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HEALTH OVERVIEW AND SCRUTINY PANEL

Thursday, 15th May, 2014
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Council Chamber - Civic Centre

This meeting is open to the public

Members

Councillor Stevens (Chair)
Councillor Claisse (Vice-Chair)
Councillor Bogle
Councillor Cunio
Councillor Parnell
Councillor Spicer

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have 6 scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the health Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview & Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2013/14

2013	2014
23 May 2013	31 January 2014
18 July	20 March
19 September	2 April
21 November	17 April
	15 May

Council’s Priorities:

- **Economic**: Promoting Southampton and attracting investment; raising ambitions and improving outcomes for children and young people.
- **Social**: Improving health and keeping people safe; helping individuals and communities to work together and help themselves.
- **Environmental**: Encouraging new house building and improving existing homes; making the city more attractive and sustainable
- **One Council:** Developing an engaged, skilled and motivated workforce; implementing better ways of working to manage reduced budgets and increased demand.

CONDUCT OF MEETING

Terms of Reference

Details above

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council’s Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members’ Code of Conduct, ***both*** the existence ***and*** nature of any “Disclosable Pecuniary Interest” or “Other Interest” they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value for the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 22 and 29 April 2014 and to deal with any matters arising, attached.

7 INQUIRY: EMERGING ISSUES AND RECOMMENDATIONS

Report of the Assistant Chief Executive, detailing the emerging issues and recommendations for the Panel's inquiry into the Impact of Housing and Homelessness on the health of single people, attached.

8 SOUTHERN HEALTH NHS FOUNDATION TRUST: DRAFT QUALITY ACCOUNT 2013/14

Report of the Head of Quality, Performance and Quality Contracts, detailing the Trust's Quality Account 2013-2014, attached.

9 UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST: DRAFT QUALITY ACCOUNT 2013/14

Report of the Director of Nursing, detailing the Trust's Draft Quality Account 2013-2014, attached.

10 SOLENT NHS TRUST: DRAFT QUALITY ACCOUNT 2013/14

Report of the Director of Nursing and Quality, detailing the Trust's Draft Quality Account 2013-2014, attached.

Wednesday, 7 May 2014 HEAD OF LEGAL AND DEMOCRATIC SERVICES

Agenda Item 6

To approve and sign as a correct record the minutes of the meetings held on 22 April and 29 April 2014 and to deal with any matters arising

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 22 APRIL 2014

Present: Councillors Stevens (Chair), Claisse (Vice-Chair), Bogle and Cunio

Apologies: Councillors Parnell and Spicer

48. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

Councillor Bogle declared an interest in that she was a Council appointed representative to Southampton University Hospital Trust and had held the position of Cabinet Member for Children's Services in the last 6 months and remained in the meeting and took part in the consideration and determination of the item on the agenda.

49. **STATEMENT FROM THE CHAIR**

50. **MINUTES OF THE PREVIOUS MEETINGS (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panels meetings held on 20th March and 2nd April 2014 be approved and signed as a correct record.

51. **LOCAL SAFEGUARDING CHILDREN BOARD - UPDATE**

The Panel considered the report of the Director, People detailing an update for the Panel on matters relating to the Local Safeguarding Children Board and the substantial transformation programme Children and Families were going through.

The Panel noted that Appendix 6 of the report should have been a confidential appendix in accordance with the Councils Constitution, specifically the Access to Information Procedure Rules contained within the Constitution and the press and public be excluded from the meeting in respect of this appendix. This was based on Categories 7 and 7A of paragraph 10.4 of the Access to Information Procedure Rules. The information contained therein was potentially exempt as it related to information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime and information which was subject to any obligation of confidentiality. Accordingly the appendix had been withdrawn from the website.

Keith Makin, Independent Chair, Southampton Local Safeguarding Children Board, Cllr Chaloner, Cabinet Member for Children's Safeguarding and Alison Elliott, Director, People and Statutory Director for Children's Services were in attendance and with the consent of the Chair addressed the meeting.

The Panel particularly noted the significant changes that were taking place within the Local Safeguarding Children Board since the appointment of the new Chair in October 2013; these included a review of membership and functions to ensure the Board was fully compliant with the new requirements of Working Together 2013. Guiding principles and areas for development had been established which would see the Board providing more strategic direction and delegating more responsibilities to the Executive and Sub Groups. Some of the emerging themes for development included children

sexually exploited, involvement in the Board of children and young people who used the services and the continuation of ongoing work with GP's. Partner agencies had acknowledged the difficult period the Board had gone through and were engaged and committed to the new way of working and had contributed to a multi agency comprehensive data set which would provide the rigour of challenge and ability to make decisions in accordance with an evidence base. A new Threshold document and Universal Help Tool had been approved by the Board. Thresholds were not considered to be an issue although stepping children and young people down had been previously but the Multi Agency Safeguarding Hub (MASH) and Early Intervention Teams which went live as of 31st March 2014 would provide a service to those being stepped down from threshold and would in the long term see a reduction of children and young people coming into care by 2017/18. Southampton's MASH was one of the largest in the country and had good multi-agency representation that would provide a single point of contact for delivery of safeguarding services. A single recording system had also been introduced as part of the MASH and the LSCB would be responsible for and monitor the progress of the MASH.

Reference was made to the new Family Justice Bill that came into force as of today and whilst the principle of permanency was welcomed would provide a challenge for all involved to meet the prescribed deadline of 26weeks for adoption. For Southampton it was noted that previously 52weeks had been the average but was now at 33weeks with some cases meeting the 26 weeks. Early Intervention would be a key target area to avoid children and young people coming into care and where they did to seek permanency much sooner. It was noted that outcomes for Looked after Children were known to be poor nationally and was not any different in Southampton, however there was good partnership working in the City and a lot of work had taken place with the virtual school and other schools in the City with particular influence around temporary exclusions. It was important for the implications of the virtual school and Looked after Children to be understood in order to meet Corporate Parenting responsibilities.

The Panel acknowledged that in relation to national and statistical neighbours the City had higher rates of teenage pregnancy and incidents of domestic violence, admission to hospital as a result of accidents and violence and there was evidence to support the sense of Southampton being a more violent City. Southampton was an urban area with high levels of deprivation which across the country was linked to domestic violence; however whilst these differences were recognised they were similar challenges to other Cities and there would be learning from these areas. It was noted that Hampshire Constabulary were very good at recording incidents of domestic violence which indicated a 11% higher incident than elsewhere, however it was referenced that these figures may be a result of more effective recording than others. Meetings had also recently taken place with Hampshire Police to look at how work with those involved in domestic violence was dealt with; traditionally it had been to undertake work with the victim but addressing the offender behaviour was a better way of working therefore work with perpetrators was to be undertaken.

The Panel also noted that there were a number of Serious Case Reviews currently taking place which would be published over the forthcoming months. The purpose of the Serious Case Reviews was to identify the learning and any changes that were needed. Lead Reviewers for each of the reviews had ensured a rigorous approach and challenge to agencies to ensure all of the learning was identified.

The Panel noted that Local Safeguarding Children Boards were now subject to Ofsted inspection in their own right and therefore would also be inspected as part of the expected imminent inspection of Children's Social Care in the next 3-4 months.

The Panel also noted the Local Safeguarding Children Board Annual Report for 2012/13 and that the 2013/14 Annual Report was in progress and would be presented in a more detailed format with particular reference to progress.

In conclusion the Panel noted that there had been a number of positive initiatives in the City including Family Nurse Partnership and an increase in Health Visitors which had a resulted in a reduction of case loads.
It was also noted that in relation to Children's Social Care caseloads were not an issue; social workers were now nearly 100% permanent staff as opposed to previously being at 50% agency staff. A recruitment and retention policy was in place together with a focus on staff development to which supervision, appraisal and workforce strategy were key areas. The authority had also been recognised nationally for support to newly qualified social workers.

Joe Hannigan, member of the public was in attendance and with the consent of the Chair addressed the meeting.

RESOLVED

i. That the Panel receive an update on Children's Safeguarding in 6 months with other matters arising, including outcomes from inspections, presented on an ad hoc basis;
ii. That the Panel gives further consideration to more detailed information on outcomes for Children Looked After, focussing on health, at a future HOSP meeting;
iii. That the Local Safeguarding Children's Board Annual Report and future inspection outcomes be presented to the Panel in a timely manner when they are available;
iv. Independent health reports to the Local Safeguarding Children's Board be distributed to the Panel for consideration and may be added as future HOSP agenda items on an ad hoc basis.

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL
MINUTES OF THE MEETING HELD ON 29 APRIL 2014

Present: Councillors Stevens (Chair), Claisse (Vice-Chair), Bogle and Spicer

52. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The Panel noted the apologies of Councillors Cunio and Parnell.

53. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

Councillor Bogle declared an interest in that she was a Council appointed representative to Southampton University Hospital Trust and had held the position of Cabinet Member for Children's Services in the last 6 months and remained in the meeting and took part in the consideration and determination of the item on the agenda.

54. **STATEMENT FROM THE CHAIR**

In accordance with accepted practice a statement was made by the Chair in relation to:-

- receipt of enforcement notice from Monitor on Southern Health and an additional meeting in this respect;
- updated recommendations from the meeting on 22nd April 2014 in relation to the LSCB; and
- invitation to the Health and Wellbeing Board meeting on 14th May 2014 when the NHS England consultation report on Specialist Services Specifications would be tabled for discussion.

55. **INQUIRY MEETING 4 - TACKLING COMPLEX HEALTH AND OTHER NEEDS ASSOCIATED WITH HOMELESSNESS**

The Panel considered the report of the Assistant Chief Executive, introducing the speakers that addressed the inquiry in relation to access to tackling complex health and other needs associated with homelessness.

