention lead (FPL) was recruited and started in August 2015.

- There was a successful study day in October 2015 that was well attended by the 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.

    - FPL continues to work with fellow falls leads across the county and within West Essex specifically.
    - FPL has become integrated within the local community charities and contributes to the Falls mapping exercise currently run by the CCG.
    - A New Falls Care plan has been introduced which addresses current NICE guidelines and actions that were identified following the Royal College of Physicians Audit in 2015.
    - A patient referral pathway for impaired vision has been established,
    - Cutting edge flat lifting equipment has been purchased to aid safe retrieval of fallen patients, training to commence soon.
    - Detailed patient brochures have been produced that contain a wealth of information around falls and well-being.
    - Ward based falls reference folders have been produced which contain master copies of paperwork, leaflets and community referral details.
    - A new bed rails/low rise bed assessment tool has been introduced.
    - Successful informal education evenings have been run incorporating documentaries and a social aspect for staff.

Further work is required on:

- Work has commenced on recruiting Rehabilitation assistants and a business plan is in development.
- More work is required to embed medication reviews as part of falls prevention.
- The monthly falls meeting requires better attendance and an action plan to address this needs formulating by FPL.
- The new falls record keeping approach is due to be audited in May 2016.
- The Royal College of Physicians will re-audit our service in September 2016.
- On-going continuous falls teaching is required to ensure embedded falls prevention knowledge across all staff to counteract the high rate of staff turnover.
- We need to become more integrated with the community services to facilitate better discharge and fewer admissions to hospital due to falls in the first place.
- The purchase of recliner chairs is an on-going challenge, the long term hire of chairs is being considered now.

Overview:

The Trust is trying to pursue a longer term approach to falls prevention and acknowledge that prevention is more effective, efficient and financially sustainable than rehabilitation.

Patients are becoming older and their needs more complex and yet we contribute to their decline by enforcing bed/chair rest when they are admitted. 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 required and staff members need empowering to mobilise and engage actively with patients. This is where the proposed rehabilitation assistants could foster real change.

Falls by Severity 2015-2016

	Death	Minor	Moderate	None	Severe	Total
Apr	0	25	0	74	0	99
May	0	27	0	69	0	96
Jun	0	21	1	54	0	76
Jul	0	25	2	54	0	81
Aug	0	31	0	70	0	101
Sep	0	25	1	65	0	91
Oct	0	33	4	72	0	109
Nov	0	26	3	73	0	102
Dec	0	27	4	54	1	86
Jan 2016	0	28	2	62	0	92
Feb	0	24	4	72	0	100
Mar	0	27	3	72	0	102
Total	0	400	34	994	1	**1135**

Scrutiny Panel Decision on falls:

Panel decision	**April 2015 – March 2016**
Avoidable	3
Unavoidable	12

Infection Prevention and Control

Our commitment to Infection Prevention and Control

Continuing and sustained commitment by clinical and management staff to patient safety and infection prevention and control, means the Princess Alexandra NHS Trust has for yet another year maintained excellent control of both health care associated infections (HCAI) and antimicrobial resistance.

Infection prevention and control (IPC) measures are now embedded in day to day clinical practice and plays an essential part in providing a safe environment for our patients. Antibiotic stewardship and the control of antimicrobial resistance complies with national standards set out by the Department of Health (DoH) in 'Start Smart then Focus 2011' and the 'UK 5 Year Antimicrobial Resistance Strategy 2013 – 2018'.

IPC is a Board to ward priority. Staff across the organisation are trained, audited and engaged in IPC measures, and the IPC team are well supported in ensuring IPC remains 'Everybody's business'. Staff of all grades remain focused on the prevention of a range of HCAIs, and preventing the emergence and spread of antimicrobial resistance, the latter being a national and global threat to the modern day practice of medicine.

The Trust IPC indicators and standards are benchmarked and monitored via the national Public Health England (PHE) mandatory surveillance system and local CCGs, and comply with all five strategic goals of the Trust:

- Excellent safety and outcomes: benchmarked against the best
- Excellent patient and carer experience: delivering personalised care
- Excellent performance: meeting regulatory and national operating standards
- Excellent value: improving efficiency and productivity and reducing costs
- Excellent morale and staff engagement: investing in staff and infrastructure to ensure we are fit for the future

Performance in 2015-2016

The Department of Health has set national non-negotiable targets for each NHS Trust with regard to MRSA bacteraemia and Clostridium *difficile* infections. Trusts are set individual trajectories annually.

Clostridium Difficile

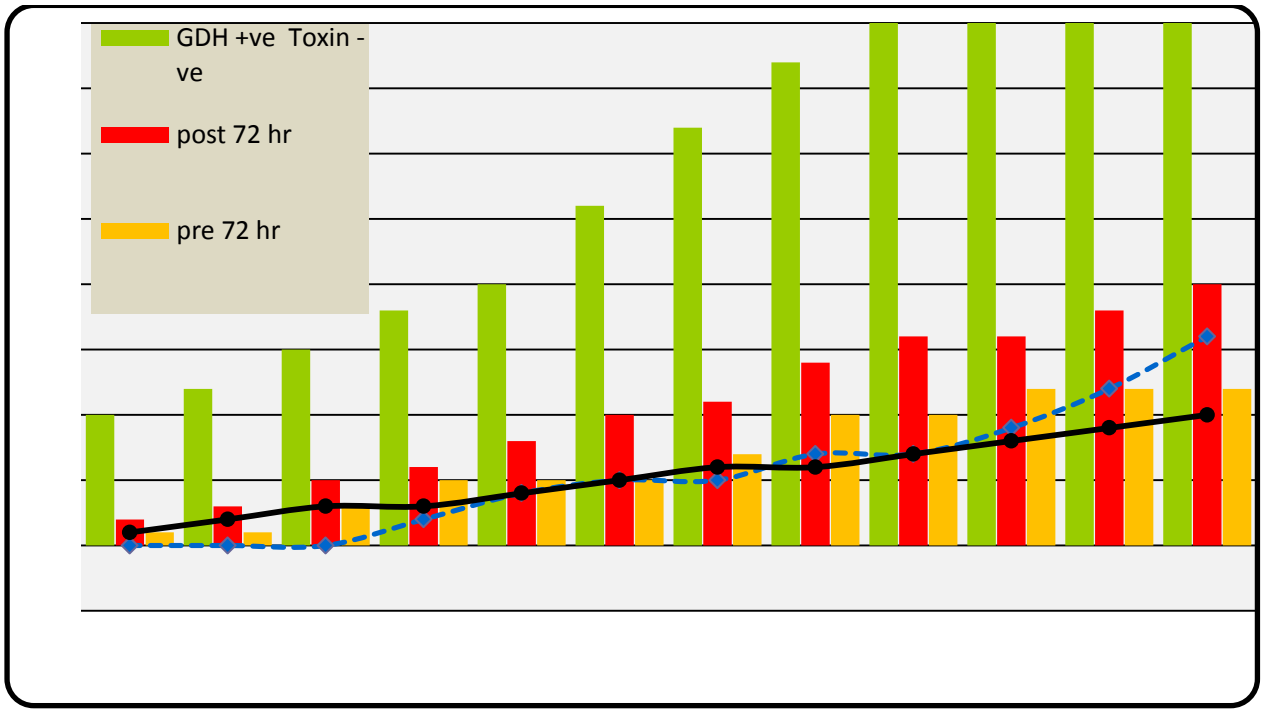
The Princess Alexandra NHS Trust infection prevention and control strategy means we have performed extremely well over the years, leading us to have one of the lowest targets set for C.*difficile* nationally, in recognition of our sustained low rates of C.*difficile* disease.

The threshold for 2014 -2015 was 16 and we met this target, having 16 Trust associated cases that financial year. In order to drive Trusts to have year on year improvements, the DoH set tighter targets year on year. Our trust trajectory was set at 10 for 2015 – 2016, much lower than neighbouring district general hospitals and similar to paediatric and specialist hospitals such as orthopaedic and maternity hospitals.

As our hospital serves a large elderly population, the common age group for *C difficile*, it was recognised from the outset including by the CCG that an annual target of 10 Trust apportioned *C difficile* cases would be a very challenging target.

In fact 20 cases were reported by us for 2015 – 2016 on the national HCAI data capture system, but the CCG appeals panel for contractual purposes are considering only 6 (of 20) cases. This is because *C difficile* is recognised as an unfortunate consequence of the use of antibiotics (which often can be life saving) and there were no lapses in care associated with 12 (of 20) cases.

Cumulative *C. difficile* cases 1 April 2015 – 31 March 2016



The graph above demonstrates the cumulative total of *C. difficile* from 1 April 2015 – 31 March 2016.

All cases, including Trust attributable cases (shown in **red** and labelled as post 72 hour cases) and community attributable (in **yellow**, referred to as pre 72 hour cases) are shown.

The Trust trajectory for 2015 /2016 is shown in **black**, and the **blue** dotted line shows actual Trust attributable *C difficile* cases last year, in 2014/2015.

The **green** bars show *C difficile* toxin *negative* cases which although being monitored by the ICT as a precaution, are not monitored by the DoH and PHE. Toxin positivity is required for *C difficile* disease.

Our standards for MRSA control continue, as follows:

Standard-	Current Mitigation
To prevent *C.difficile* cases occurring.	**S –**suspect/assess (algorithm/pt assess tool) **I** - Isolate - all patients with *C.difficile* must be isolated **G –**Gloves/aprons (protective equipment) **H –** Hand washing (soap and water) **T –** Test (toxin test) ➢ Antimicrobial stewardship (antibiotic ward rounds, with antibiotic pharmacist/consultant microbiologist, antimicrobial audits/antibiotic app ➢ Teaching and education (stat/mandatory/grand rounds) ➢ Hydrogen Peroxide Vaporiser decontamination of environment ➢ Root Cause Analysis of all cases (shared learning) and Scrutiny Appeals Panel (CCG) Mock CQC Inspection Programme
	Proposed Future Mitigation
	➢ On going training and education (including more robust Link Practitioner programme to encourage 'champions' for each area) ➢ Focus on lapses on quality of care provided and continue to work with clinical staff to improve care. The Commissioner will continue to exercise discretion in deciding whether individual cases should be counted towards, or be removed from trajectory. ➢ On-going antimicrobial stewardship ➢ On-going 'shared learning' at monthly CCG Scrutiny Panel ➢ Review of existing RCA tool to incorporate all factors in NHS guidance Clostridium difficile checklist (developed by PHE CDI 'Lapse in Care' sub group) ➢ Microbiology/IPC joint ward rounds for review of Clostridium difficile cases.

MRSA Bacteraemia

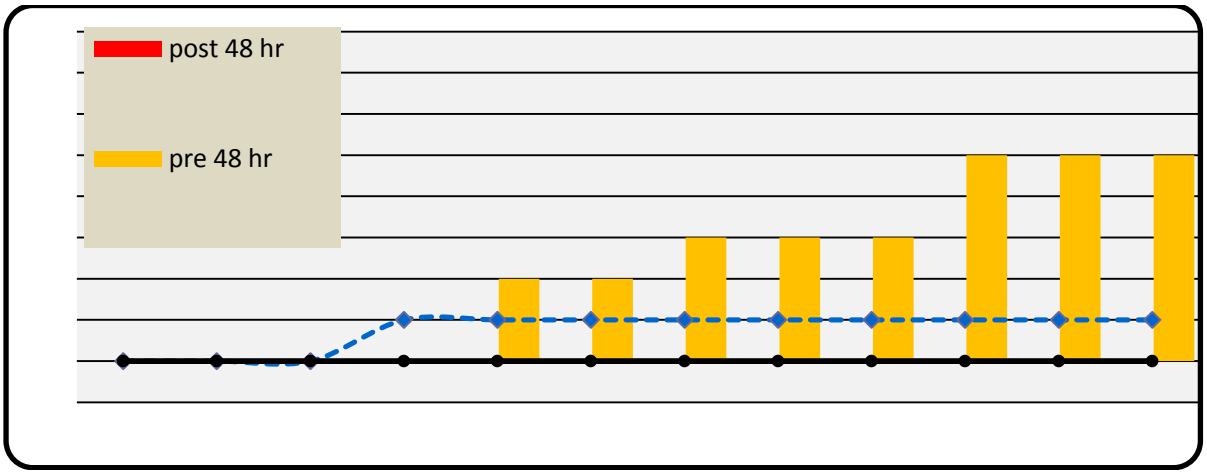
Since July 2014 we are very proud of our performance in having no Trust apportioned MRSA bacteraemias; the Trust has been one of the top performing Trusts nationally in regards to our MRSA bacteraemia rates (as well as C diff).