The Panel received presentations from the Council's Children Looked after Social Working Team and a representative of the Southampton Safeguarding Adults Board in relation to Children Looked After and Adult Safeguarding processes and procedures and noted:-

Children Looked After

- that the Council had a statutory responsibility to provide support to all care leavers until they reached the age of 21, or if they were assisted with education and training, to the end of the agreed programme which could take them beyond their 25th birthday;
- the importance of staying in touch with care leavers with regards to accommodation, education and training issues. There had been significant

improvement in these figures and the local authority were in touch with 90% of young people. The Department for Education (DfE) required that the Council provided a report on the number of 19 year-old children they were in touch with and whether they were in suitable accommodation as well as the number of NEET children;

- that "staying put" arrangements were being prioritised to ensure that young people were being enabled to stay in foster care;
- Ofsted were now specifically monitoring how care leavers were looked after in terms of resources and how authorities, as Corporate Parents, were continuing to fulfil their obligations and responsibilities relating to children looked after and leaving care;
- phase 2 of the Transformation Structure provided more of a multi- agency response to children in care and looked after children and care leavers were being split into 2 groups, namely up to the age of 14 years and over 14 years;
- the number of care leavers had increased and to date numbered 333, with 211 children looked after and 122 care leavers;
- the Pathways Team's focus was on providing suitable accommodation and increasing the number of children "staying put" with foster carers; and
- a strategic review of housing and care leavers was being undertaken with focus on increasing the number of supported lodgings in the city, dedicated support time from the 3rd Sector and working with foster carers in terms of preparing young people to live independently. NEET young people remained a concern and work was being undertaken in terms of apprenticeships, work experience and working with 3rd Sector providers.

Adult Safeguarding

- adults vulnerable to abuse was defined as "A person who was 18 years of age or over and who was or might be in need of community care services by reason of mental or other disability or illness; and who was or might be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation";
- with adult safeguarding there was a difference as vulnerable adults had the right to consent to abuse and people's rights had to be respected;
- homeless people did not fall easily into care categories and only a minority of homeless people would have a care assessment and were signposted to relevant services, with accommodation services being part of the system of keeping people safe;
- "revolving door clients" which were young people not known on the system were an issue for the city; and
- the importance of holding the Mental Health Trust to account to ensure that they met the expected standards when dealing with people with mental health problems.

The Panel received presentations from representatives of the Probation Services and the Police and noted:-

Probation Services

- 15% of people entering probation services were homeless and 32% of people who were homeless were re-convicted;
- when offenders were released from prisons outside of Southampton and returned to the city, there was great difficulty in finding beds and accommodation for them, as neither beds nor accommodation could be held indefinitely and offenders were at a high risk of being harmed;
- No Limits were doing great work in assisting 18 – 24 year olds in getting accommodation; and
- multi-agency working and probation health trainers working alongside other health professionals was extremely important.

Police

- the statistics on offending homeless people were not accurate and there was no formal recording process; if a homeless person was injured they would be directed to a walk-in centre and if it was a mental health issue they would be directed to Antelope House. If a homeless person was not at risk the police would not get involved. The police would be willing to assist other agencies and signpost homeless people to the relevant agencies if they were provided with more information.

The Panel received presentations from the Councils Improvement and Housing Needs Managers and a representative from the EU Welcome Project in relation to the impact of wealth reforms, migration and situations where there was no recourse to public funds. The Panel noted:-

Improvement and Housing Needs

- the welfare reforms were the biggest change to the system in 60 years with an overall financial loss of £53 million and 34,157 households in the city affected;
- welfare and housing benefit reforms, with the increased conditionality and increase of sanctions, would be the biggest challenge to preventing and tackling homelessness;
- there was strong evidence that the above reforms (for example the single room rate for under 35 year olds, reforms to disability allowance and movement to a daily sign-on for jobseekers allowance) and subsequent sanctions were not motivating people back in to work, but putting them in severe hardship, which resulted in further disengagement. Compliance with conditionality, especially for those with complex needs was a huge challenge as many required additional support to understand the conditions and find work and homeless people often did not have a support network of family or friends;
- clients with no previous history of homelessness had, through rent arrears, lost accommodation and more young people who were no longer eligible for full housing benefit were accessing the service since the criteria was raised to above 35. There was an increase in debt related support and DWP benefit claim support;
- a Working Together Event involving the Homeless Link/Jobcentre Plus and other local providers had been held on 28th April 2014 which had been successful; and
- a 44 page booklet had been published, providing information on how to claim benefits and what sanctions were incurred if conditions were not adhered to.

EU Welcome Project

- this project supported and signposted migrants from the EU countries to various agencies;
- many homeless migrants had mental health and addiction issues ; and
- most migrants did not want to return to their home country and found it difficult to find accommodation, especially as Day Centres were monitored by the UK Border Agency.

The Panel received presentations from representatives of University Hospitals Southampton, Local General Practitioners and Healthwatch Southampton and the Panel noted:

Vulnerable Adult Support Team (VAST) and Discharge Bureau

- the Emergency Department managed the care of about 280-320 patients a day;
- VAST had been funded from May 2012, but from September 2014 future funding was at risk;
- since the introduction of VAST, 219 patients had disclosed that they were homeless or at risk of street homelessness;
- VAST worked in close liaison with the Cranbury Avenue Day Centre, Street Homeless Prevention Team, the Healthcare Team and No Limits to provide a robust referral pathway for homeless patients; and
- VAST provided and promoted expertise with complex adult vulnerability, by way of a consistent approach, risk management/safeguarding, access to community services, multi-agency collaboration and compassionate care.

Psychological Approach to Homelessness

- formal research at the University of Southampton had shown that there were psychological factors implicated with homelessness as well as mental health issues such as anxiety, depression, psychosis, with associated drug and alcohol use and self-harm;
- significant factors identified were childhood neglect and abuse and associated difficulties in managing emotions and attachment problems, which again were a significant barrier to healthy societal living and these factors were important when living in structured social environments such as hostels or shared housing;
- a number of psychological interventions were designed to address a number of these factors which might enable people to operate more efficiently in structured environments; and
- wider use could be made of psychological knowledge generated through training delivered in hostels.

General Practice

- homeless people made greater use of hospital services, particularly Accident and Emergency departments as many of them had no ID and the amount of information available to GP's was minimal, with there being no medical information available on ex offenders;
- if a patient had a number of long term conditions and this was complicated by mental health problems or misuse of drugs or alcohol, it would not be possible to help them in a 10-15 minute consultation without access to medical records;

- homeless people had a high incidence of mental health problems which sometimes required drugs and many GP's did not have experience in managing drug problems and access to substance misuse services was very slow; and
- the Homeless Healthcare Team was better geared to care for the homeless and had greater expertise to meet their needs than ordinary practices.

RESOLVED that the presentations made at the meeting be noted and the information provided be entered into the Inquiry's file of evidence.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		INQUIRY INTO THE IMPACT OF HOUSING AND HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE: EMERGING ISSUES AND RECOMMENDATIONS		
DATE OF DECISION:		15 MAY 2014		
REPORT OF:		ASSISTANT CHIEF EXECUTIVE		
CONTACT DETAILS				
AUTHOR:	Name:	Dorota Goble	Tel:	023 8083 3317
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STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The Health Overview and Scrutiny Panel have undertaken an inquiry considering the impact of Housing and Homelessness on the Health of Single People over four meetings from February to April 2014. The Panel have heard from a wide range of services and stakeholders over the course of these meetings and will now review the evidence they have heard to agree the inquiry's final recommendations.

RECOMMENDATIONS:

(i) The Panel is recommended to consider the information provided through out the inquiry including background information, presentations and discussions from the four meetings, and agree the findings and recommendations.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Panel to consider the evidence in order to agree findings and recommendations at the end of the inquiry process.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not to proceed with considering the final recommendations would be a waste of the time and effort that witnesses and members have invested into the Inquiry process.

DETAIL (Including consultation carried out)

3. The purpose of the Inquiry is to consider the impact of housing and homelessness on the health of single people, a significant number of whom have complex needs, and live unsettled and transient lifestyles, and to examine the difficulties that their everyday life presents to deliver a preventative and planned approach to improve their health and well being and access to a settled and decent home.

4. The Panel have heard from a wide range of Southampton City Council services, health professional, homeless housing providers, agencies and many stakeholders on the complexities, difficulties and health issues affecting single homeless people. Appendix 1 provides a summary of the meetings and guests giving evidence to the Inquiry.

5. The Panel is invited to consider the information provided through out the inquiry including background information, presentations and discussions from the four meetings, and agree the emerging inquiry findings and recommendations.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None

Property/Other

7. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

9. None

POLICY FRAMEWORK IMPLICATIONS

10. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Summary of meetings and guests giving evidence to the Inquiry

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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APPENDIX 1

SUMMARY OF INQUIRY MEETINGS AND WITNESSES

MEETING 1: 20 FEBRUARY 2014
SETTING THE SCENE

Sarah Gorton - *Homeless Link, South East Regional Manager*
Liz Slater - *Housing Needs Manager*
Matthew Waters - *Commissioner Supporting People and Adult Care Services*
Pam Campbell – Consultant nurse, Homeless Healthcare Team

MEETING 2: 20 MARCH 2014 - SERVICE AND HEALTH PROVIDERS

Part A: Accommodation and support services through the voluntary sector

Liz Slater, Housing Needs Manager
Guy Malcolm *Society of St James*, Operations Director
James McDermot, *Two Saint,* Regional Director
Alison Ward, *No Limits* Project Manager
Tina Hill *Chapter 1*, Service manager

PART B: Access to and discharge from health services

Pam Campbell, Homeless Healthcare Team
Jackie Hall - Substance Misuse, SCC Integrated commissioning Unit
Dr Shanaya Rathod - Mental Health, *Southern Health*

MEETING 3: 2 APRIL 2014
ACCESS TO AND SUSTAINING LONG TERM ACCOMMODATION

PART A: Access to suitable long term accommodation for single homeless people.

Sherree Stanley, Manager- Housing Delivery & Renewal

Mitch Sanders, Head of Regulatory Services and Janet Hawkins, Team Leader.