In the graph below, the Trust trajectory of zero for 2015 /2016 is shown in **black** (a target of zero tolerance has been set by the DoH for all NHS hospitals). The **blue** dotted line shows the single Trust attributable MRSA case in the year 2014/2015 (in July 2014).

West Essex and Herts CCGs however had between them 5 CCG attributable cases of MRSA bacteraemia in patients in their care (yellow bars in graph below referred to as pre 48 hr cases). These patients presented to our A & E department, and were found at the point of presentation to have MRSA bacteraemia. Detailed multi-agency root cause analyses were carried out for all five cases, chaired by CCG IPC leads, with full co-operation and support from the Trust ICT and clinicians.

Action plans and remedial work were presented to CCG Committees by the CCG Lead nurses, as well as at other forums and committees, to ensure shared learning across the organisation.

Cumulative MRSA Bacteraemia cases 1 April 2015 – 31 March 2016:



Our standards for MRSA control continue, as follows:

Standard	Current Mitigation
MRSA control	➢ Mandatory MRSA screening ➢ All in-patients prescribed decolonisation (topical skin wash) for duration of admission ➢ All known positive patients prescribed MRSA decolonisation (full MRSA protocol) ➢ Protocol for high risk patients (as per criteria on MRSA care pathway) is provided in Pre-assessment ➢ Antimicrobial policy/stewardship, including App in place ➢ Use of Chloraprep for skin decontamination ➢ Documentation tools for patients with invasive devices e.g. Body Map Tool, Visual Infusion Phlebitis (VIP) scores ➢ Monthly Hand Hygiene (and other) audits in place ➢ Isolation of patients (where possible) ➢ Training and education for all grades of staff Trust-wide. ➢ Ring fenced surgical ward (no patients with history of MRSA or other infections can be admitted) ➢ Surveillance of MRSA transmissions, including RCA meetings ➢ Mock CQC Inspection programme
	Proposed Future Mitigation
	➢ Future implementation of extension sets for lines/cannulation packs to reduce risk ➢ Implement additional High Impact Intervention (DOH *Saving Lives)* audit tools for invasive devices (Trust Wide) including peripheral line care, urinary catheter care, and Central line care ➢ Revision of MRSA policy ➢ On-going work to improve compliance with documentation of body maps

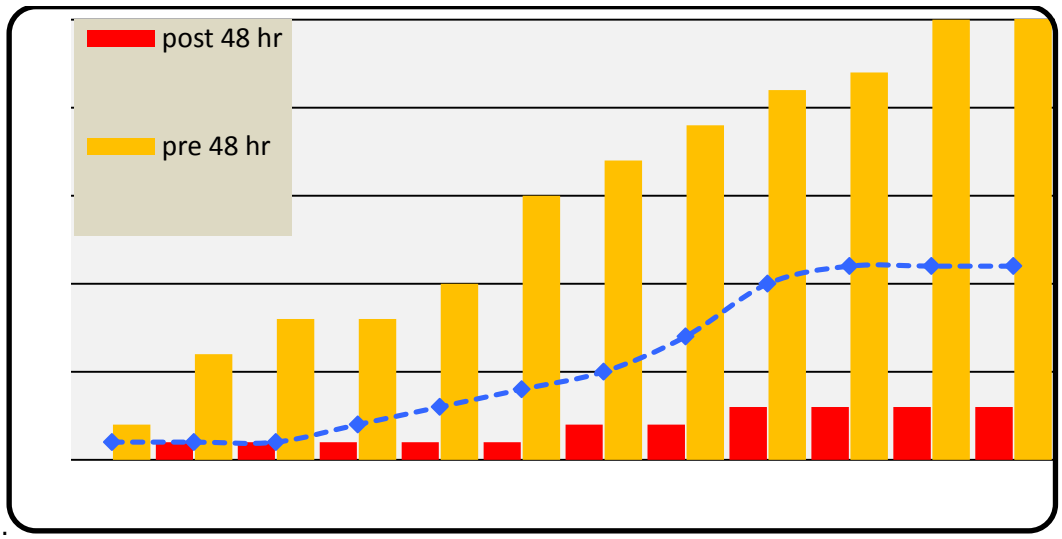
MSSA (Meticillin sensitive *staphylococcus aureus*) Bacteraemia

MSSA is the normal *staphylococcus aureus* strain that many patients carry in the anterior nares of the nose as part of their 'normal' flora. It is never normal to have MSSA in the blood stream; this is then referred to as an 'MSSA bacteraemia'. MSSA strains can be treated with the narrow spectrum antibiotic Flucloxacillin, which cannot be used in *MRSA* treatment, as MRSA is by definition Flucloxacillin resistant.

In the cumulative MSSA graph below, there is no black trajectory line, as the DoH has not set Trust targets for MSSA. However the ICT continue to monitor cases and work with clinical teams to reduce Trust attributable cases, as MSSA infection causes significant morbidity and even death. The **blue** dotted line shows the Trust attributable MSSA cases in 2014/2015. The **red** bars (2015/2016 case numbers) indicate we have been very successful in reducing significantly the number of patients who develop MSSA infection in hospital.

This has been achieved by multiple measures such as strict adherence to the aseptic insertion of venflons, monitoring of phlebitis scores using the 'body map', and by monitoring the use and early removal when possible of venflons and other invasive devices. Many measures used to control MRSA also control MSSA. The IV to oral switch of antibiotics also helps control MSSA bacteraemia indirectly by enabling cannulae to be removed early in a large group of patients, as at any one time 25 -30% of hospital patients receive an antibiotic, often intravenously.

Cumulative MSSA Bacteraemia cases 1 April 2015 – 31 March 2016:



Improving in 2016-17

2016-2017 will not be without challenges and we cannot allow for complacency. The *C. difficile* trajectory for next year remains at 10 cases. In addition to further reducing our *C.difficile* cases, and achieving zero cases of MRSA bacteraemia, we face other difficult challenges. There is increasing global concern pertaining to multi-resistant organisms.

At Princess Alexandra Hospital we have observed an increase of Vancomycin Resistant Enterococci isolates year on year (in line with a national increase). This organism has not caused infections, however it has been detected in clinical samples at a higher frequency than a few years ago. Monitoring and surveillance must continue for other multi-resistant organisms too. Extended spectrum beta lactamase (ESBL) producing organisms and Carbapenemase producing Enterobacteriaceae (CPE) continue to be monitored. A new CPE policy will be implemented this year with screening for CPE, if patients present to PAH from hospitals abroad where CPE is common.

Good antimicrobial prescribing is one of the most important measures to be taken, and the development and implementation of an antimicrobial phone app in the Trust in 2014 has been useful. This allows medical staff access to the Trust antimicrobial policy at the bedside. The

antimicrobial pharmacist post has been made full time (from part-time) from May 2016, and further shows our commitment to antimicrobial stewardship. Work is in progress also for full compliance with the recent NICE guidance, NG15 dated August 2015, on 'Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use'.

International travel and the proximity of Stansted airport has meant our front line staff have received training and support in recognition and in the early management of suspected cases of Ebola virus (a viral haemorrhagic fever), and MERS-CoV (Middle Eastern respiratory virus). These are unfamiliar clinical illnesses caused by dangerous pathogens, and our front-line staff have accepted the challenge with dedication and a strong commitment to patient care and safety.

The Trust outbreak control policy has been updated. The only hospital outbreaks last year have been due to Norovirus. This virus which causes a self limiting disease with diarrhoea and vomiting has been rapidly controlled with support from our multi-disciplinary professional teams including the Facilities team. The Facilities team continue to play an important role in maintaining high standards of cleanliness and using hydrogen peroxide vapour to further decontaminate ward environments, including providing out of hours support.

The IPC team are confident that they will continue to receive engagement and support from all levels of Trust staff, the CCGs, Public Health England, and the local (Essex) Health Protection Unit. The close working relationship with our on-site Microbiology Laboratory means there is real-time access to IC information and rapid infection testing technology.

The Executive team continue to ensure IPC is an essential quality standard at PAH. Cross-over audits and performance monitoring ensures clinical teams have on-going feedback and support. This will facilitate the delivery of the IPC annual programme and the IPC audit programme for 2016 - 2017 and ensure our Trust continues to provide safe care for our patients.

Pharmacy – improving medicines management

Medicines are the most common intervention in medical care. The costs of medicines amount to around 10% of NHS expenditure. A Cochrane review "Interventions for enhancing medication adherence" concluded that improving how and when medicines are taken could have a far greater impact on clinical outcomes than an improvement in treatments.

However, it has been variously estimated that between a half and third of all medicines prescribed for long-term conditions are not taken as recommended, and wider than this the costs of non-adherence are both personal and economic. The economic costs are not limited to wasted medicines but also include the knock-on costs arising from increased demands for health and social care as health deteriorates.

The national drivers for Medicines Optimisation also recognise that support for effective use of medicines spans all sectors of health and social care. There are significant gains to be made financially for all partners in healthcare if medicines are well managed and patients adhere to treatments. To achieve these benefits, there needs to be a significant enhancement of the traditional function of the Pharmacy team to incorporate a more patient facing role working as part of the Consultant led teams.

Lord Carter's review of English NHS acute hospitals recommends that NHS trusts use at least 80% of their pharmacist's resource for direct medicine optimisation activities, medicine governance and safety remits. Lord Carter judges the delivery of hospital pharmacy services to be inseparable from the optimisation of medicines. The report says 'in hospital pharmacy we know that the more time pharmacists spend on clinical services rather than infrastructure or back office services the more likely medicine use is optimised'.

The report also says that 'Trusts should ensure clinical pharmacists are in place, with sufficient capacity, to meet this challenge'. Lord Carter proposes a 'Hospital Pharmacy Transformation programme (HPTP) to ensure trusts implement his recommendations, which also include the accurate cost coding of medicines and the consolidation of medicines stocks to reduce stock holdings.

He also wants NHS Improvement to publish a monthly list of the top 10 medicines that provide Trusts with savings opportunities. Trusts will need to have plans in place by April 2017 to achieve the recommendations by April 2020, says the report.

The report also highlights the potential of centralised dispensing for increasing efficiencies in the supply of medicines to outpatients and to patients when they are discharged from hospital. Lord Carter also recommends that every trust should adopt electronic prescribing and medicine administration systems.

The pharmacy department also had an external pharmacy review last year. This review made a number of observations and recommendations including a number of additional core and specialist posts to support medicine optimisation and significant improvements in the infrastructure of the pharmacy department.

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

Pharmacy

- A monthly report on TTA performance is sent to each healthcare group. This provides information on the number of TTAs received 24 hours and 48 hours in advance of patient's discharge and the number of TTAs prescribed on the day of discharge. This is

set up as a measure of improving patient safety, experience and discharge. A TTA performance report is also provided to the Medicine Management and Incident Committee (MMIC) and to Medical Advisory Committee (MAC).

- A Pharmacist and pharmacy technician are now present in the discharge lounge with a dispensing cart to support patient discharge
- A pharmacist is now based on Kingsmoor ward to support medicine management
- EPR validation of formulary medicines to DMD codes has been completed and ready for the implementation of electronic prescribing module. Matching of formulary medicines to DMD codes will become mandatory in the next few years and the Trust already achieved this standard before the deadline.
- Consolidation of a Trust Medicine Management and Incident Committee (MMIC) and development of Medicines Management Action Plan
- Consolidation of a West Essex Medicines Optimisation Programme Board (WEMOPB) to ensure a joint formulary across the whole health economy
- Production of a quarterly CDLIN report to demonstrate how the Trust manages controlled drugs appropriately and sharing the learning from CD incidents across the organisation.
- Approval of phase 1 of the pharmacy workforce plan which will allow the pharmacy department to recruit a further 17 staff including pharmacists, pharmacy technicians and assistant technical officers. Recruitment is now under way and has also included two very successful pharmacy open days for potential new staff. This has formed part of the response to the external pharmacy review
- Recruitment of a medication safety officer and lead paediatric pharmacist
- Installation of a new pharmacy computer system to improve financial reporting and help manage the drug budget
- Installation of a new tracking system for prescriptions
- Approval of a new temperature monitoring system within pharmacy to ensure medication is stored at the correct temperature
- The pharmacy department has gone through a successful engagement programme with its entire staff as part of trust organisational development. A number of staff led initiatives are now being developed as a result of this including ward pharmacy services
- Following comprehensive drug use reviews patient safety and cost effective prescribing have continued for total parenteral nutrition and anaesthetic agents
- Pharmacy has engaged with health groups to help manage safe and cost effective prescribing e.g. biosimilar switching and prednisolone use in paediatrics. This has also resulted in the approval of specialist pharmacist posts in gastroenterology and rheumatology.

Medication safety

The following has been achieved as part of the medication safety programme:

- Delivery of Medicines Management training sessions including those on safe prescribing, antibiotic management and anticoagulant management to clinical staff. These are led by Pharmacy Department. Prescribing assessments are completed by junior doctors and feedback is given. Introduction of prescribing training and assessment for non-medical prescribers are also provided to ensure safe prescribing.
- The Pharmacy Department is leading on security and suitability of drug storage, ensuring that the senior clinical management staff within each Health Group produce action plans to resolve areas of non-compliance with Trust policy.
- Pharmacy staff is monitoring the extent of transfer of medication from one ward or department to another, including assurance that the transfer documentation is completed accurately.

- Pharmacy staff ensures that medicines administered to patients take into account the patient allergy status and that the Trust policy for the administration of medicines is adhered to. In particular, that the patient's allergy history has been taken and is documented in the Integrated Patient Record (IPR); that allergies are recorded on the inpatient prescription chart; that the date and signature are visible in the allergy box on the prescription chart and that the patient's allergy status been recorded on the patient demographic form.
- There are regular medication safety clinical pharmacy audits to ensure appropriate usage and storage of medicines across the organisation. This includes audits of omitted doses, standards of chart endorsements by pharmacy staff, standards of transcribing onto new charts and extent of dispensing errors.
- A business case has been written for the upgrade of out-of-date equipment and the automated dispensing robot to improve patient safety and pharmacy efficiency
- The Medicines Policy was reviewed and submitted to MMIC for approval in January 2015 and has been further updated to reflect the changes brought in by the NICE appraisal of allergy recording and management.
- Introduction of medication error reports to MMIC by healthcare groups to help to ensure learning takes place within their healthcare group and across the organisation and the resulting action plans produced by the senior clinical management staff within each Health Group.
- Improvement in the time lapse between ordering and delivery of medicines, especially for out-of-hours admissions to improve patient safety by reducing missed doses and actions required within Health Groups to encourage staff to ensure that the number of delayed or missed doses is minimised.
- Improvement in the number of medication incidents reported within the Trust, compared to the same period the previous year.
- Production of a Medication Safety Bulletin with the aim of increasing the number of medication incidents reported on Datix.

Plan for the next 12-36 months

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

Medicine Optimisation
A review of Medicines Management action plan to identify gaps in relation to TDA's Medicines Optimisation Framework Tools, implementation of Royal Pharmaceutical Society hospital standards, implementation of the Carter report recommendations as well as a response to the external pharmacy review is to take place.

This will also involve the completion of phase 2 of the pharmacy workforce plan and a plan to develop integrated pharmacy services in line with the Trust strategy.

The Trust is also reviewing the post of director of pharmacy as part of an integrated care approach. This will also help to ensure that the trust board is assured that the use of medicines within the organisation is optimised and to increase the profile of medicine optimisation in line with Trust strategy.

Medication Safety to Improve Patient Experience and Reduce Patient harm
The most recent NRLS report showed that PAH was in the top 25% of Trusts for reporting incidents with a reporting rate of 9.01 incidents per 100 admissions, however of the incidents reported 6.5% were medication incidents.

This is much lower than the average for other Trusts which are 11%. This indicates that whilst PAH is good at reporting incidents it is not good at reporting medication incidents or sharing lesson learnt locally and outside the organisation. There is a risk that the Trust will not learn and improve medication practice if problems are not known about

Following an MHRA alert it was recommended that the Trust appoint a Medication Safety Officer (MSO) who was appointed during the year.

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

Examples of patient safety work to be done for 2016/17 include:-

- Continue to develop the TTA performance dashboard for each healthcare group. The dashboard will be managed by each healthcare group. This will help to improve patient experience, patient safety and TTA performance. Implementation of these KPIs and medicines prescribing training for all doctors should help reduce TTAs prescribing errors by at least 10% from 72% to 62%.
- The Trust quality and safety committee will receive reports from MMIC and West Essex medicine optimisation programme board to increase the profile of medicine management in line with Trust strategy
- Implementation of prescribing stickers for antibiotics across the Trust. This will help to support safe prescribing practice across the organisation
- Production of a register for unlicensed drugs detailing indications for use, dosage, frequency, course length and approved prescribers
- Improve transfer of medication between healthcare settings and wards to prevent loss, missed doses and re-dispensing of medication
- Continue to update the Trust formulary including assurance that NICE approved drugs have been included on the formulary
- Look at pre-packs for admitting wards and development of policy for implementing discharge using TTA packs and use of pre-printed prescriptions to speed up discharge of elective patients.
- Improvement in attendance at the MMIC to ensure that medication safety has a higher profile within the organisation and across the whole health economy.
- Improvement in the quality of the reporting of medication error incidents on Datix.
- Increase the number of Datix reports for medication incidents which have 'action taken' and 'lessons learned' completed.
- Reduce the proportion of medication incidents classified as 'other'.
- Produce regular Medication Safety Bulletins to highlight particular incidents or related incidents, prioritising those that caused harm or have occurred more than once.
- Examine all medication error incidents reported on Datix in the previous 6 months and group together any which involve a particular medicine, group of medicines or any other trends
- Create and distribute posters to share learning regarding particular medicines or ways in which they should be used.

Capital, Equipment and IT

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

For over a decade the external Quality Control Auditor, East of England has been auditing the aseptic preparation facility at the Trust. Since their first inspection in 2001, they have been highlighting that the current facility does not meet the current standards for the preparation of sterile medicines. The most recent audit assessment of the Technical Services Unit (TSU) categorised the facility as a 'major deficiency'. There are significant risks to staff, patient safety and this has been highlighted on the risk register. In addition the unit is working significantly over capacity at 120% against a MHRA standard of 70-80% which increases the risk to patient safety. Following publication of the audit results the lead specialist pharmacist for quality assurance in East of England recommended to the Chief Executive that the Trust pursue the building of a new unit as a matter of urgency. This has now been agreed and various options are now being considered.

Upgrade of automated dispensing system and out-of-date equipment have also been ring fenced for investment by the Trust

IT projects are underway for the chemotherapy management system (CMS) and electronic prescribing and administration system (EPMA)

Further work needs to be undertaken in the following areas:

- To promote temperature monitoring in medication storage areas across the Trust to ensure medication is stored at the correct temperature and investment is made in temperature regulation where deficiencies are identified to meet MHRA standards.
- To promote electronic medication cupboards across the Trust to comply with the Mazars medicine management external audit for reconciliation of medication stock at ward level

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 patient and service user satisfaction survey. This will enable the pharmacy department to review its current service provision and ensure patient and staff engagement is achieved, leading to implementation of 7 days working.
- To increase awareness across the organisation of pharmacy performance and the impact of other departments on pharmacy workload. This will include the performance already recorded on the pharmacy dashboard i.e. TTA turnaround times, clinical pharmacy intervention recording and medicine reconciliations undertaken by pharmacy staff. This data will also be used as evidence to support compliance with CQC medicines management and patient satisfaction.
- To improve the number of TTA's turned around within 2 hours by 10%. This will improve patient experience and reduce medication errors and will be managed by healthcare groups through the introduction of a TTA dashboard.
- Further use of dispensing carts at ward level to improve the timeliness, patient's experience and safety of patient discharge.
- To recruit to a lead pharmacist post for surgery and specialist posts in critical care, gastroenterology and rheumatology.
- To increase the hours of the antimicrobial lead pharmacist to make this post full time and to recruit to the vacant post of procurement lead technician

Pharmacy Transformation Programme

The pharmacy review will help with the implementation of healthcare group pharmacists to ensure we have the appropriate knowledge for clinical pharmacy and skills for more detailed reporting to healthcare groups and for the Trust to manage its resources most effectively.

The appropriate transfer of information from existing IT systems to EPR and implementation of the medicine management module of EPR to ensure electronic prescribing across the trust is required.

The following areas are part of the pharmacy transformation programme for 2016/17:-

- To complete drug usage review for high use medicines to reduce wastage and cost effective use of medicines.
- Expansion of dispensing for discharge on admission, use of patients own drugs (POD) and self-administration of medicines (SAM).

Education and Training

To introduce mandatory medicine management training for all clinical staff to ensure safe prescribing and administering of medicines to reduce harm to all patients.

All medical and Non-medical prescriber staff that prescribe medication to receive prescribing training and competency assessment

The Trust is now working on a formal process for the management of prescribing errors. This will need to be introduced in conjunction with the Chief Medical Officer to ensure there is a consistent approach to the management of prescribing errors

Incident and Safety Improvement

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 *(NPSA).*

For the reporting period 1 April 2015 to 31 March 2016, a total of 9,596 incidents were reported on the Trust's Datix incident management system as having occurred in PAH, an increase in incident reporting compared with 8,529 over the same period last year, with a decrease in severity of incidents reported. This represents a 12% increase. An increase in incident reporting is viewed as an indicator of a good and effective safety culture as it allows the Trust to identify and address any areas requiring improvement.

The majority of incidents reported were no harm incidents (5,868) representing 61% of the total incidents for this period. Approximately 87% of reported incidents during this period were a combination of no harm (5,868) or minor harm (2,505).

All these incidents are 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.

Serious Incident Themes and Trends

There have been 61 PAH serious incidents (SIs) for the reporting period 1 April 2015 to 31 March 2016. This figure has been drawn from the StEIS reporting system. This excludes SIs that have been de-escalated as there were no care or service delivery problems or were found not to meet the SI threshold with the emergence of further information.

In addition to increasing focus on safety across the organisation, it is important to note that reporting requirements and categories changed in March 2015 nationally and were implemented in May 2015 locally. This eliminated the need to have a list of incidents that must be reported. The new framework encourages the discussion and review of incidents on a case by case basis and a discussion of the level/ degree of harm caused.

This is a reduction in numbers compared with 140 SIs in the same period last year although with similar themes. This is due to an increasing focus on safety by the organisation and the vigilance of staff.

Although incident reporting has increased overall, seen as a sign of a positive safety culture, the severity of reported incidents has decreased. It should be noted, however, that direct comparisons and conclusions across periods should be drawn with caution.

The most frequently reported SIs during this reporting period are Hospital Acquired Pressure Ulcers Grade 3 (10), with the numbers reported including both avoidable and unavoidable events, falls (5) and suboptimal care of the deteriorating patient (5). There are on-going safety initiatives focused on the themes and the number for these have fallen over the latter part of the year.

Never Events

There were two reported Never Events in 2015-16. These occurred in April 2015 (wrong site surgery) and March 2016 (wrong surgical implant). Comprehensive Root Cause Analysis (RCA) investigations were initiated and improvements have and are being made.

Some of the immediate changes made include:

- The World Health Organisation checklist for safe site surgery has been adapted to include a body map. Introduction of a new induction/orientation pack to support bank and agency staff
- Increase in the clinic time per patient (from 20 minutes to 30 minutes)
- Re-audit of notes to be undertaken to ascertain if the WHO surgery checklist is being used. Identification of site for surgery needs to be audited also. This needs to be a formalised local audit.
- The procedure for checking implants prior to implantation has been reviewed and changed. From now onwards there will be a pause in surgery to enable a verbal as well as visual check of the implant (Pause for Prosthesis).