Fred Knight, Southern Landlords Association South Hampshire Branch

PART B will focus on supporting people into sustaining long term accommodation:

Peter Walton - Booth Centre, Operations Manager

Steve Curtis - Family Mosaic, Regional Manager

MEETING 4: 29 APRIL 2014
TACKLING COMPLEX HEALTH AND OTHER NEEDS ASSOCIATED WITH HOMELESSNESS

PART A Children Looked After and adult safeguarding. Including:

Fiona Mackirdy, Mary Hardy - Children looked after

Carol Judge, SSAB Board Manager

Matthew Waters - *Commissioner Supporting People and Adult Care Services*

PART B: Police and Probation identification and support

The Police perspective – Inspector **Sharman Wicks**, Portswood HQ

Probation Services - **Robbie Turkington,** Operations Manager, Southampton Probation

PART C: Impacts of Welfare Reforms, migration and No Recourse to Public Funds

Sara Crawford, SCC Improvement Manager and
Liz Slater, Housing Needs Manager - Welfare Reforms
Dave Adcock, Project Manager EU Welcome

PART D: Primary care and services connected with the hospital

Sara Charters, UHS Emergency Department VAST
Meriel Chamberlain, UHS Integrated Discharge Bureau
Nick Maguire – Southampton University, Dept of Psychology
Dr Steve Townsend, Southampton CCG
Annabel Hodgson, Healthwatch Southampton Manager

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<tr><td>SUBJECT:</td><td colspan="4">SOUTHERN HEALTH NHS FOUNDATION TRUST: DRAFT QUALITY ACCOUNT 2013/14</td></tr>
<tr><td>DATE OF DECISION:</td><td colspan="4">15 MAY 2014</td></tr>
<tr><td>REPORT OF:</td><td colspan="4">HEAD OF QUALITY, PERFORMANCE AND QUALITY CONTRACTS</td></tr>
<tr><td colspan="5" align="center"><u>CONTACT DETAILS</u></td></tr>
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<tr><td colspan="5">STATEMENT OF CONFIDENTIALITY</td></tr>
<tr><td colspan="5">None</td></tr>
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BRIEF SUMMARY

A Quality Account is an annual report to the public about the quality of services delivered by NHS service providers. Since June 2010 it has been a legal requirement that every NHS service provider should produce and make their Quality Account available. Briony Cooper, Head of Quality Performance and Quality Contracts and Helen McCormack, Chief Medical Officer, will present an overview of the Southern Health NHS Foundation Trust annual report, providing a particular focus on issues for Southampton patients.

RECOMMENDATIONS:

(i) To note and provide comment with regard the draft Quality Account

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Panel to consider the evidence in order to agree findings and recommendations at the end of the inquiry process.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. To be assured that SHFT are continuing to deliver high quality and relevant care for the population it serves and that the priorities it has set for the coming year are in line with commissioning and JSNA intentions.

DETAIL (Including consultation carried out)

3. Southern Health NHS Foundation Trust is one of the largest providers of mental health, community, learning disability and social care services in the country. This year almost 8000 dedicated staff enabled us to treat or support approximately 255,000 people through providing 1,510,760 community contacts, 282,031 outpatient appointments and 235,257 occupied bed days across Hampshire and beyond.

4. Southern Health Foundation Trust's Draft Quality Account is attached at Appendix 1. Their Quality Account includes series of improvement indicators which have been selected in consultation with stakeholders and approved by the Trust Board. Every Quality Account must contain a minimum of three indicators each for patient safety, clinical outcomes and

patient experience. We emphasise that the chosen indicators form only a small sample of all the quality improvement activities being undertaken across the Trust and that quality of care is widely reviewed and monitored at team, service, divisional and Board level.

5. Southern Health has faced significant quality challenges in some of its services in 2013/14 which are acknowledged within this report. On April 23rd 2014 the health sector regulator, Monitor announced its decision to take enforcement action against Southern Health. We have been under investigation by Monitor following a CQC inspection at our learning disability inpatient unit at Slade House in Oxford in September 2013.

6. Despite these challenges the Trust state that they have made a number of quality achievements this year:
   - We successfully achieved 6 of the 10 quality improvement priorities we set last year. For those we did not meet, we are planning further work this year to build on the partial successes achieved.
   - Over 96% of patients would recommend our services to friends and family;
   - We are in the top 20% nationally for well-structured appraisals for staff;
   - Healthcare acquired infections remain very low with cases of C. Difficile falling to their lowest level with only 3 this year;
   - We achieved all of the Monitor access to care and outcome standards to improve patient experience;
   - CQC carried out 41 unannounced inspections this year;
   - We launched our new Recovery College this year which embeds the principles of recovery in mental health services and has been a huge success with our patients and the local community.

7. Briony Cooper, Head of Quality Performance and Quality Contracts and Helen McCormack, Chief Medical Officer, will present an overview of the Southern Health NHS Foundation Trust annual report, providing a particular focus on issues for Southampton patients.

8. Members are asked to consider the attached report and discussions at the meeting and provide comment on the draft Southern Health NHS Trust Draft Quality Account. They are also asked to consider if there are any matters within the report that they wish to receive further information as part of their work programme for the next year.

RESOURCE IMPLICATIONS

Capital/Revenue

9. None

Property/Other

10. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11. The duty to undertake overview and scrutiny is set out in Section 21 of the

Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

12. None

POLICY FRAMEWORK IMPLICATIONS

13. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Southern Health NHS Foundation Trust; Draft Quality Account

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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Southern Health NHS

NHS Foundation Trust

QUALITY REPORT AND QUALITY ACCOUNT 2013/14

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Statement on Quality from Katrina Percy, Chief Executive Officer of Southern Health NHS Trust

Our vision at Southern Health is to build a sustainable, person centred health and care system through delivery of high quality services that put patients, service users and their families at the centre of everything we do. I am therefore pleased to be able to summarise the Trust's view on the quality of its services during 2013/14.

Before doing so, I would like to personally thank everyone who has worked for the Trust in the past twelve months for their hard work, dedication and commitment. I see and hear of staff going the extra mile for our patients each and every day. Although I see all the complaints made to the Trust I also receive many letters from grateful patients and carers praising the care and compassion shown by staff and I would like to take this opportunity to express my thanks to staff for their dedication and loyalty.

Southern Health has faced significant quality challenges in some of its services in 2013/14 and it is important to me we are open and honest about this in our Quality Report and Account. Southern Health is one of the largest providers of mental health, community, learning disability and social care services in the country and from 1 November 2012 includes the services formerly known as Oxfordshire Learning Disability Trust. We provide services across some 170 sites and it is a matter of major regret that a small number of these locations have been found to be unsatisfactory by external inspection.

Care Quality Commission (CQC) inspections found some of the former Oxfordshire Learning Disability Services and one Adult Mental Health unit did not meet all the Essential Standards of Quality and Safety and issued warning notices. We took immediate action to rectify the problems and put plans in place to drive long term sustainable improvements and I am very pleased that on re-inspection by CQC the warning notices for all sites/sites re-inspected so far have been lifted. However we are not complacent and we know there is more to do.

On April 23rd 2014 the health sector regulator, Monitor announced its decision to take enforcement action against Southern Health. We have been under investigation by Monitor following a CQC inspection at our learning disability inpatient unit at Slade House in Oxford in September 2013. We have agreed with Monitor that we need to do a number of things to demonstrate improvements. These are:

- Deliver our improvement plan for our learning disability services
- Address the action plans for CQC warning notices across all of our services
- Deliver improvements in our quality governance and Board governance

Monitor's role is to protect the interests of patients, and we take their concerns extremely seriously. Over the coming weeks our focus will be on ensuring we make the improvements needed, to reassure both Monitor and our patients and their families about the quality of care we provide across all of our services day in, day out. I fully understand why Monitor has raised their concerns and I welcome the

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opportunity to work with them to demonstrate that the issues they have identified are not an ongoing cause for concern.

Despite these challenges we have made a number of quality achievements this year:

- We successfully achieved 6 of the 10 quality improvement priorities we set last year. For those we did not meet, we are planning further work this year to build on the partial successes achieved.
- Over 96% of patients would recommend our services to friends and family;
- We are in the top 20% nationally for well-structured appraisals for staff;
- Healthcare acquired infections remain very low with cases of C. Difficile falling to their lowest level with only 3 this year;
- We achieved all of the Monitor access to care and outcome standards to improve patient experience;
- CQC carried out 41 unannounced inspections this year and assessed xx outcomes, with the Trust being fully compliant with 76% of these;
- We launched our new Recovery College this year which embeds the principles of recovery in mental health services and has been a huge success with our patients and the local community.

I am also incredibly proud the Trust won the Leadership Innovation category in the first ever Guardian Healthcare Innovation Awards this year; we see the continual investment and development of our staff and building strong leadership as key to the delivery of quality care for patients. I am delighted that we have several individual staff and teams shortlisted for awards, including the West Hampshire Community Diabetes team in the British Medical Journal awards and 'bank nurse of the year' body awarding?

The Board approved its new Quality Governance Strategy 2014-2016 "Getting it right first time, every time". The Strategy sets out how our patients and staff will become our leaders in patient safety, improving the effectiveness of care and ensuring we act on patient experience. The Trust continues to work to ensure the recommendations of the Francis Report following the inquiry into events at Mid Staffordshire NHS Foundation Trust and the Department of Health's response 'Patients First and Foremost' are implemented in full.

Finally, the Council of Governors, Board of Directors, our senior managers, clinical leaders and I are committed to delivering a programme of continuous quality improvement during 2014/15. We will ensure quality improvement and standards of care always have our full attention and will continue to respond promptly and positively to any initiatives which help us maintain a strong and clear focus on quality. Above all we value the feedback of patients and their carers, family and friends to guide us in improving the quality of our services.

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The content of the report has been reviewed by the Board of Southern Health NHS Foundation Trust therefore on behalf of the Board and to the best of my knowledge; I confirm the information contained in it is accurate.