All identified actions on both reports have been completed and audits of continue.

Sharing the Learning (STL) Events

The Trust's central Patient Safety & Quality Team working with relevant experts have held one STL event during 2015-2016.

This was held in June 2015 and focussed on the Deteriorating Patient, and Sepsis 6 Care Bundle. Newsletters were also released in that month and in September 2015 and which provided links to further information on the Deteriorating Patient, Sepsis, Sign Up to Safety and Duty of Candour.

The Sign Up To Safety campaign was widely publicised throughout the Trust through communications and events. The launch was on 12th April 2016, with events occurring throughout the week, and was well received by staff and patients alike with 55 people attending the main launch and many more attending the information stands throughout the week. The three focal areas were;

- Acute Kidney Injury
- Sepsis 6 care bundle
- End of Life Care

These are known as the Big Three Dot items and are endorsed by the Trust Board.

Duty of Candour has been a focus this year. Posters designed and printed by the central PSQ Team can be seen placed in different areas across the Trust, reinforcing the Trust's commitment to transparency and candour. A Duty of Candour flowchart has been developed to guide individuals into ensuring all processes are followed with Being Open with patients and their families.

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

Safety Improvement Training – The Trust continues to invest in Root Cause Analysis (RCA) investigation training and ensuring that staff are supported in having *Being open/ Duty of Candour* conversations with patients and families when things go wrong. Sessions were scheduled for November 2015 to March 2016.

RCA training has been provided and attended by a further 80 staff this financial year bringing the total staff trained to 136 (recorded from 2014 – current). Feedback received from staff for these sessions were positive, and these staff have been supported to undertake RCA investigations for the Trust.

The Trust has collaborated with our Patient Panel in implementing quality improvements following incidents, particularly with the patient information leaflets on steroids. The Patient

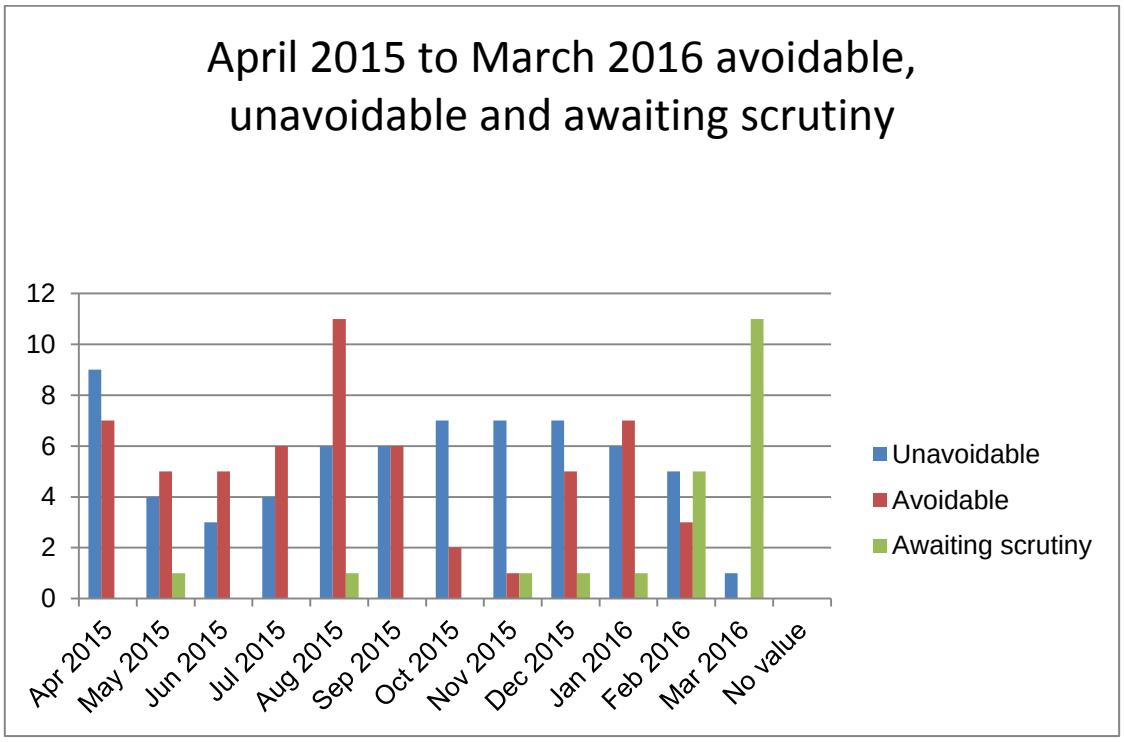
Panel identified that many patients who take Prednisone (steroids) - although there is an information leaflet with the medication - are still not aware how they should take the medication. A leaflet has been produced by the Panel with the assistance of the Pharmacy team and is currently being printed for new and existing users of the medication.

On-going Quality improvements at the Trust

Focus on improving care for patients with Learning Disabilities and Autism
Focus on improving dementia care
Focus on the Tissue Viability Service
Focus on Falls improvement

Pressure ulcers

The goal for 2016-2017 continues to be zero-tolerance of hospital-acquired, avoidable pressure ulcers. Staff within the Trust have continued to work hard to reduce avoidable harm but there is still some work to be done.



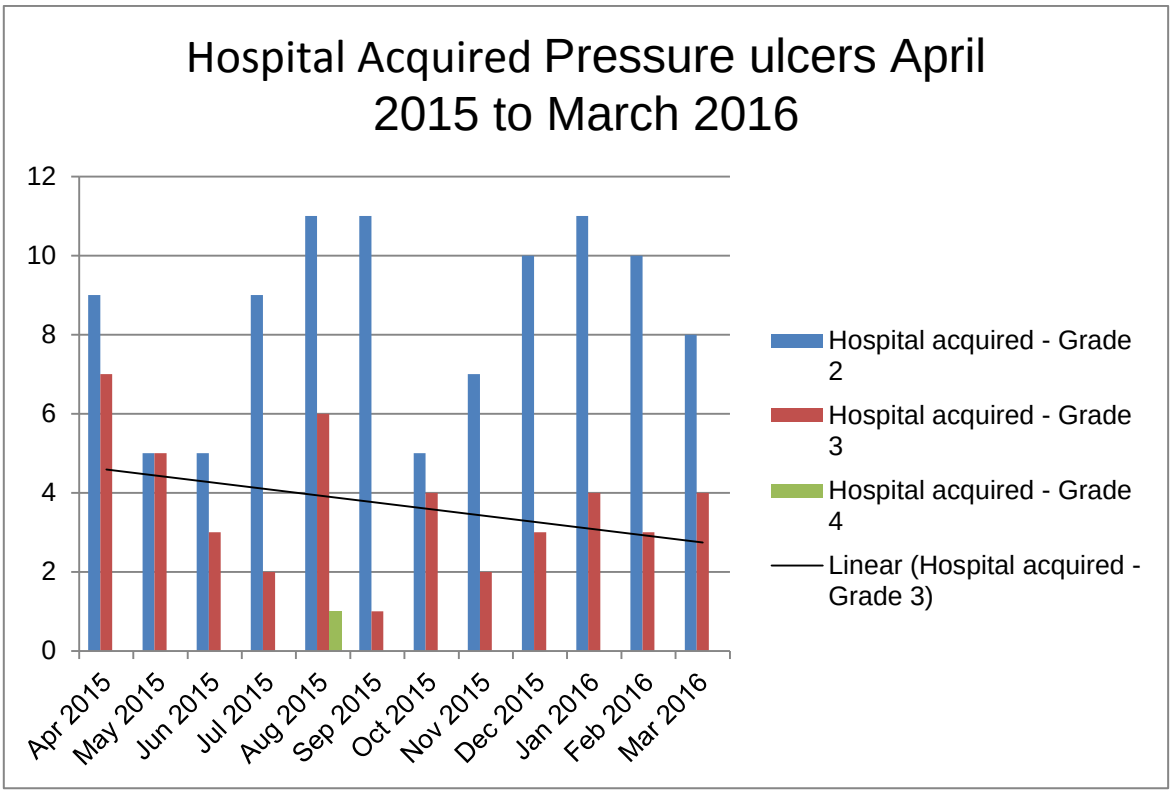
Notes regarding data from April 15 to March 16:

- There are 17 pressure ulcers awaiting scrutiny in 2016
    - The levels of staffing on wards has made attendance at Scrutiny Panel challenging hence delay in processing February pressure ulcers.
- The rise in number of avoidable pressure ulcers in August has no single cause; however factors include: delays in risk assessment; gaps in Intentional Comfort Rounding (repositioning etc) and reduced staffing.
- The percentage of pressure ulcers deemed 'avoidable' following scrutiny panel is currently 48% and the number of 'unavoidable' is 52%. The number of patients with 'avoidable' pressure ulcers is predominantly due to poor documentation rather than delivery of poor or inadequate care.

Data 2012 to March 2016:

Year	Unavoidable	Avoidable	Not been to scrutiny	Total number
2012/13	141	87	79	307
2013/14	162	72	3	237
2014/15	129	49	7	185
2015/16	65	58	21	144

- Data showing clear reduction of over 50% in total number of pressure ulcers in 3 years
- It should be noted that the incidents which have not been to scrutiny panel from March 2013 to December 2015 are those raised by SEPT or East Herts, none of which have been resolved in spite of them being challenged by PAH.



There has been a decrease in number of grade 3 pressure ulcers although the number remains unacceptably high. There has been one grade 4 pressure ulcer in 2015 which was deemed 'unavoidable' at CEO Scrutiny Panel. There have been no avoidable grade 4 pressure ulcers since October 2013.

Grades of Hospital acquired pressure ulcers in 2015-2016 (totals)

April 2015 to March 2016 hospital acquired pressure ulcers				
Month	**Hospital Acquired - Grade 2**	**Hospital acquired - Grade 3**	**Hospital acquired - Grade 4**	**Totals**
Apr	9	7	0	16
May	5	5	0	10
Jun	5	3	0	8
Jul	9	2	0	11
Aug	11	6	1	18
Sept	11	1	0	12
Oct	5	4	0	9
Nov	7	2	0	9
Dec	10	3	0	13
Jan	11	4	0	15
Feb	10	4	0	14
Mar	8	4	0	12
Totals	101	45	1	144

Suspected Deep Tissue Injury:

Since May 2015 the Tissue Viability Specialist Nurses (TVNs) have been keeping detailed data about Suspected Deep Tissue Injuries (SDTI's) following a change in classification requested by Midlands and East.

There is a flow chart to ensure patients with SDTI's are followed up by TVN for revalidation within 14 days of first validation.

One surprising result is that 25% of patients found to have an SDTI have died within a week of identification of SDTI. This is an area the TVN's are following and hope to write a paper about this year.

Achievements:

Improvement in equipment provision:
In conjunction with Medstrom there are now 'standby' dynamic mattresses in following departments ensuring high risk patients receive appropriate equipment in a timely fashion:

ITU 3
Harold 2
EUA 5

The TVNs work closely with the Medstrom technicians and the new Trust coordinator to jointly oversee this work.

Monthly Newsletter
A monthly newsletter has been circulated since December 2015 which highlights a variety of issues and information for all staff. It always includes the Monthly Pressure ulcer data and any learning from Scrutiny Panel so that this is shared with all staff.

Intentional Comfort Rounding:
Work has been on-going to develop improved ICR documentation jointly with PDT and Falls coordinator. This is being currently evaluated prior to being rolled out on all wards.

Education and Staff development:

ANT programme:
The ANT programme has continued in spite of the loss of our Nutrition Nurse colleague in September 2015. It remains popular and well evaluated with staff. In addition some staff are attending a 'Wound management' module at UEA.

A Nutrition Practitioner and dietician, has been appointed and started their induction on 04.04.16. The TVN's are really looking forward to working with and supporting them as they develop this role. The role will be leading the Nutrition aspects of the ANT programme.

VAC Academy:
Two evening events have been held in 2016 already to teach staff the principles of management of a complex wound with vacuum assisted closure therapy. A further one is planned for Critical Care Unit in May.

Allied Healthcare Professional teaching;
The TVNs have given teaching sessions to AHP's regarding pressure ulcer prevention and complex wound care healing. There are further sessions planned for AHP's and Junior Doctors in April and May 2016.

Challenges regarding education:
Attendance at mandatory training sessions is an on-going challenge in spite of TVN's taking the sessions to the wards and departments. This is due to low staffing levels and nurses and HCSW's not being able to be released by shift coordinators whilst maintaining safe level of staffing on the ward.

This has a knock on effect in terms of education relating to patient assessment i.e. Waterlow and this is a recurrent theme at Scrutiny Panel.

System wide working with Community colleagues

The Princess Alexandra Hospital TVN's are leading on a System wide programme to prevent pressure ulcers, which involves commissioners from West Essex and Hertfordshire CCG's. This work initially stemmed from the high numbers of patients admitted with pressure ulcers, generally 75% of all pressure ulcers within the Trust are admitted ones and only 25% are hospital acquired.

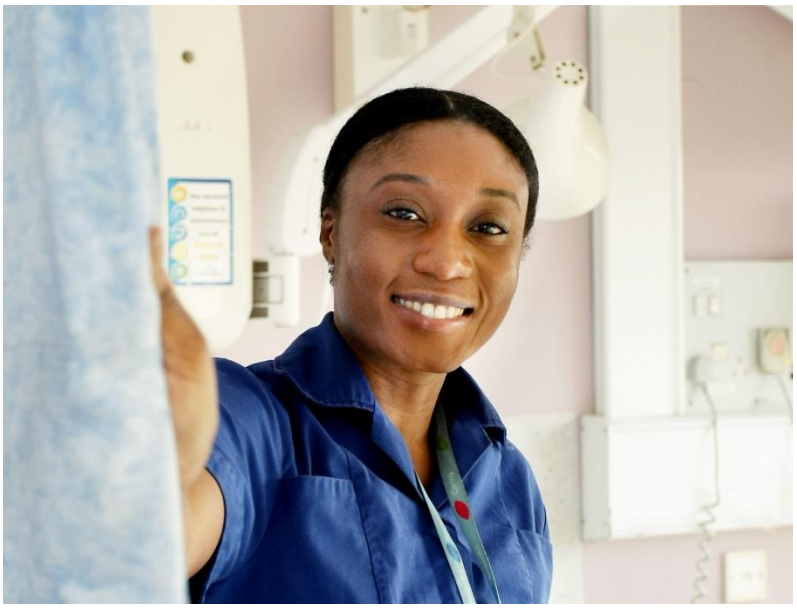
The TVNs continue to work collaboratively with their community colleagues to facilitate targeted actions regarding preventing pressure ulcers in the community. In addition there is a long term aim to standardise wound care across the locality. This work has been enhanced in SEPT by the recruitment of a new team of 3 TVN's. We are pleased with the improvements in collaboration and communication this has engendered and are delighted that they are all attending the ANT programme.

Stroke Services

The year of 2015-16 has been a challenging year for stroke services at the Trust, after the resignation of the substantive consultant in April 2015 with no success in recruiting to the post. Despite this, we managed to sustain stroke services for the majority of the year using our excellent team of specialist therapists and nurses on the Acute Stroke Unit, and locum consultants. We treated 279 stroke patients in our designated unit, supported by specialist community services in both Essex and Hertfordshire to enable us to facilitate safe discharges home and transfers to rehabilitation units.

In 2014-15 it was identified that it was unlikely to be sustainable to maintain hyperacute stroke services (including thrombolysis) at PAH, given the low patient numbers. Different models of service provision were worked up with West Essex CCG and East & North Hertfordshire CCG. In August 2015 patient and public engagement in relation to the proposed changes to stroke services started, led primarily by West Essex CCG. Feedback was taken on board to begin planning for a new model of care where patients in the PAH catchment area would be taken to their nearest hyperacute or specialist stroke centre (for example Queen's Hospital or Lister Hospital), with West Essex patients being transferred back to PAH for their acute care and ongoing rehabilitation. The Trust has been actively involved throughout this process designing new pathways and processes to deliver the best care for our patients when this new model is implemented.

However, due to the ongoing difficulties with recruitment, the Trust made a very difficult decision in March 2016 to temporarily suspend stroke services at PAH for a period of six months, in the interest of ensuring the care and safety of stroke patients. The Trust is committed to reinstating this service in the future, in line with the new model of care and are working closely with partners to establish the necessary staffing to deliver a safe and effective service. The Trust has an enthusiastic team of nurses, therapists, and support staff dedicated to the care of stroke patients at PAH, and are actively seeking to recruit stroke consultants joint with Queen's Hospital, Romford.

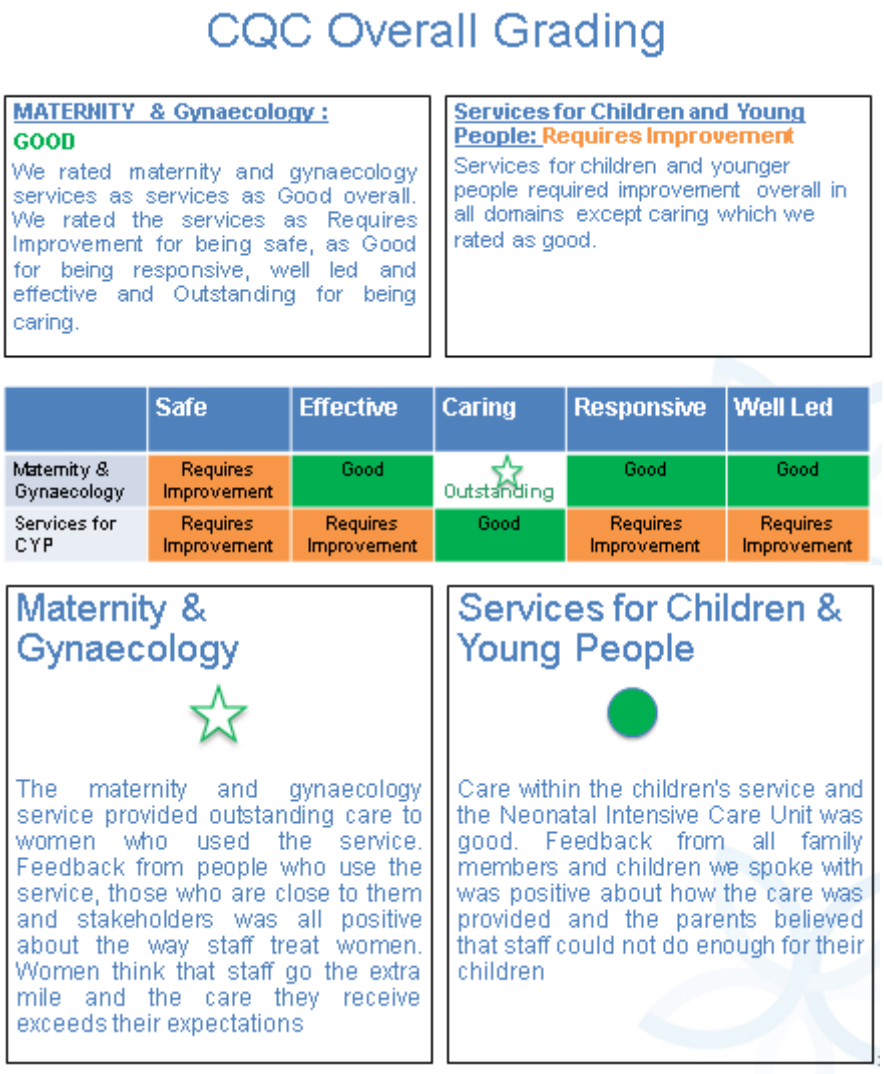


Family and Women's Services

CQC

It has been a successful year for Family and Womens Health Group. Following the CQC inspection in July of last year, Maternity and Gynaecology were awarded a Good overall with maternity getting an outstanding for care. This has made a difference to women wanting to give birth at PAH and at the recent Womens Health recruitment day, the candidates all knew that outstanding had been given and gave that as one of the reasons they wanted to come and work at the Trust.

Within Child Health we received requires improvement but with the appointment of new staff and training within the department we are hoping to achieve good at our inspection in June of this year.



The Trust again made a successful bid to the Department of Health and the unit has been fortunate in previous years too. The unit were awarded £20,000 to improve the birthing experience of women accessing the Maternity Unit. This money has been identified to improve the environment of Room 9, one of the delivery rooms. Room 9 has previously been used as a theatre and is very outdated. The plan is to remove any old theatre equipment (theatre light, outdated scrubbing sink etc.) and redecorate to ensure it is a room fit for purpose for women to give birth in.

The maternity unit has also been successful in a bid through Health Education in becoming an early adopter of Maternity Safety training and received an innovation fund of £10,000. This is going to be used to purchase training techniques for the use of Midwives, Obstetricians, Anaesthetists and Allied Health Care Professional's together in the clinical area. Staff will then be equipped with the knowledge and skills to disseminate the knowledge and be in a position to train the trainers. The preferred mode for training is through simulation known as PROMPT who provides the necessary training and materials.

Mortality rate

Three years ago the mortality rate within maternity for stillbirths was above the national stillbirth rate. Extensive work was undertaken within the Health Group, reviewing all the cases and even having an external review on some cases. Although no trends were identified reduced fetal movement continues to be one of the main causes. Bookmarks were introduced and are given to all women during their pregnancy; they highlight fetal movements in different languages as well as English. With increased surveillance and appointment of a fetal medicine consultant, the stillbirth rate at the Trust for the past 12 months is 1.45 per 1000 births; which is below the national stillbirth rate of 4.2 per 1000 births.

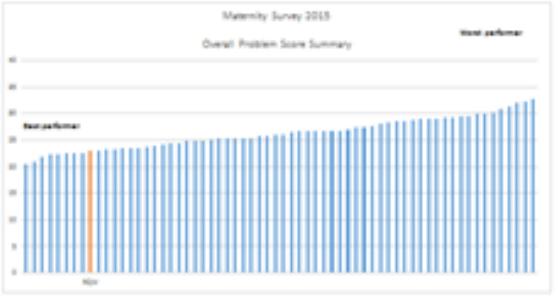
In the November the maternity survey was published which highlighted PAH being the 9th best performing out of 64 Trusts and the second best performing Trust since 2013. The Trust performed significantly better on 13 questions compared to 2013 but not worse on any. The two main questions that indicated needing improvement were the birthing partners staying on the postnatal ward with their new baby and partner.

In response, we extended the visiting time in the evening for birthing partners until 22:00; we are working on a code of conduct in line with other hospitals for partners staying all night on the main ward which is already happening in the side rooms. We are particularly taking into account the privacy and dignity of the other women.

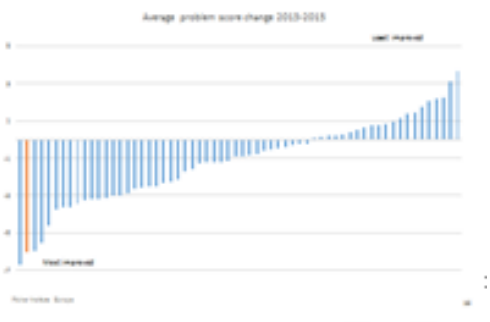
RESPONSIVE: Picker Maternity Survey 2015

- National NHS Patient Survey; 48% of all NHS trusts (64 trusts)
- Covers all aspects of the mother's 'journey': antenatal, labour and birth, feeding, postnatal care in hospital and at home
- PAH 9th best performing out of 64 Trusts & 2nd most improved Trust since 2013 Survey

League Table



Improvement League Table



Paediatrics

The paediatric ward underwent an external review due to concerns raised by the staff for the increase of High Dependency care and skill mix of nursing staff. Following this review and listening to the staff, the level of support to the ward has been increased. The ward now has a full time practice development nurse (PDN) and the hours of the High Dependency facilitator has been increased to full time the PDN maintains a high clinical presence on the paediatric ward and is available to support staff in the clinical areas. The PDN also takes responsibility for on-going training and staff development.