[signed]

Katrina Percy
Chief Executive Officer, Southern Health NHS Foundation Trust
Xxxxx 2014

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Part 2: Priorities for improvement and statements of assurance from the board

Southern Health NHS Foundation Trust is one of the largest providers of mental health, community, learning disability and social care services in the country. This year almost 8000 dedicated staff enabled us to treat or support approximately 255,000 people through providing 1,510,760 community contacts, 282,031 outpatient appointments and 235,257 occupied bed days across Hampshire and beyond.

Developing our priorities for 2014/15

Our Quality Account includes series of improvement indicators which have been selected in consultation with stakeholders and approved by the Trust Board. Every Quality Account must contain a minimum of three indicators each for patient safety, clinical outcomes and patient experience. We emphasise that the chosen indicators form only a small sample of all the quality improvement activities being undertaken across the Trust and that quality of care is widely reviewed and monitored at team, service, divisional and Board level.

The information we have used to identify the annual priorities includes:

- What patients tell us about our services and how we can improve;
- What our commissioners have told us is important for us to provide to their patients;
- What our Governors have told us is important to them;
- What staff have told us is important to them;
- Consultation with Healthwatch organisations;
- What we have learnt from reviewing our performance and the quality of our services and where improvements are required; and
- Review of national priorities as identified in the NHS Operating Plan.

We have a Quality Improvement Plan which provides detail of the action we will take to meet the quality improvement priorities with progress being monitored by Quality Improvement and Development Forum, Quality and Safety Committee and the Board and included in the Quality Account for 2014/15.

These priorities reflect our Quality Governance Strategy 2014- 2016 which supports delivery of the Trusts vision and values and overarching Clinical Strategy and sets out our approach to continually improving the quality of care for our patients, users, their families and carers. It will be formally launched in 2014/15.

Detail of the priorities for improvement for 2014/15 is included later in this section.

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A review of our performance for clinical quality

The tables below summarise some of the quality information we regularly review as part of quality performance monitoring and includes the indicators chosen for 2013/14. The acquisition of Oxford Learning Disabilities Trust (OLDT) in November 2012 impacts on direct comparison of performance data.

Patient Safety

	2011/12	2012/13	2013/14	2013/14 target	Met/not met	comments
Serious Incidents Requiring Investigation	390	353	389			Trend being monitored
Never events	1	0	0			Remain rare
Healthcare associated infection Clostridium difficile	7	5	3			Steady reduction from 27 in 2009/10
Suicide (includes patients discharged within 12 months)	47	34	43			Numbers are within national benchmarking
Attempted suicide	12	6	14			Numbers are within national benchmarking
High harm falls	31	31	22	To reduce	✓	**Achieved** 90% inpatients have falls care plans
Pressure ulcers grade 3 (avoidable and unavoidable)	141	144	143			
Pressure ulcers grade 4 (avoidable and unavoidable)	95	101	134			
Avoidable Pressure ulcers grade 3 and 4 in community care teams	149	166	124	<116	x	Prioritised for 14/15. Nationally PU reduction is challenging
Medicines review within 24 hours	tbc	tbc	tbc	80%	x	Prioritised for 14/15.

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Clinical outcomes

	2011/12	2012/13	2013/14	2013/14 target	Met/not met	comments
Violence and aggression incidents resulting in physical injury	736	627	864	532	x	Prioritised for 2014/15. Increase may reflect nature of caseloads in former OLDT

Use of track and trigger early warning system (clinical audit)	75% (community hospital)	n/a	91%	90%	✓	**Achieved**
Outcome frameworks	n/a	n/a	5	5	✓	**Achieved**
Dementia friendly environments in Community Hospitals	n/a	n/a	100%	100%	✓	**Achieved**
% of patients receiving a 7 day follow up	95.4	96.9	97.0	95.0		Met Monitor target
% crisis resolution teams acted as gatekeeper	97.9	97.4	99.7	95.0		Met Monitor target
Readmission rates within 28 days to hospital	10.2	8.7	7.4			Downward trend

Patient experience

	2011/12	2012/13	2013/14	2013/14 target	Met/not met	comments
Total complaints	342	398	470			Increase being monitored
Total concerns	544	475	488			
Total compliments	854	1511	1732			Doubled since 2011/12: approx. 4 times complaints
Patient experience surveys: recommend trust to family and friends	tbc	tbc	96.1% (90.6% for mental health services)	95% (75% for mental health services)	✓	**Achieved**
Patient experience surveys: support for carers	tbc	84.9%	87.6% (67.5% for mental health services)	95% (75% for mental health services)	x	Carers survey launched early 2014
Duty of Candour	n/a	n/a	100%	100%	✓	**Achieved** being open principles in place

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2.1 Priorities for Improvement 2014/15

The priorities for improvement for 2014/15 are shown below. We have included information about why these indicators are important and how we plan to manage and measure progress towards these our aims.

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Priority 1: Improving Patient Safety 2014/15

Priority 1.1 Reduce the number of pressure ulcers			
Aim To share and implement learning across the Trust to reduce pressure ulcers	**Why is this important?** Pressure ulcers can be painful and increase the risk of associated infection for a patient. We want to minimise this risk and any potential harm to the patient by doing all we can to prevent pressure ulcers developing. We were successful in reducing pressure ulcers in some of our divisions this year and want to repeat a similar indicator for 2014/15 with learning and good practice being shared across the whole Trust, resulting in fewer pressure ulcers.	**Our aims for 2014/15** To share and implement learning from regional initiatives which are reviewing good practice, developing evidence based guidance and targeted outcomes for pressure ulcer reduction. To share learning and good practice from teams who have successfully reduced numbers of pressure ulcers to all teams across the Trust. To raise awareness of pressure ulcer causes, prevention and signs of tissue damage to patients, carers and staff with person specific concerns identified and advice given. To reduce number of new avoidable grade 3 and 4 pressure ulcers.	**How we will measure progress** SPC charts for grade 3 and 4 avoidable pressure ulcers acquired in our care in community services in 2014/15 will show a reduction when compared to SPC charts for 2012/13 and 2013/14.
Priority 1.2 To improve the management of incidents of violence and aggression			
Aim To improve the management of incidents of violence and aggression so that patients are cared for in safe environments which use least restrictive interventions	**Why is this important?** We aim to support patients with Mental Health problems to recover in safe, calm and therapeutic inpatient environments, and to engage patients to work in collaboration with us. We know that patients experiencing Mental Health distress can sometimes express this through violent or aggressive behaviour. Our aim is to work with patients to manage their distress and avoid violence and aggression wherever possible. If it occurs we want to address it in a way that is safe for all concerned, and maintains the dignity	**Our aims for 2014/15** To minimise the use of Restrictive Practice in working with patients who exhibit violence and aggression. To introduce a framework for Positive Behavioural Support (PBS), this will include the introduction of Behavioural Support Plans. To improve environments thereby minimising the negative impact of	**How we will measure progress** We will develop an audit and assurance programme to measure standards which are required to minimise the use of restrictive practice. We will undertake an audit against the standards to identify how we are progressing our annual plan to promote SAFER services and minimise restrictive practice.

	and respect for the individual, and minimises the use of coercion (including restraint and seclusion). We aim to respond proactively to the Department of Health objectives outlined in their publication *'Positive and Proactive: Reducing the need for Restrictive Interventions' (April 2014).*	oppressive environments on how patients behave and recover.	We will report on our progress. Our report will show that we are using evidence based interventions to minimise the use of restrictive practices. We will highlight areas of exceptional or good practice and also where we have made improvements to environments. We will include stories and perspectives from those who use our services around how we are working in a safe and therapeutic way.
Priority 1.3 To improve medicines reviews for people			
Aim To improve the medicines review of patients being admitted to our inpatient units/hospitals	**Why is this important?** Patients are often taking medicines before being admitted to our inpatient units/hospital and then may be prescribed more medicines. The National Institute for Health and Clinical Guidance (NICE) found medication errors most commonly occurred at the time of admission. We aim to check that medicines prescribed on admission correspond to those that the patient was taking before admission. This will ensure safe care and reduce any potential harm to the patient from taking the wrong medicine. We did not consistently meet our target across all inpatient sites in 2013/14 and are therefore repeating a similar indicator for 2014/15.	**Our aims for 2014/15** To increase the percentage of patients who have their medicines reviewed by a pharmacist within 48 hours of admission using Q1 figures from 2014/15 as a baseline. To continue the roll out of updated training for nurses started in 2013/14. To use the new monthly medicine reconciliation report to identify trends in performance with action taken to ensure progress against target.	**How we will measure progress** Data from Q1 2014/15 on the percentage of patients admitted to our inpatient units/hospitals who have level 2 medicine reconciliation completed by a pharmacist/pharmacy technician within 48 hours of admission to be used as a baseline. Progress to be shown by an increase from this baseline on the percentage of patients admitted to our inpatient units/hospitals who have level 2 medicine reconciliation completed by a pharmacist/pharmacy technician within 48 hours of admission by the end of March 2015.