A registered paediatric Nurse has also been introduced into paediatric outpatient department to meet the Best Practice Tariff.

The whole time equivalent for paediatric consultants has increased from 8 to 10, which allows a hot week consultant for Neonatal unit and maternity, and another one for Paediatric ward and Paediatric Emergency Department. The presence of the consultant supports the training of the juniors on a daily basis.

The paediatric department are now achieving 100% for the Diabetic best practice tariff, with an increase of consultant support and a psychologist.

The Health group have had two very positive recruitment days in February and April this year for Paediatric, neonatal nurses, maternity nurses and midwives. Hoping the Health group will see the benefits initially in June and then in September/October as the majority of the students qualify.

Safeguarding Children

Key areas of improvement:

- 2015/6 has seen an expansion of the Safeguarding Children Team from September 2015 from one Named Nurse (WTE) to an additional senior Safeguarding Children Nurse WTE and a Safeguarding Children Nurse (0.2 WTE)
- The implementation of safeguarding supervision from January 2016 to health practitioners who work directly with children and their parents/carers achieving a rate of 64% in Q1 against a target of 80%. This is a rolling programme and the supervision of staff is offered each quarter. It is expected that staff access a supervision opportunity in each quarter.
- The Trust now have a Child Sexual Exploitation (CSE) lead. 12 CSE champions have been identified across the Trust, a ‘Task and Finish’ group was held in March and an action plan is being devised with a deadline beginning in May 16
- FGM is being reported nationally on a monthly basis. The information team load the information from the safeguarding children team onto the national template. An FGM policy has been out for consultation in April 16 and has been forwarded to the policy group for ratification in May 16
- Following recommendations from the SCR ‘John’ a new information sharing process has been implemented within maternity services. Once a vulnerable pregnant mother is identified the booking midwife will complete an information sharing form (ISF). It is sent to the maternity safeguarding generic e-mail address and triaged by the Named MW. She will propose a plan of action and return the ISF to the referring MW, to the safeguarding team administrator, the GP surgery and the HV service. The safeguarding administrator will either add to a high risk maternity database – for

regular review or the universal services database where the case will continue being managed in universal services. A file is created for the woman and linked to the database. It is intended that all staff that need to have access (i.e Hospital midwives) to the information will do so once the process is securely embedded.

- A new safeguarding dashboard to monitor our safeguarding activity has been devised and is ready for population from Q1 2016/7. This will give the Trust an indication of the number of referrals made to children social care by the Trust, CP medicals undertaken, training figures.
- We have seen a 60% increase in our consultation figures over the last year – we believe this is due to better recognition by staff and a higher profile of the safeguarding children team

Safeguarding Children Activity Q3 2015 & Q4 2015/16

	Q3			Q4		
	OCT	NOV	DEC	JAN	FEB	MAR
Number of Safeguarding Consultations	175	87	103	76	77	113
Number of child protection medical examination referrals	7	6	0	4	1	1
Number of safeguarding children referrals to social care	14	18	8	16	14	24

Safeguarding Children Key Performance Indicators

Quality, Performance & Productivity Performance Monitoring

Performance Indicator	Indicator	Threshold	Method of Measurement	Frequency of Monitoring	Compliance
All staff will attend safeguarding children and young people training relevant to their level of expertise and in line with Intercollegiate document	Training will be measured as % of those trained against the relevant cohort of staff.	G= 95% A=<95% (94%-86%)* R=<85%	Performance report Detailed exception report	Quarterly	Amber

The Trust currently has a rag rating in Amber (90%) for Level 1 Safeguarding Children training and Amber (89%) for Level 2 training. The Trust's training department undertook a review of all statutory/mandatory training in January 2015 and presented their recommendations to the Trust Board. Level 1 & 2 training is now delivered during the induction programme. Updates for clinical staff are provided in the mandatory Vulnerable Patients study day on a three yearly basis.

West Essex CCG has set a CQUIN project for employing rotational posts that include AHP's, Nurses, Health care support workers with the main employers being SEPT & PAH. This involves an integrated induction programme for new starters. The safeguarding children/adult training element is being delivered by the safeguarding team from PAH until March 2016. This is going to have an additional impact on the safeguarding teams training capacity.

All staff who require Level 3 training at specialist level (staff working with CYP and who may make a referral) will attend additional Level 3 training in line with the intercollegiate document 2014. (As mentioned in Schedule 6)	Training is measured as % of those trained against the relevant cohort of staff.	G= 95% A=<95%* R=<85%	Performance report Detailed exception report	Quarterly	Red 69%

The Trust currently has a rag rating of red (69%) for level 3 safeguarding children training. This trend has occurred due to a change in the delivery of level 3 training from 3 yearly to annually. The current situation is due to a major drive three years ago to ensure appropriate staff were trained at level 3. In conjunction with the introduction of annual level 3 training to all staff who work directly with children and their carers, we will now have an increase in numbers requiring level 3 training and a high expiry rate for staff who are no longer compliant.

The safeguarding children team are offering additional level 3 training opportunities over 2016/7 to meet this need and improvement will be seen over the course of the year with support from the health group managers to ensure their staff are booked onto the training and assisted to attend. It is essential that the safeguarding children team are supported by the Trust board in this drive to improve the attendance rate of staff.

In December staff who were non-compliant with level 3 safeguarding children training were identified. It became evident that a number of individuals believed to be non-compliant actually had received level 3 training but were not reflected in the figures received from the training department. Had they been included the figure would have been at 95% creating a green rag rating.

The largest group of clinicians not up to date were found to be the midwives. The Named Nurse – Safeguarding Children has highlighted this with midwifery managers and arrangements have been made to address this within maternity services.

- Training is been highlighted as a risk to the organisation and is on the risk register
- The safeguarding children team work closely with the training department and are sent a list of all non-compliant professionals every month.
- Managers will be advised with a monthly rag rating (red, amber, green) about their health group performance. They are accountable for ensuring their staff are safe, competent and effective practitioners in their safeguarding work. It is expected they will ensure their staff members book onto and attend training.

A meeting was held with the training department in January and agreement reached to begin level 3 training on an annual basis from April 2016. Sessions have now been booked with the training department to accommodate the increased numbers and there is a training opportunity for every member of staff who works directly with children or their parents/carers.

A review of the training content has taken place to ensure full coverage of FGM, CSE and trafficked children is incorporated in the learning package and is being delivered from April 16. This will be reviewed and updated annually to encompass new topics and to learn lessons from SCR's

- Clinical Friday is a means to assure the Trust that the training offered to staff is fit for purpose. An audit of safeguarding knowledge was undertaken in January 2016 with good results (report to follow)
- The safeguarding children team keep a dashboard of referral activity. Monitoring referrals to Social services provides reassurance that Trust staff are recognising and responding to their safeguarding responsibilities

All staff working with children and young people regularly whereby they are required to make safeguarding referrals will receive supervision on a 3 monthly basis	Supervision are measured as a % of staff who have completed supervision within a 3 month cycle	G= 80% A=>80% (70%-79%) R=<70%	Performance report Detailed exception report	Quarterly	Amber

The Trust remains non-compliant (Amber) in relation to the safeguarding supervision of staff but the proposed programme has begun for all clinicians who work with children either in groups or individually on a three monthly basis working There are now six safeguarding children supervisors in the Trust and an implementation trajectory has been completed that demonstrates achievability. The safeguarding team began supervising from the middle of January and have achieved 67% in Q4 2015/16.

The Named Midwife and the Named Nurse for Safeguarding Children are supervised by the Designated Nurse on a six weekly basis. The Designated Nurse has now resigned and the Acting Designated Nurse will be providing this in the foreseeable future.

The current Named Midwife will continue providing supervision for community midwives until the appointment in July of a new Named Midwife when hospital midwives will also be included in supervision provision. For the year 2015/16 it is anticipated that safeguarding supervision will be achieved in the following way:

- Named Midwife will provide group supervision for community midwives on a three monthly basis with monthly supervision provided for the teenage pregnancy midwife, the vulnerable women midwife, and the Harlow community team due to the higher risk cases they carry.
- The Named Nurse is providing group safeguarding supervision to the Head of Children Services, Matron and Paediatric Managers on a three monthly basis. This will include paediatric matron, Dolphin Ward Manager, Paediatric A&E lead nurse,

NICU Manager, Paediatric Oncology Nurse Specialist, Paediatric Risk Facilitator, and Paediatric HDU facilitator
- The implementation of safeguarding supervision to be provided to members of staff on NICU, Paediatric ED and Dolphin ward on a regular basis is underway. See the trajectory for implementation.

Future plans
- The Safeguarding Children Team intend to roll out the supervision programme further to include Adult ED staff during the course of 2016/7 once the programme is firmly embedded in practice to those professionals who work directly with children and their parents/carers
- To roll out the new safeguarding children level 3 programme from April 2016 on an annual basis to those professionals who work directly with children and their parents/carers
- To promote the CSE agenda across the Trust, implement the action plan
- To review and update the Domestic Abuse policy
- To continue promoting the safeguarding children agenda by increasing Team visibility across the Trust
- To meet our KPI requirement in relation to safeguarding children training

Safeguarding Adults

In 2014/2015 the Safeguarding Adults Lead Nurse worked hard to continue to raise the profile and agenda of Safeguarding Adults.

Key Areas of improvement over the last year are:

- The Trust has seen a continued increase in Deprivation of Liberty (DoL) applications.(table 1)
- Continued partnership working with the supervisory body for Deprivation of Liberty Safeguards (DoLs) to ensure the Trust meets the requirements for applications.
- Achievement of 93% compliance with the training of staff in safeguarding adult's
- Introduction of Level 2 training on safeguarding adults for all clinical staff
- Introduction of the DAISY Training for all clinical staff
- Significant increase in the number adult safeguarding consultations over the past 12 months.
- Referrals to social care continue to be at a consistent level.
- PREVENT training introduced as part of the Vulnerable Patients 2 day course
- Introduction of safeguarding booklet for Safeguarding
- Continued Daily sitrep for safeguarding cases including Deprivation of Liberty patients and under 18 year olds on an adult ward
- The Trust continues to be represented at all regional/Local forums for safeguarding adults
- Continued development of the Joint Safeguarding Nurse role
- DAISY Project was shortlisted for an award at the 2015 Nursing Times awards
- Worked alongside the Essex Safeguarding Adults board in submission of the Trust bi- annual audit in January 2015

Safeguarding Adults Activity

	2011/2012	2012/2013	2013.2014	2014/2015
Number of DoLs completed	21	38	83	197
Number of SetSaf completed by PAH	104	107	99	120
Number of SetSaf against PAH	21	15	23	32
Number of MCA's completed	75	183	198	159
Percentage of Level 1 Adult Safeguarding Training completed	61%	87%	95%	93%

Since the Supreme Court ruling nationally Deprivation of Liberty applications have increased and this is reflected in the Trust applications in relation to last 2 year's applications presented below

Applications of Deprivations of Liberty Safeguards 2013 /2014 /2015

Dols Applications	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
2013	**1**	**6**	**4**	**4**	**8**	**7**	**5**	**8**	**13**	**5**	**6**	**7**
2014	**9**	**7**	**4**	**11**	**12**	**21**	**22**	**13**	**14**	**19**	**21**	**16**
2015	**17**	**13**	**18**	**10**	**14**	**10**	**21**	**11**	**12**	**15**	**7**	**11**

Prior to the ruling there was a clear process for all application's and staff were engaged with this, which has meant the Trust has been in a positive position compared to other acute Trusts who have had difficulty in engaging/developing clinical staff in making applications.

This process remains in place for the Trust Staff to follow and will be reviewed after the Law Commission consultation period on the Deprivation of Liberty Safeguards

Future plans

- Review the PREVENT agenda and training and policy for 2015/2016
- Introduce NHS England – Best Practice Guidance – March 2016
- Introduce Best Practice Guidance as "App" when launched by NHS England
- Continue with the DAISY Project for Domestic abuse and as Partnership working with the Safer Harlow Partnership to introduce the J9 resource for staff.
- Continue to Pilot Key areas within the Trust on the Deprivation of Liberty Process to raise the agenda and increase staff knowledge in this area, as since the Supreme Court ruling it is likely more of our patients will meet these criteria.
- Review the Trust Safeguarding Adult's policy to ensure the Care Act 2014 Guidance in relation to safeguarding, is reflected in this.