Priority 2: Improving Clinical outcomes 2014/15

Priority 2.1 Holistic care planning for people			
Aim To improve holistic assessment and care planning for patients	**Why is this important?** Our services are caring for patients who are increasingly unwell, many of whom have long term conditions and complex needs. A first step in our care is to complete a holistic assessment of all needs and to work in partnership with the patient and their carers to develop care plans that are centred on their needs and include goals important to them. We will work in partnership to review progress against the care plan and ensure it is leading to improved outcomes for the patient and their carers and continues to be focused on what is important to them. Evidence demonstrates effective care planning ensures better continuity of care, clinical outcomes, safety and experience for the patient. We want to ensure we have an effective care planning process in place across trust.	**Our aims for 2014/15** • To work collaboratively with patients and their carers to develop holistic, patient-centred care plans. • The plans will be goal orientated, and address all identified care needs with evidence that progress against the care plans are monitored and that they lead to improved outcomes for the individual. • To demonstrate we have effective care planning process in place by auditing community services: o All patients on caseload have appropriate assessment and related care plan which include patient identified goals and outcomes. o Care plans for patients diagnosed with dementia reflect management of condition. o Evidence that action plans had led to changes and improved patient care.	**How we will measure progress** • Clinical audit of community team's caseload with audit tool to include key questions as shown in the aims. • Audit results to show how many teams were compliant with set standards. • First audit results to be the baseline for the year with improvement in standards being met shown in subsequent audits throughout the year.
Priority 2.2 Learning from information about quality of care			
Aim To improve and learn from data about quality of care including analysis of	**Why is this important?** We want to learn from the information we have about the quality of care we are providing to patients, identifying and acting on key themes where we could do better and which will lead to improvements in quality of care.	**Our aims for 2014/15** • Implement the Quality & Organisational Learning Strategies across the Trust.	**How we will measure progress** • Track progress with implementation of the Strategies at the Quality Improvement & Development Forum.

incidents, serious incidents requiring investigation and complaints.	We want to be an organisation which encourages a culture of active review and learning across our services and which supports staff to make changes where appropriate to ensure improved quality of care. This is a new indicator this year.	• Embed triangulation of information and thematic analysis within divisions. • Learning is shared and changes embedded across the trust.	• Quarterly reporting to identify how learning has been shared from key themes following analysis of data. • We will look at the number of repeat complaints of same theme in a team or division within 3 month period to see if these are decreasing. • We will look at the number of repeat SIRIs of same theme in a team or division within 3 month period to see if these are decreasing.
Priority 2.3 Learning from deaths			
Aim To learn from and take action from reviewing suicides and unexpected deaths	**Why is this important?** Tragically, some of the patients in contact with Mental Health services die by suicide. Sadly, some of the patients supported within our community hospitals die. While the numbers are small, it is a priority for us to ensure that we learn from each incident, and take action to ensure that the learning is shared across our services, and that it results in improvements in the quality of care.	**Our aims for 2014/15** Thematic review of all deaths with a thorough, open and transparent process of investigation, reporting and acting on any learning to arise. Wherever possible to involve the families in this process and share investigation outcomes with them. To benchmark our Mental Health services against data produced by the National Confidential Enquiry into Suicides. To develop and implement metrics, both quantitative and qualitative, which will help us better understand mortality in community services and support benchmarking with other Trusts.	**How we will measure progress** • Evidence of learning shared and action plan tracked • Benchmarking numbers of patients dying by suicide in the Trust against national averages. • Development and use of mortality metrics in community services.

Priority 3: Improving Patient Experience 2014/15

Priority 3.1 Improve the experience people have of our services			
Aim To improve the experience patients have of our services	**Why is this important?** Seeking and acting on patients feedback is key to improving quality of healthcare services. A patient experience survey offers the opportunity to patients to give their views on the care or treatment they have received. This feedback, alongside other information, will be used to identify and tackle concerns at an early stage, improve the quality of care we provide and provide more positive experience of our care.	**Our aims for 2014/15** To improve levels of positive feedback on patient experience surveys from 2013/14 baseline. To increase number of patient experience surveys returned from 2013/14 baseline. Narrative reports published on Trust website to show changes made to services as result of people's feedback.	**How we will measure progress** All positive responses (i.e. top two) to survey question 'How would you rate your experience of our service overall? Improve results in 2014/15 from 2013/14 baseline. Increase numbers of surveys returned in 2014/15 from 2013/14 baseline. Narrative reports published on Trust website to show changes made to services as result of patient feedback.
Priority 3.2 Support carer involvement and listen to their feedback			
Aim To learn from feedback from carers as to how we can improve our services	**Why is this important?** Carers often provide key support to patients we are providing services for and can help to improve or maintain a patient's health and well-being. We want to provide appropriate support and information to enable carers to do this effectively. We have therefore developed a carer's feedback questionnaire which focuses on how carers feel about the support and recognition they have received as a carer. We will use this feedback to identify areas where we can improve our services.	**Our aims for 2014/15** To roll out new carers feedback questionnaire across the Trust in 2014/15. To analyse feedback results and make changes to practice as needed. Ensure carers feel adequately supported.	**How we will measure progress** All positive responses (i.e. top two) to three questions on the carer survey: 'When I am in contact with your services and/or staff, I feel welcome'. 'Staff recognise me as a carer of the person who will be using the service'. 'How likely would you be to recommend this service to friends or family, if they needed similar care or treatment? Narrative reports to show changes made to services as result of carer's feedback.
Priority 3.3 Use feedback from complaints to improve our services			
Aim Demonstrate to complainants we have acted on their experience to improve our services	**Why is this important?** We want to be an organisation which listens to patients and their families and acts when they say we have not got things right. National reviews, including the Francis, Berwick, Clwyd reports recommend that it is good practice to	**Our aims for 2014/15** To introduce in April 2014 a process to feedback to complainants 6 months after the complaint had been resolved what actions or changes in practice have been made as a result of their complaint.	**How we will measure progress** Number of complaints Number of complaints where there were actions Number of complaints where complainant

	let complainants know it was worth telling us about their experience and that we have taken actions as a result of their feedback.	To contact 100% of those applicable From October 2014 to publish on the Trust's website a summary of actions or changes in practice have been made as a result of complaints received by the Trust	would like a response Number of complainants contacted at 6 months with target of 100% Summary of actions taken in response to complaints published on the Trust's website NB: initial results due October 2014

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2.2 Statements of assurance from the board

These are nationally mandated statements which provide information to the public which is common across all quality accounts. They help us demonstrate:

- We are actively measuring clinical processes and performance.
- We are involved in national projects and initiatives aimed at improving quality, for example, recruitment to clinical trials or through establishing quality improvement and innovation goals with commissioners using the Commission for Quality and Innovation (CQUIN) payment framework.
- We are performing to essential standards (CQC) as well as going above and beyond this to provide high quality care.

Review of services

During 2013/14 Southern Health NHS Foundation Trust provided and/or sub-contracted 47 relevant health services. Southern Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 47 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents xxxx per cent of the total income generated from the provision of relevant health services by Southern Health NHS Foundation Trust for 2013/14.

Clinical audits and national confidential enquiries

Clinical audit supports the Trust's overall aim to provide high quality and safe services; it helps to embed clinical quality within services and deliver demonstrable improvements in patient care through the development and measurement of evidence based practice.

During 2013/14 5 national clinical audits and 2 national confidential enquiries covered relevant health services that Southern Health NHS Foundation Trust provides.

During that period Southern Health NHS Foundation Trust participated in 60% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

National Audit /Confidential Enquiry	Eligible
Elective Surgery (National PROMS Programme – eligible for hernia surgery only)	✓
National audit of Schizophrenia	✓

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National comparative audit of blood transfusion (eligible for consent audit only)	✓
Prescribing Observatory for Mental Health (POMH-UK)	✓
Sentinel Stroke National Audit Programme (SSNAP)	✓
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness	✓
National Confidential Enquiry: Gasterointestinal Haemorrhage	✓

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in during 2013/14 are as follows:

National Audit /Confidential Enquiry	**Participated in**
Elective Surgery (National PROMS Programme – eligible for hernia surgery only)	✓
National audit of Schizophrenia	✓
National comparative audit of blood transfusion (eligible for consent audit only)	✓
Prescribing Observatory for Mental Health (POMH-UK)	x
Sentinel Stroke National Audit Programme (SSNAP)	x*
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness	✓
National Confidential Enquiry: Gasterointestinal Haemorrhage	✓

The Trust has recently subscribed to the Prescribing Observatory for Mental Health (POMH-UK) and will be participating in audits led by POMH-UK in 2014/15.

*The Trust currently completes the Sentinel Stroke National Audit Programme (SSNAP) as a local audit but does not submit audit results to the national programme. A process to submit results nationally is being put in place for 2014/15.

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National audit /Confidential enquiry	**% of required cases submitted**
Elective Surgery (National PROMS Programme – eligible for hernia surgery only)	100%
National audit of Schizophrenia	51%
National comparative audit of blood transfusion (eligible for consent audit only)	100%
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness	100%
National Confidential Enquiry: Gasterointestinal Haemorrhage	data collection is underway

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The reports of 0 national clinical audits were reviewed by the provider in 2013/14 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

The Trust has registered to receive the results of the Elective Surgery (hernia) audit and will review the results once received and take action as appropriate.

The national audit report (part two) on schizophrenia is yet to be published. The submission rate for this audit was low with some of the random sample of patients chosen for audit having been discharged or died since audit selection took place.

The national comparative audit of blood transfusion report is yet to be published.

The reports of 66 local clinical audits were reviewed by the provider in 2013/14 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	**Actions**
Health Records – Paper Records Including Quality Aspects - Physiotherapy	All staff to familiarise themselves with the requirements as defined in SHFT Record Keeping Policy and to document; • the service user's perception of their needs • the service user's expectation of intervention • that the clinical impression has been discussed with the patient • that the goals have been agreed with the patient
Choking Screening	• Review and develop staff knowledge in screening for risk of choking in patients with learning disabilities. • To use choking screening assessment tool and specific dysphagia assessment tool. • To ensure relevant information is available when patient is admitted.
Antenatal and Postnatal Care and Perinatal Mental Health	• To review perinatal mental health guideline and RiO Standard Operating Procedure V1.7 [p94] to ensure consistency with recording processes. A family health assessment to be completed at the initial contact with the mother. • All mothers, where a mental health concern is identified, should be assessed for risk of self-harm and this should be documented. • Where a risk of self-harm is identified an action plan should be documented in the RiO record.
Antipsychotic Medication in Dementia	• Consultants /Registrars to discuss and document risks with family member in clinic, CPA or family meeting. • Doctors, nurses and therapists to seek out, implement and document alternative treatments for behavioral, psychological treatments in dementia.
Urinary Catheter Insertion and Ongoing Care	• Meatus to be cleaned with sterile normal saline prior to catheter insertion and urinary catheters should be inserted using an aseptic technique. • All staff who catheterise patients are trained in correct procedures. Antibiotic prophylaxis to be considered for patients who experience trauma during catheterisation. • Reflux of urine is associated with infection and consequently drainage bags should be positioned in a way that prevents back flow

Audit title	Actions
	of urine. • Urine samples should be obtained from the sampling port using an aseptic technique.
Asepsis in Theatre	• To maintain optimal oxygenation during surgery ensure haemoglobin saturation of 95% is maintained. (NICE 2008). • All patients to have temperature measured and documented before the administration of anaesthesia, and then measured and documented every thirty minutes until the end of the procedure. (AFPP 2011). • If detergent and water are used for cleaning, the surface must be physically dried before re-use.
Nasoendoscope Decontamination	• All patients about to undergo surgery or endoscopy should be asked if they have ever been notified as being at increased risk of CJD or vCJD and the response recorded in the patient's notes. • Follow updated decontamination policy in correct storage of nasoendoscopes and maintenance of dirty to clean flow of medical devices. • When/if area is due for refurbishment consider having separate areas dedicated for decontamination. • All work surfaces to be clean and free from clutter. • PPE should be worn as per the SOP for nasoendscope decontamination.