Pain Recording

The acute pain service at The Princess Alexandra Hospital acknowledge their commitment to continuously educate, update and support patients, carers and staff to facilitate safe and effective acute pain management.

Effectively managed pain serves to maintain the well-being, integrity and dignity of the individual person and effective pain relief is an essential element of good quality care.

Pain is a personal experience that can only be perceived by the sufferer. The team acknowledge that each person's response to pain is unique to that individual and that the experience of pain can be affected by many variables.

Since the service was formed it has continued to develop and extend. Currently many inpatients are reviewed experiencing acute pain and we are available for surgical and medical wards throughout the hospital. The team is led by a consultant anaesthetist and we have two full time nurses.

This year we have commenced training of an anaesthetic fellow for pain, with recognition from the Royal College of Anaesthetists. It is a six month placement which allows for the trainee fellow to be allocated to the pain team on a daily basis. There will also be short placements with the palliative care team, physiotherapy and occupational therapy.

As a team we are continually reviewing the service and pain management within the hospital. We frequently assess whether changes are required to improve pain assessment and management, to ensure patients' pain is effectively managed and improve the patient experience.

Monthly half day teaching sessions were organised and delivered, however due to staffing issues and pressure on beds many staff who had booked to attend, cancelled. We currently deliver sessions to the Healthcare Support Workers, Preceptor Nurses, Overseas Nurses recruited to the Trust and we also encourage pain champions to attend as many training sessions as they can. We will be looking into options for staff training over the next few months, possibly delivering sessions in clinical areas.

We have now established a second acute pain practitioner and we now work 8 - 5 Monday to Friday and 8.00 - 1:30 on Saturdays. We have close links with pharmacists and physiotherapists and we liaise with many other teams including critical care outreach.

The acute pain team conduct daily nurse-led ward rounds and there is a consultant ward round twice a week. We provide advice and guidance to ward and medical staff with regards to patients' pain management including any patient with a patient controlled analgesia (PCA) or epidural pain management pumps in progress.

The first group of Pain Champions for clinical areas have achieved their competencies and have received their certificates and badges. The 13 Champions are available to staff on the wards/clinical areas for advice relevant to pain management and will be trained and signed off to deliver micro-teaching and disseminate information on related policies and competencies. The first planned micro-teaching session will be on assessment and re-assessment of pain. They will be the key people to ensure practice is evidence-based and up-to-date in their areas, facilitating relevant audits and liaising with their colleagues to ensure best practice is implemented effectively.

A shared IT area has been set up for Pain Champions discuss relevant research and ideas and suggestions for best practice. We are also presently sending invitations for a new cohort to ensure Pain Champions are available across all clinical areas in the hospital.

The acute pain team is available to review/advise regarding the following pain problems throughout the day:

- All post-operative / procedural pain
- Management of pain due to trauma, pancreatitis, sickle cell crises.
- Management of patients with continuous epidural analgesia pump in progress.
- Management of patients with patient controlled analgesia pump in progress.
- Advice regarding prescribing for acute pain management.

The acute pain CNS has worked with a group from the Royal College of Nursing (RCN), Pain and Palliative Care Forum to develop and produce three leaflets for those patients who have learning difficulties or dementia. These leaflets were launched at the RCN Congress in Brighton, June 2015, and available throughout the Trust.

In June 2016 the acute pain team are hosting our first national study day – 'Pain Management in the Complex World of a District General Hospital'. We have both local and national keynote speakers who will be delivering interesting and thought provoking talks on pain management.

The Acute Pain Team has received 48 feedback forms in the past year, 100% of which were compliments and state that patients feel we offer an excellent service. The Acute Pain CNS was awarded staff member of the week as published in the Trust newsletter, In Touch.

The acute pain teams future plans:

- The Acute Pain Team will continue to provide safe and supportive care for patients who are experiencing acute pain. Care direct and indirect is individualised though current research and National guidance. Care of the patient with acute pain is planned through a systematic problem solving approach, utilising a holistic concept emphasising human rights, values and beliefs, whilst maintaining the privacy and dignity of the patient.

- A pain study day in November 2016 for trust employees is currently being organised. This will involve the delivery of sessions by local / Trust speakers

- The continuation of the Fellowship programme. The current trainee fellow is developing a guideline for chronic abdominal pain. He is also conducting an audit on persistent pain following surgery.

- The acute pain team are working towards becoming a seven day service for patients and staff alike.

- The Acute Pain CNS will be undertaking the non-medical prescriber's course, which will reduce the time that some patients have to wait for appropriate analgesia to be prescribed / given.

- Recognising the importance of even greater interdisciplinary connection, the Acute Pain Team is planning to work with the pre-admission clinic and with the various programme teams to ensure that pain management is co-ordinated throughout the patient experience

- The acute pain team have produced a sample newsletter and would like to develop this into a quarterly publication.

- To review and develop all policies / guidelines / standard operating procedures relating to pain assessment and management within the Trust.

- To develop and deliver a module on pain management for nurse training at Princess Alexandra Hospital, with accreditation from a local university. We will also be one of the teams to be utilised for short student nurse placements.

- The acute pain team are working to develop and training in pain management on a rotational basis for CT Trainees.

- We are developing a pain champion annual update to include an individual meeting with the acute pain CNS to discuss the Princess Alexandra Hospital pain champions network accessed via the shared folder, promotion of safe, effective, pain management in their area and to assess any further education, training or support they may require.

Statement of Director's Responsibilities in Respect of the Quality Accounts

The 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 or 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 presents a balanced picture of the Trust's performance over the reporting period.
- The performance information reported in the Quality Accounts 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 the Quality Accounts.

By order of the Board

Douglas Smallwood
Chairman

Phil Morley
CEO

Statements from Stakeholders

Response to The Princess Alexandra Hospital NHS Trust (PAH) Quality Account 2015-16 from Healthwatch Essex

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

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

From the 2015/16 priorities, PAH have made improvements to the way that they manage patient and carer involvement. The Trust actively encourages feedback, learning from incidents, and the improvement of services. In this regard, the Trust is working alongside Family Mosaic and Action for Family Carers. The Trust has an active Patient Panel, which has held events on emergency department changes and end of life care. The Trust has seen a reduction in complaints with 171 open complaints reported April 2015 compared to 75 in April 2016. There has also been a reduction in the number of referrals to Ombudsman and fewer cases were upheld. The Trust's Friends and Family Test recommender score is 93.5%, which is slightly below average.

Targets around staff retention for 2015/16 were not achieved, creating pressures that can impact upon quality and patient experience. However, we recognise that there is a general shortage of nursing staff in Essex and Harlow has additional retention issues because of its proximity to London. The Trust has recruitment and retention strategies in place, and they are working on approaches such as the 'Home to Harlow' campaign and working with Health Education England to put in place career development opportunities within PAH for staff. This remains a priority for 2016/17.

We commend the Trust for its success in maternity services, for being in the top 20% nationally based on the National Patient Experience Survey results. The maternity services achieved an 'outstanding' rating for Caring in the CQC inspection in July 2015. Overall maternity services are rated highly, though some negative issues were reported by the CQC, such as accessibility of birthing partners to staying with their partner and new babies on the post-natal ward.

However, end of life care and related pain management were reported to be in need of improvement by the CQC. We're pleased that PAH has chosen end of life to be a quality priority in 2016/17, with plans to improve care plans and early discharge to preferred place of care.

Healthwatch Essex has worked closely with PAH in undertaking a research project to capture people's lived experience of hospital discharge. We have had excellent co-operation from PAH, who have engaged constructively in the light of some of issues identified in our analysis, which include a lack of information and involvement in discharge planning and care post-discharge. However, most patients spoke well of staff, praising their efficiency and felt that they were doing their best given that they were very busy and at times appeared to be short staffed. Indeed, in response to our survey, many rated their overall experience of discharge as good or excellent.

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

Dr Tom Nutt
Chief Executive Officer, Healthwatch Essex

May 2016

NHS
East and North Hertfordshire
Clinical Commissioning Group

East and North Herts Clinical Commissioning Group's Response to the 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 2015/16, based on the data submitted during the year as part of the on-going quality monitoring process.

During 2015/16 ENHCCG has met regularly with both the host commissioner, West Essex CCG (WECCG), and PAH to review progress in relation to quality improvement initiatives.

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

The CQC inspected PAH services in July 2015, with the Trust rated overall as 'requires improvement'. The CCG was pleased to note the Trust received a rating of 'good' in relation to caring. The Trust has clearly been working hard to make the required improvements as identified by the CQC, and the focus for 2016/17 must now be on completing the required actions and ensuring improvements are sustained.

ENHCCG would like to acknowledge the Trust's performance in relation to infection prevention and control. Whilst the Trust reported 20 cases of c-difficile against a challenging ceiling of 10 cases, the CCG recognises that 14 of these cases were successfully appealed as no lapses in care were identified. No cases of MRSA bacteraemia were reported by the Trust during 2015/16.

ENHCCG also acknowledges the positive improvement in the rate of incidents reported by the Trust, demonstrating an open safety culture. The CCG also notes the positive work in relation to improving complaints handling and the on-going patient engagement and patient experience work of the Trust.

During 2015/16 PAH has failed to achieve a number of key performance metrics relating to A&E, stroke and Referral to Treatment (RTT) times. The CCG acknowledges the actions being taken to make the required improvements for A&E and RTT, and on-going progress will continue to be monitored closely. Following the suspension of stroke services at PAH ENHCCG will continue to work closely with all partners to ensure stroke patients receive timely and high quality care.

The Trust's 2016/17 Quality Priorities demonstrate the commitment to further improve the quality of care provided to patients and improve staff experience. ENHCCG is also pleased to see the on-going focus on reducing falls, improving end of life care and enhancing the quality of care for patients with dementia during 2016/17.

Overall we acknowledge the improvements made during 2015/16; however ENHCCG wishes to see significant focus and drive to ensure on-going improvements in the quality of services delivered to patients, particularly in relation to areas identified during the CQC's inspection and A&E performance.

ENCCG looks 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 2016/17.

Beverley Flowers
Chief Executive Officer
June 2016

West Essex Clinical Commissioning Group

Statement from West Essex Clinical Commissioning Group

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

The Trust had ambitious plans for 2015/16 regarding the improvements they wished to make in relation to safety, effectiveness and improving positive patient and staff experience. They fully achieved five of these priorities, partially achieved five and did not achieve three. Most of the priorities are part of larger schemes of work which are on-going, for example the Trusts Sign up to Safety campaign. The priorities that the Trust has not fully achieved have been carried forward to next year.

We are particularly supportive of the Trusts set of priorities that relate to staff; improvement in staff morale and values will directly enhance the experience of patients and their families. Recruiting and retaining staff has been an on-going issue for the Trust, these priorities are designed to reduce the number of staff leaving voluntarily and to develop a stable, committed workforce.

The Trusts CQC inspection in 2015 had an overall result of “requires improvement” which the Trust is robustly addressing in the relevant areas. It is important to recognise that the element of the CQC inspection that had a consistently good rating, across all areas, was patient care. Feedback that staffs are caring and demonstrate this throughout their work correlates with Friends and Family Test information, a reducing level of complaints and a steadily increasing rate of compliments. Despite the workforce issues the Trust has had this year, patients and their families are clear in their opinion, that staff are caring and do go the extra mile.

The CCG are fully supportive of the Trusts quality priorities for the year ahead, they will all improve the quality of care delivered in the Trust and the experience of working for the Trust. The addition of a priority relating to improvements in transfers of care is welcome and relates to direct patient feedback. The Trusts continued engagement in cross organisational working will be key in order to achieve this priority for patients.

We would be grateful if the Trust would include in the report the governance arrangements for producing the quality account, so it is clear to patients and families how this complex document is created.