Clinical research

The Trust considers research a critical component of a successful NHS provider organisation. It is our vision that all patients have the opportunity to participate in research.

We aspire to:

- Embed a culture in the organisation that ensures research is a core part of clinical services;
- Embed a culture of evidence based clinical practice;
- Be seen as a leader and host to research in mental health, learning disability and community services;
- Encourage clinical academics, studentships and practitioner researchers; and
- Continue to attract nationally and internationally recognised and funded research, ensuring that we can continue to deliver significant and relevant research for Southern Health NHS Foundation Trust into the future.

The research department supports research in dementia, mental health and community services, such as stroke, diabetes, tissue viability, MSK, Parkinsons and respiratory. Jointly, with the University of Southampton, we host the Memory Assessment and Research Centre (MARC), which is internationally renowned for its research activity into dementia. In 2013/14 we received a certificate of recognition from the National Institute of Health Research (NIHR) for maximising research and we also met our activity targets.

In 2013/14 we hosted 94 clinical research studies (57 Portfolio and 37 Non-portfolio).

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The number of patients receiving relevant health services provided or sub contracted by Southern Health NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 528.

Increasing Patient and Public Involvement (PPI) in research is central to the Research Business Plan. We launched a major PPI in research initiative in March 2013. We have and will continue to engage service users, carers and members of the public in research.

R&D will be expanding in estate and infrastructure to develop a clinical trials facility and increase uptake of clinical trials.

Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Southern Health NHS Foundation Trust income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between Southern Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at: www.gov.uk/government/news/commission-for-quality-and-innovation-scheme-data-available

In 2013/14 income totalling xxxxxxx(available 1.6.14) was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals. In 2012/13 income totalling xxxxxxxx was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals, of which payment of xxxxxxx were received.

Our CQUIN schemes for 2013/14
Insert table – figures available end April

Care Quality Commission registration and actions

Southern Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered in full with no conditions.

The Care Quality Commission has taken enforcement action against Southern Health NHS Foundation Trust during 2013/14.

Southern Health NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2013/14.

The Trust's Quality and Risk Profile (QRP) formulated by the CQC at the end of February 2013 identified the Trust as being at low risk of non-compliance against each of the Essential Standards of Quality and Safety. The QRP is currently being phased out as CQC start their Intelligent Monitoring.

Southern Health NHS Foundation Trust has 51 locations registered with CQC under the Health and Social Care Act (2008) and is compliant with the registration requirements; however in-year inspections by CQC found several units which were not compliant with all Essential Standards of Quality and Safety.

Each Clinical Division is required to have in place local arrangements for reviewing compliance with the CQC Essential Standards of Quality & Safety; expectations are twofold: Divisions must have a systematic way of monitoring evidence of compliance with each of the essential standards for each team/service through the use of the CQC Provider Compliance Assessments and secondly, Divisions must also have local arrangements in place for site visits, peer reviews, mock inspections, etc, to ensure information on PCAs is accurate and standards are being met.

During the spring and summer of 2013/14 inspection toolkits and PCA guidelines were provided to all Divisions and a number of CQC workshops held across the Trust and attended by over 300 staff. Divisional compliance is monitored by the Quality Improvement & Development Forum and details of local monitoring arrangements were requested from Divisions on three occasions during 2013/14.

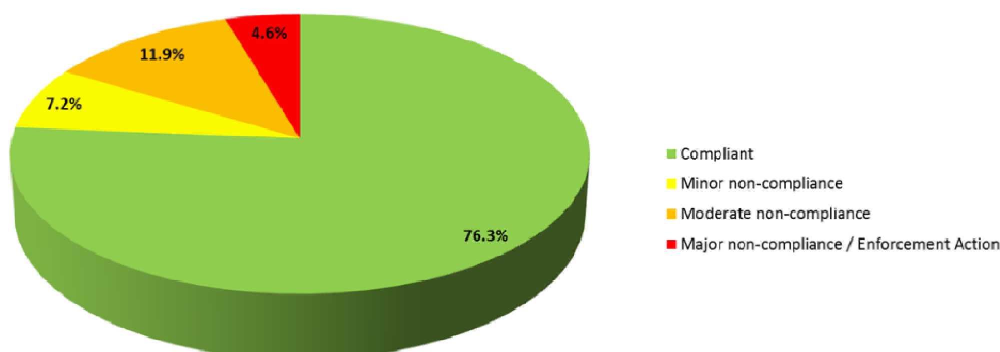
The Chief Operating Officer requested details of each Divisions CQC monitoring arrangements in April 2013, more in-depth detail was requested by the Governance Department in August 2013 and all Divisions were required to complete a modified version of the Monitor Quality Governance Framework in November 2013. The QGF was modified to include additional questions specifically about CQC compliance and serious incident management and reporting.

A central programme of validation of the evidence provided in support of Divisional QGFs is taking place during March to May 2014 following which a report on the status of Divisional Governance arrangements will be presented to the Trust Board and to each Division.

From 1 April 2013 to 31 March 2014 the Trust was inspected by the Care Quality Commission (CQC) against the Essential Standards of Quality and Safety on 41 occasions.

Number of CQC Essential Standards Inspections	**Number of inspections found to be fully compliant**	**Number of inspections found to be non-compliant**
41	24	17

CQC have concentrated their inspections on the Trust's mental health, learning disability and social care services with a total of 194 Outcomes inspected during this period. The chart below details the percentage of these outcomes found to be compliant.



Of the 17 inspections identified as not meeting essential standards, 38 compliance actions and 10 enforcement actions have been issued. The level of concern relates to the potential impact on patients and service users of non-compliance with the standard.

Compliance actions		**Enforcement actions**	
Minor concern	**Moderate concern**	**Moderate concern**	**Major concern**
15	23	2	8

The Enforcement Actions have resulted in nine Warning Notices being issued against the Trust;

- Six at Slade House, Oxford (John Sharich House and the Short Term Treatment & Assessment Team (STATT));
- One at Antelope House, Southampton;
- One at Piggy Lane, Oxfordshire; and
- One at Postern House, Wiltshire.

Plans were implemented on the day of the inspection at each location to address the issues raised and this has meant that several concerns had been resolved prior to CQC's reports being published. CQC have subsequently returned to Slade House to re-inspect and three of the Warning Notices have been lifted. They have also re-inspected Antelope House and have lifted this warning notice. Further warning notices should be lifted following CQC draft report on Slade received 28.4.14.

Analysis of all inspections of Trust services has identified three outcomes where the majority of non-compliance concerns have been identified:

- Outcome 4 – Care & Welfare of People who use the Service;
- Outcome 9 – Management of Medicines; and
- Outcome 16 – Assessing and Monitoring the Quality of Service Provided.

The same issues have been found in more than one unit including:

- Care planning and assessment of the physical health needs of mental health patients, including their medication needs;
- Care plans not reflecting the needs of the person;
- Medicines management on inpatient wards;
- Audits and matron walk rounds not reflecting what is actually seen on units; and
- Actions not being taken following routine assurance checks.

A Trust CQC Steering Group was established in November 2013 to direct, advise and support Divisions to ensure frontline services remain compliant with the Essential Standards. Based on the analysis of inspections above, the priorities for the CQC Steering Group in its 2014/15 work plan will be:

- Establishing baseline compliance statement for every ward/unit/team in the Trust against the current Essential Standards;
- Scrutiny of divisional assurance processes to ensure routine monitoring of quality and standards of care are in place;
- In-depth review of Trust compliance against Core Standards where non-compliance issues have emerged; and
- Review of Action Plans monitoring arrangements at Divisional level to ensure these are implemented effectively and signed off by Divisional Directors.

CQC is developing new approaches to inspections for each care sector which they plan to implement in October 2014. The Trust has asked to be one of the first Trusts inspected under the new mental health and community services regime.

Quality of data

Southern Health NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS Number was:
  99.7% for admitted patient care;
  99.9% for outpatient care; and
  97.0% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was:
  99.9% for admitted patient care;
  99.9% for outpatient care; and
  98.4% for accident and emergency care.

Southern Health NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 80% and was graded green satisfactory.

Southern Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission. A scheduled audit in February 2014 has been postponed until April 2014.

Southern Health NHS Foundation Trust will be taking the following actions to improve data quality:

- Significant work has been undertaken and will continue to ensure the data quality underpinning our reported performance is of a sufficiently high standard this year;
- The Trust has achieved this through a dedicated data quality work programme that has supported clinicians to ensure the data held within our Electronic Patient Record is robust and updated in a timely manner; and

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- As such the Trust ensures clinical data is used to report performance, avoiding the need for manual collection of performance information.

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2.3 Reporting against Core Indicators

From 2012/13 NHS foundation trusts are required to report against a core set of indicators relevant to the services they provide, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012. The data is presented in the same way in all quality accounts published in England so that readers can make a fair comparison between trusts.

Southern Health NHS Foundation Trust is reported and compared as a Mental Health/Learning Disabilities Trust.

As required by point 26 of the NHS (Quality Accounts) Amendment Regulations 2012, where the necessary data is made available by the Health and Social Care Information Centre, a comparison is made of the numbers, percentages, values, scores or rates of each of the NHS foundation trust's indicators with
a) the national average for the same; and
b) those NHS Trusts and NHS Foundation Trusts with the highest and lowest of the same.

Our Patients on a Care Programme Approach who were followed up within 7 days of discharge
The data made available to the National Health Service Trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

The Southern Health NHS Foundation Trust considers this data is as described for the following reasons, taken from national dataset using data provided.

Inconsistences in the approach to reporting of this indicator were identified and Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services,

- Re-affirmed guidance based on Monitor criteria to clinical services regarding documentation in the patient electronic record
- Clinical services completed data quality review of this indicator with audit of 7 day follow up data to be completed on regular basis within services

Indicator	Percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	95.4%	96.9%	97.0%
Average Trust Score			For Dec 2013-Jan 2014 74.7%
Highest Scoring Trust			
Lowest Scoring Trust			

Our crisis resolution teams
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

The Southern Health NHS Foundation Trust considers this data is as described for the following reasons, taken from national dataset using data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by reviewing information per team and identifying areas where improvements may be made. These are further detailed in our Performance reports to Board.

Indicator	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	97.9%	97.4%	99.7%
Average Trust Score		97%	
Highest Scoring Trust		100%	
Lowest Scoring Trust		20%	

Our readmission rate for children and adults
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged-
(i) 0 to 15; and
(ii) 16 or over
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.

The Southern Health NHS Foundation Trust considers this data is as described for the following reasons, taken from national dataset using data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by reviewing our discharge procedures and analysing information to identify areas for improvement with action plans developed as required. These are further detailed in our Performance reports to Board.

Indicator	The percentage of patients aged 0-15 years readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	0.0%	0.0%	0.0%

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Average Trust Score			
Highest Scoring Trust			
Lowest Scoring Trust			

Indicator	The percentage of patients aged 16 or over years readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	10.2%	8.7%	7.4%
Average Trust Score			
Highest Scoring Trust			
Lowest Scoring Trust			

The percentage of staff who would recommend the trust as a provider of care, to their family of friends
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to 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.

The Southern Health NHS Foundation Trust considers this data is as described for the following reasons, taken from national dataset using data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by developing a workforce strategy and action plan based on key findings from the staff survey. These are further are detailed in our Performance reports to Board.

Indicator	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.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	63%	62%	61%
Average Trust Score		60%	59%
Highest Scoring Trust	Not available		
Lowest Scoring Trust			

Patient experience of community mental health services
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust’s ‘Patient experience of community mental health services’ indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.

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The Southern Health NHS Foundation Trust considers this data is as described for the following reasons, taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by analysing results from the patient survey and discussing with service users and carers improvements to be made. These are further detailed in divisional action plans and Performance reports to Board.

Indicator	Patient experience of contact with a health or social worker		
	2011-12	2012-13	2013-14
Southern Health	Not available	8.9	8.0
Average Trust Score	Not available		
Highest Scoring Trust		9.1	9.0
Lowest Scoring Trust		8.2	8.0

Our rate of patient safety incident reporting
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to 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 patent safety incidents that resulted in severe harm or death.

The Southern Health NHS Foundation Trust considers this data is as described for the following reasons, taken from national dataset using data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by rolling out a training programme to staff on accurate completion of incidents including correct categorisation, auditing random samples of incidents for accuracy and feedback to managers on the timely review of incidents. These are further detailed in our incident reports to Board.

Indicator	Number of patient safety incidents reported to the National Reporting and Learning Service.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	5704	5106	7586
Average Trust Score			
Highest Scoring Trust			
Lowest Scoring Trust			

Indicator	i)Number and ii)percentage of such patient safety incidents that resulted in severe harm or death.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	1.26%	i) 118 ii) 1.94%*	i) 58 ii) 0.8%
Average Trust Score		Oct 2012-Mar 2013	

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		1.3%	
Highest Scoring Trust			
Lowest Scoring Trust			

*these are updated figures and so are different to those reported in the 2012/13 Quality Report.

Friends and Family Test
Southern Health NHS Foundation Trust currently provides all physical health community patients with the option of completing a Friends and Family survey. During 2013/14 a total of 28,014 surveys were responded to with 96.2% of patients saying they would recommend our services to friends and family.

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Part 3: Other Information

Progress made in meeting our priorities for improvement in 2013/14
In the 2012/13 Quality Report we set out specific areas for improvement based on the three dimensions of quality identified by Lord Darzi and chosen following feedback from our patients, stakeholders and staff. These priorities for quality improvement are chosen to be representative of our work on continually improving the quality of care we provide and there are many other areas of quality improvement across the Trust – these priorities are just a selection. We have monitored and reported to the Board our performance against these priorities throughout the year.

In 2013/14 as in previous years, we set ourselves challenging and aspirational targets to support the three dimensions of quality:

- Improving patient safety;
- Improving clinical outcomes; and
- Improving patient experience.

Priority 1: Improving Patient Safety

1.1 To reduce the risk of falls by ensuring 90% of inpatients in Community Hospitals and Older People's Mental Health wards at risk of falling have a falls care plan completed within 6 hours of admission

Our aim
Falls are one of the highest reported patient safety incidents in our inpatient settings, and although most do not result in serious harm, we recognise that any fall can lead to loss of confidence and increased length of stay in hospital. We want therefore to ensure patients are safe in our care and that we minimise the risk of falling by completing a falls care plan on admission.

What we have achieved
We have achieved this target. Results from a check of patient's records by the matron when doing a quality focused walk round of the ward found over 90% of patients had a falls care plan completed within 6 hours of admission.

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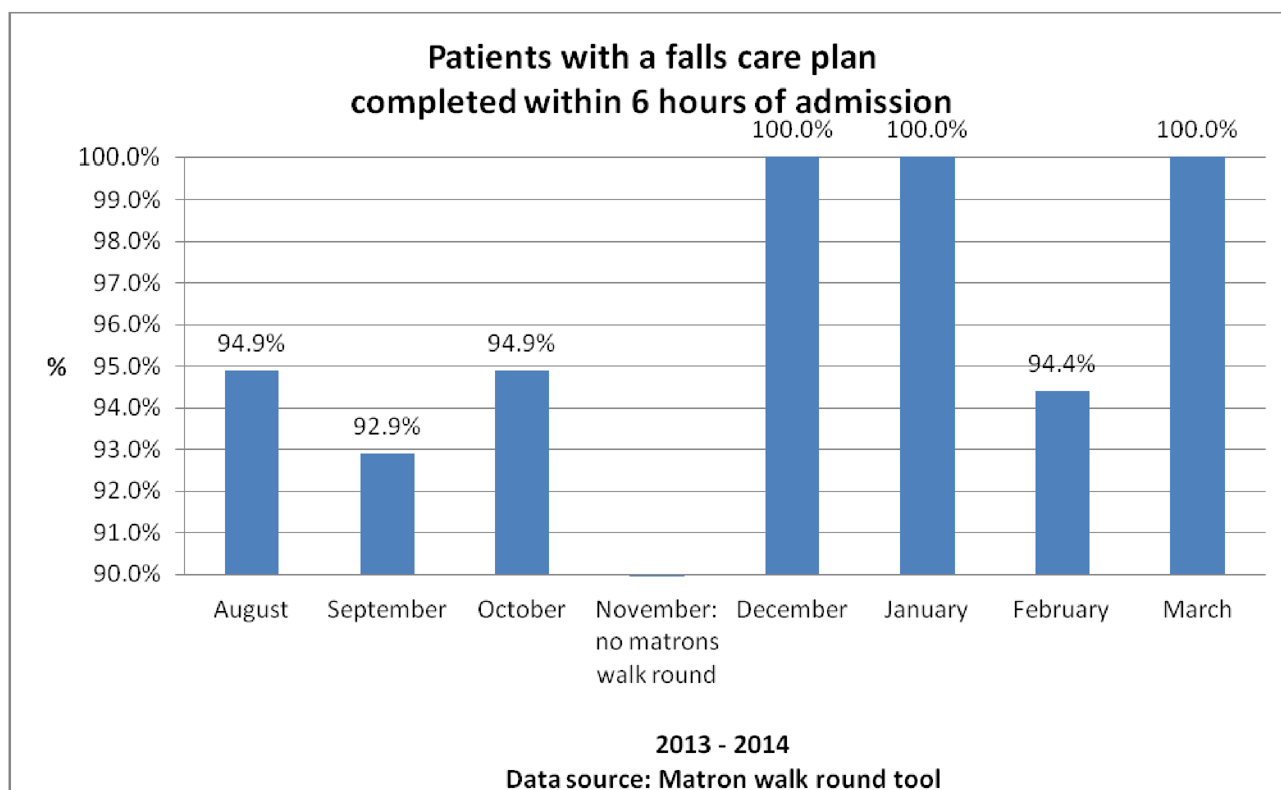

- There has been a 29% reduction in 2013/14 in the number of patients who have had a fall which resulted in major surgery, for example, a broken hip, with 22 incidents compared to 31 in 2012/13. This means 9 fewer patients experienced pain, distress and an acute hospital admission.

What we did in 2013/14 and future plans

- We identified a staff member on each ward to be a 'falls champion' who works closely with the falls prevention team to analyse trends in falls and share learning with actions taken as required. These can be quite simple, for example, providing slippers for patients with inappropriate footwear.

- We continued the development of falls training making the Royal College of Physicians e-learning programme, 'preventing falls in hospital' available on our website for all staff to use.

- Following the successful pilot of a new inpatient falls care plan which provides clear guidance to staff in screening and assessing people at risk of falling, we are rolling out the new falls care plan across the whole Trust.