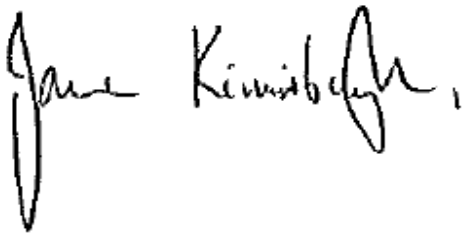
We would also appreciate if the Trust would consider the use of the Crystal mark standard for plain English in future reports.

We 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 include a comparison of the Trust results to the highest and lowest scores of other organisations has not been included; this is likely to be due to national data sets being out of date and local data being used instead.

The explanation of the Trust view of why certain data sets are as they are, has not 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. There is a required section on the Trusts participation in and review of national audits and their local audit activity that was not included in the draft we reviewed. This is likely to be corrected in the final version.

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



Jane Kinniburgh

Director of Nursing and Quality
West Essex Clinical Commissioning Group.
May 2016

Statement on Quality Accounts from Patient Panel

Thank you for the opportunity to view Princess Alexandra Trust's Quality Account for 2015/16. I have been asked by the patient panel to prepare a response to your Quality Account on behalf the members.

The patient panel feels that the Trust's Quality Account is broadly representative of the quality of service provided by the Trust and gives a comprehensive coverage of the services delivered.

We consider that there is evidence that the Trust is carrying out work to improve the way it relates to patients and carers.

They also feel that the information contained in the Quality Account seems accurate and they do not feel that there are any significant omissions of issues of concern that have been previously discussed with the Trust.

Chair

Patient Panel

Healthwatch Hertfordshire's response to Princess Alexandra Hospital NHS Trust (PAHT) Quality Account 2016

Healthwatch Hertfordshire thanks PAHT for the opportunity to comment on their Quality Account. Priorities for 2016-2017 are clearly set out and show a practical focus to enhance clinical outcomes and improve the experience of patients and staff. This is a detailed report covering a wide range of information but the structure at the beginning is a little disjointed and could be improved. A glossary of terms is welcomed as the report is quite technical at times.

HwH is pleased to see the continuation of the 'Improving Dementia Care' priority and that the Trust has taken note of the recent Alzheimer's report 'Fix Dementia Care' in the setting of their action plan. The increase in trained/aware staff is good news as well as the investment in volunteers. The active participation in the local and national Dementia Action Alliances is to be applauded and we hope that there will be a link with the East Herts Ageing Well Dementia Action Alliance. It is good to see that carers are also included in this priority.

The Trust responded well to the results of the CQC inspection with a detailed action plan and we hope to see marked improvements particularly in outpatients and diagnostic imaging which was rated as inadequate last year. Emergency care as with most acute hospitals in the area has been under intense pressure and this has impacted on other areas of the hospital. We note the new models of care and other initiatives implemented by the Trust to transform the delivery of urgent care to try and ease the situation.

The Trust should be congratulated for its work in Maternity Services and for obtaining an 'outstanding' from the CQC in caring for Maternity and Gynaecology Services. Feedback recently received by HwH also emphasised the caring qualities of staff in other departments which echoes the CQC findings.

HwH was concerned about the impact of the issues around stroke care for east Herts residents which led to the earlier than expected temporary closure of services at PAHT but we note that the Trust is still committed to the new model of care proposed. We also acknowledge the work of East and North Herts Clinical Commissioning Group to safeguard Hertfordshire patients who may need stroke services.

We welcome the Trust's commitment to patient engagement such as the Annual Patient Panel Conference and the work around complaints handling and the commitment to incorporate the learning from complaints to improve patient outcomes.

Healthwatch Hertfordshire is pleased at the way the Trust has engaged with HwH both in terms of wanting to hear about patient feedback but also in discussing strategic priorities and future plans, including the Trust coming to speak to the HwH Board about plans and

services. We have also been welcomed at the annual Patient Led Assessment of the Care Environment (PLACE) audit which was well organised. We therefore look forward to a continued working relationship with PAHT in the coming year to support improvements to patient experience.

Michael Downing, Chair Healthwatch Hertfordshire, May 2016

Essex Health Overview and Scrutiny Committee's response to Princess Alexandra Hospital NHS Trust

Thank you for the opportunity to comment on your latest Quality Accounts.

This a clear reflective document covering performance and outcomes during 2015-16. There is a justifiable sense of pride in the way that challenges are acknowledged and outcomes have mostly been achieved. Data for 2015-16 is still awaited.

Patient safety, patient experience and staff experience are at the forefront in the report. Patient reported outcome measures and managed incident reporting are clearly important to the Trust.

The clinical areas where most pressure has been experienced are outlined in some detail and the importance of working with partners is acknowledged. In particular, steps to manage pressure in the ED during the winter but also now all year round, are spelled out in clear steps.

There are clear plans for the future - again based on putting the patient first, in terms of outcomes and experience.

This is an excellent document.

Yours sincerely

Jillian Reeves,

Chairman,
Health Overview and Scrutiny Committee

June 2016

Amendments made following stakeholder engagement and internal committee review.

Thank you to East and North Hertfordshire CCG, West Essex CCG, Healthwatch Essex, Healthwatch Hertfordshire, Essex Overview and Scrutiny and the Patient Panel for their feedback.

The following amends were received and have been made to the Account.

- Cancer survey data added.
- Patient panel involvement statements added.
- Mortality rates added into Quality Improvements highlights.
- Added statement about data on the quality of services review.
- Added statement about % income
- Included participation in clinical audit and national enquiries section
- Added wording about the ethics committee
- Updated reporting against core indicators to included, where possible data is local, national and include national averages or highest and lowest.
- 24 - actual cases added as well as rate per 100,000 bed days
- CQC inspection outcomes are not mentioned in earlier in the accounts and have now been referenced the visit in the CEO introduction
- Acknowledgement of the impact of further delays in implementing the new EPR system.
- Included reference to how the quality priorities have been chosen.
- Updated service to say that Sexual Health Services and The Genito-Urinary medicine service is no longer provided from 31.03.16
- New HSMR – supporting information and actions required.
- Updated indicator 20 to be a composite indicator based on 5 patient survey questions not PALS enquiries as previously detailed.
- Big Dot – more thoroughly explained.
- Corrected 2014-15 priorities for 3.2 and 3.3 as partially achieved and explanations detailed.
- Efficiency measures plans are detailed for 2015/16 changed to achieved.
- Added statements to FFT graph that data for 2015/16 and 2014/15 are not comparable due to different method of calculating score.
- FFT graph broken down into A&E, inpatient etc. as this is how it is reported nationally.
- Corrected Still birth rate; as the 2 rates where currently different.
- Added more specific targets for the 16/17 quality priorities.
- Safer Staffing section included regarding safer staffing levels, number of red shifts and how these are mitigated.
- Removal of Liverpool Care Pathway from the Glossary of terms.

External audit limited assurance report

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

We are required to perform an independent assurance engagement in respect of The Princess Alexandra Hospital NHS Trust's Quality Account for the year ended 31 March 2016 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections

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

Respective responsibilities of Directors and auditors

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 published on the NHS Choices website in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.
-

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

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners, West Essex Clinical Commissioning Group dated 18 May 2016, and East and North Herts Clinical Commissioning Group dated 10 June 2016;
- feedback from Healthwatch Essex dated 24 May 2016 and Healthwatch Hertfordshire dated 23 May 2016;
- feedback from the Trust's Patient Panel dated 10 June 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 dated 26 May 2016;
- feedback from Essex County Council Health Overview and Scrutiny Committee dated 6 June 2016;
- the latest Care Quality Commission inpatient survey dated 2015;
- the latest national staff survey dated 2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated April 2016;
- the annual governance statement dated 2 June 2016; and
- the Care Quality Commission's Intelligent Monitoring Report dated May 2015.

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

This report, including the conclusion, is made solely to the Board of Directors of The Princess Alexandra Hospital NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Princess Alexandra Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

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

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

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

Basis for qualified conclusion

The indicator reporting the percentage of patients risk assessed for VTE did not meet the six dimensions of data quality in the following respects:

- Validity – our testing of a sample of 20 patient episodes on the Trust's electronic record system where the VTE assessment was flagged as having been completed found that in one case there was not a completed VTE assessment in the patient's medical records.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

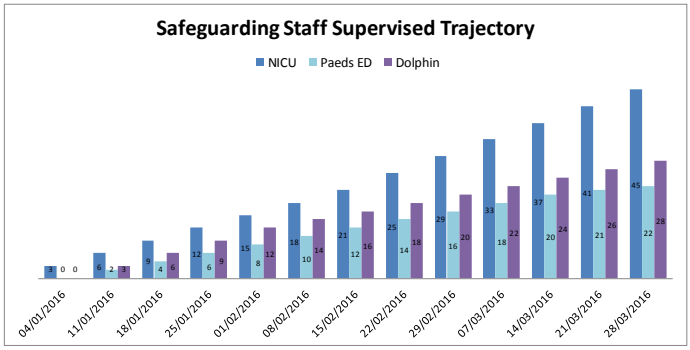
Ernst & Young LLP
400 Capability Green
Luton
LU1 3LU

24 June 2016

Appendix

Safeguarding staff supervised trajectory

	Staff Supervised					
	NICU		Paeds ED		Dolphin	
Week Commencing	Staff supervised per week	Trajectory	Staff supervised per week	Trajectory	Staff supervised per week	Trajectory
04/01/2016	3	3	-	-	-	-
11/01/2016	3	6	2	2	3	3
18/01/2016	3	9	2	4	3	6
25/01/2016	3	12	2	6	3	9
01/02/2016	3	15	2	8	3	12
08/02/2016	3	18	2	10	2	14
15/02/2016	3	21	2	12	2	16
22/02/2016	4	25	2	14	2	18
29/02/2016	4	29	2	16	2	20
07/03/2016	4	33	2	18	2	22
14/03/2016	4	37	2	20	2	24
21/03/2016	4	41	1	21	2	26
28/03/2016	4	45	1	22	2	28



Glossary of terms

Ambulatory Care
A personal health care consultation, treatment, or intervention using advanced medical technology or procedures delivered on an outpatient basis.

Amniocentesis
Amniocentesis is a diagnostic test carried out during pregnancy.

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

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

Appraisals
An act of assessing something or someone.

Audiology
The branch of science and medicine concerned with the sense of hearing

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.

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

Chloraprep
A type of antiseptic.

Chorionic Villi Sampling (CVS)
Chorionic villus sampling (CVS) is a prenatal test in which a sample of chorionic villi is removed from the placenta for testing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DNR/DNAR
A do-not-resuscitate and do not attempt resuscitation order tells medical professionals not to perform CPR. This means that doctors, nurses and emergency medical personnel will not attempt emergency CPR if the patient's breathing or heartbeat stops.

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

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

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

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

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

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.

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.

Hard Truths
Associated with publishing staffing data regarding nursing, midwifery and care staff levels.

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.

League of Friends
A group of volunteers who help at The Princess Alexandra Hospital NHS Trust.

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

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

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

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

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

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

Malignant spinal cord compression (MSCC)
When cancer grows in, or near, the spine and presses on the spinal cord and nerves.

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

Neonatal
New born children.

Net Promoter Score (NPS)
Result based on the following question; 'How likely it is that you would recommend our company to a friend or colleague?'

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

Neutropenic Sepsis Policy
The guidance surrounding the development neutropenia. Neutropenia relates to a patient with an abnormally low number of neutrophil granulocytes (a type of white blood cell) in the blood.

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

NHS Safety Thermometer
This provides a ‘temperature check’ on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients.

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

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

Oncology
The study and treatment of cancer and tumours.

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

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

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

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

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

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

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

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

Patient Safety Thermometer
The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

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.

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

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

Respiratory
The act of breathing.

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

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

Safeguarding
Protection or defence that ensures safety.

Serious Clinical Incident Group (SCIG)
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.

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.

Summary Hospital-level Mortality Indicator (SHMI)
Ratio between the actual number of patients who die following treatment at the trust and the number that would be expected to die, on the basis of average England figures given the characteristics of the patients treated there.

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

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

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

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

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

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

Venous Thromboembolism (VTE)
Collective name for deep vein thrombosis (DVT) and pulmonary embolism.

WHO
World Health Organisation