- Clinical audits showed an increase in the numbers of patients with a falls care plan completed within 6 hours of admission in community hospitals with the percentage rising from 80% in April to 93% when re-audited in November. There was a dip in audit results on Older People's Mental Health wards from 89% in April to 73% in November. The falls team are working closely with these ward staff to ensure that falls care plans are completed.

- This indicator has been met and so is not repeated in 2014/15, although work programmes to reduce falls will continue.

1.2 Numbers of avoidable grade 3 and 4 pressure ulcers acquired whilst in our care to reduce by 30% from baseline prevalence identified in each Integrated Service Division.

Our aim

Pressure ulcers are wounds that develop when constant pressure or friction on one area of the body damages the skin. They can be painful and lead to an increased risk of infection. Pressure ulcers are graded using the European guidance system from grade 1 to 4 with 4 being the most serious. The number of patients who develop pressure ulcers while in our community hospitals has reduced significantly over the past two years, while numbers have remained essentially the same for patients cared for by our community teams in their own homes. We want to see a similar reduction for these patients and ensure they are safe in our care. We have therefore repeated a similar indicator from last year.

What we have achieved in 2013/14 and future plans

We have partially achieved this target with a 30% reduction in avoidable grade 3 and 4 pressure ulcers in two divisions with community care teams in South East and North Hampshire successfully meeting the target.

Every grade 3 and 4 pressure ulcer is investigated by a senior staff member with support from the tissue viability team to identify causes and contributory factors. Six key themes have been identified, which mirror national trends; documentation, staff/patient/carer education, communication between multidisciplinary teams and agencies, equipment and staff factors such as leadership, vacancy rates and use of key workers. A Trust wide pressure ulcer reduction plan has taken these key themes into consideration with specific work undertaken during the year to address these issues.

Numbers across the Trust were on a downward trend in quarters 1-2 but there has been significant rise in quarter 4, mostly in West Hampshire. The West division has seen an increase in the numbers of patients who at the end of their life are choosing to die at home and who are at increased risk of pressure ulcers. There are also recruitment pressures across the Trust with difficulties filling vacancies which reflect the national picture.

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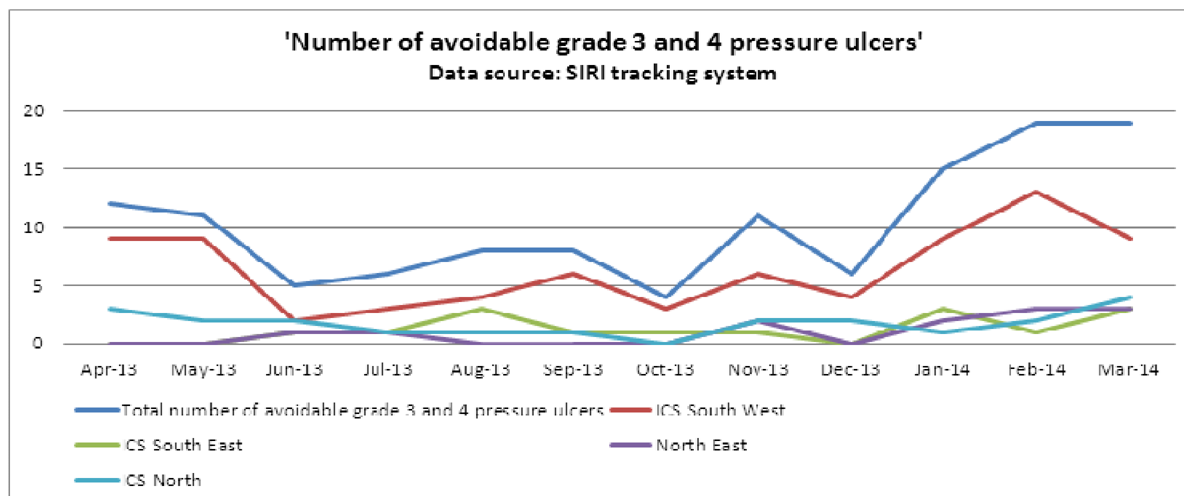

Avoidable grade 3 and 4 pressure ulcers			
Division (community care teams)	**Target** (based on 2013/14 figures from Pressure Ulcer report)	**Actual**	**30% reduction achieved**
South East	36	15	
Southampton and West	51	76	
North	24	21	
North East	6	12	

What we did in 2013/14 and future plans

- We have implemented a Trust wide plan to reduce numbers of pressure ulcers which includes sharing learning from analysis of the causes of pressure ulcers and actions to be taken. A key focus is to embed learning from divisions who have successfully reduced pressure ulcers to all clinical teams and ensure learning is sustained over time.

- A clinical academic fellow has been appointed to complete a four year study into the role of nursing and other staff in pressure ulcer reduction.

- A flow chart has been developed to help staff identify that they have taken all the necessary actions to avoid pressure ulcers developing.

- In November, pressure ulcer prevention week saw the launch of ‘spot the signs’ and a patient specific leaflet ‘how to prevent pressure ulcers’ aimed at supporting discussion of key issues with patients and carers.

- Training is provided by the tissue viability team to all relevant staff including primary care and residential home staff. They have also introduced a very successful telephone support line to give advice and support.

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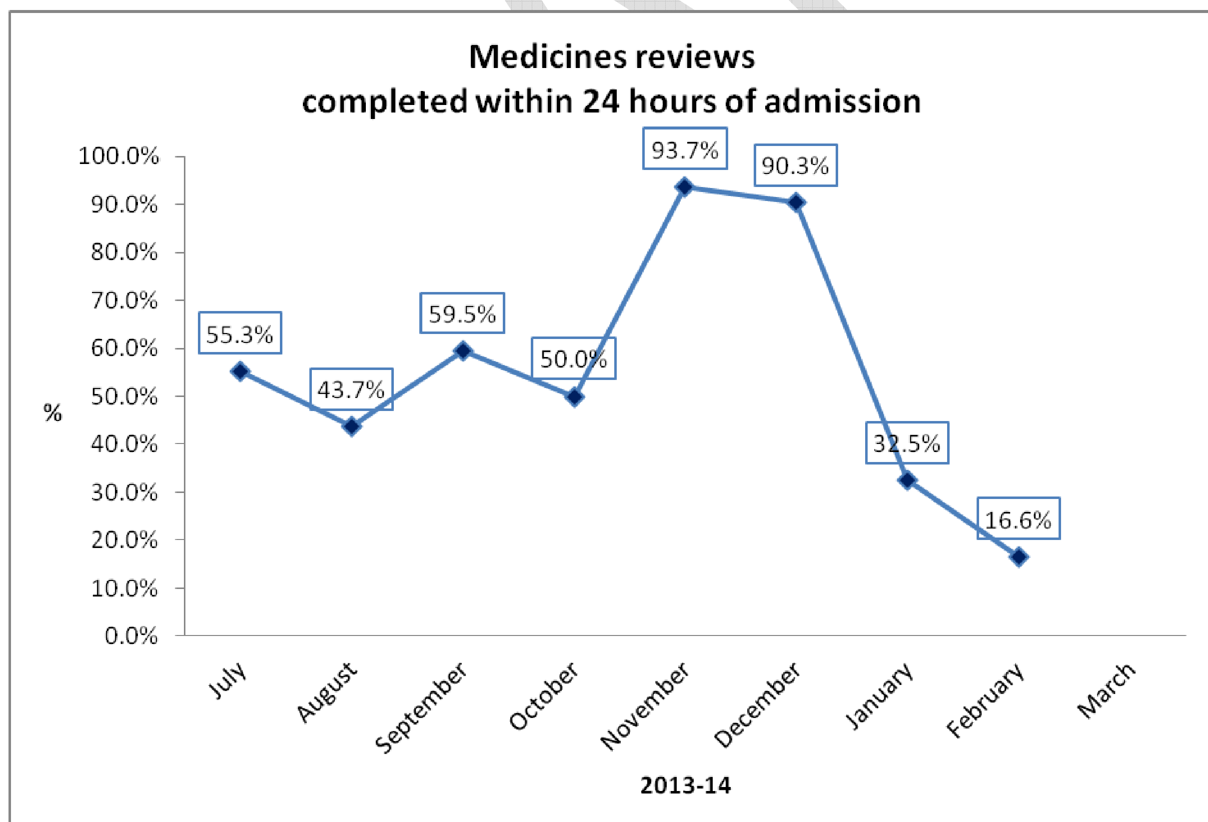
- We will engage in new initiatives, for example 'stamp out sores' campaign, in collaboration with our commissioners, acute hospitals and others to reduce pressure ulcers in 2014/15.

- We are repeating a similar indicator for 2014/15.

1.3 80% of inpatients have their medicines reviewed within 24 hours of admission

Our aim
We aim to review the medicines patients are taking when admitted to our inpatient units to ensure safe care and reduce any potential harm to the person from taking the wrong medicines. Last year we found variability between services in their ability to carry out medicines reviews within the set time frame and so repeated a similar indicator this year to ensure that medicine reviews are available to all inpatients in a timely way.

What we have achieved
There have been technological difficulties with the web based data collection system which makes it difficult to interpret the results. Manual data collection in November and December resulted in a large increase in reported results which may represent a more accurate picture of medicines reviews within 24 hours of admission and would mean that the target was achieved.



Feb/March data needs to be added

What we did in 2013/14 and future plans

- We introduced a web based data collection system so that data can be collated and analysed centrally with the aim to identify trends across inpatient sites and highlight areas of underperformance which can be targeted. However there have been technological difficulties with the system which are being resolved so that collation of data is accurate.

- Current training programmes have been updated with particular focus on junior doctor training.

- A proposal for increased pharmacy capacity was presented to the Board in January with agreement reached for additional funding for the pharmacy team enabling recruitment of additional staff so as to provide more effective medicines cover across the whole Trust.

- We are repeating a similar indicator in 2014/15 to confirm that medicines reviews are being completed within best practice time frames.

Priority 2 Improving Clinical Effectiveness

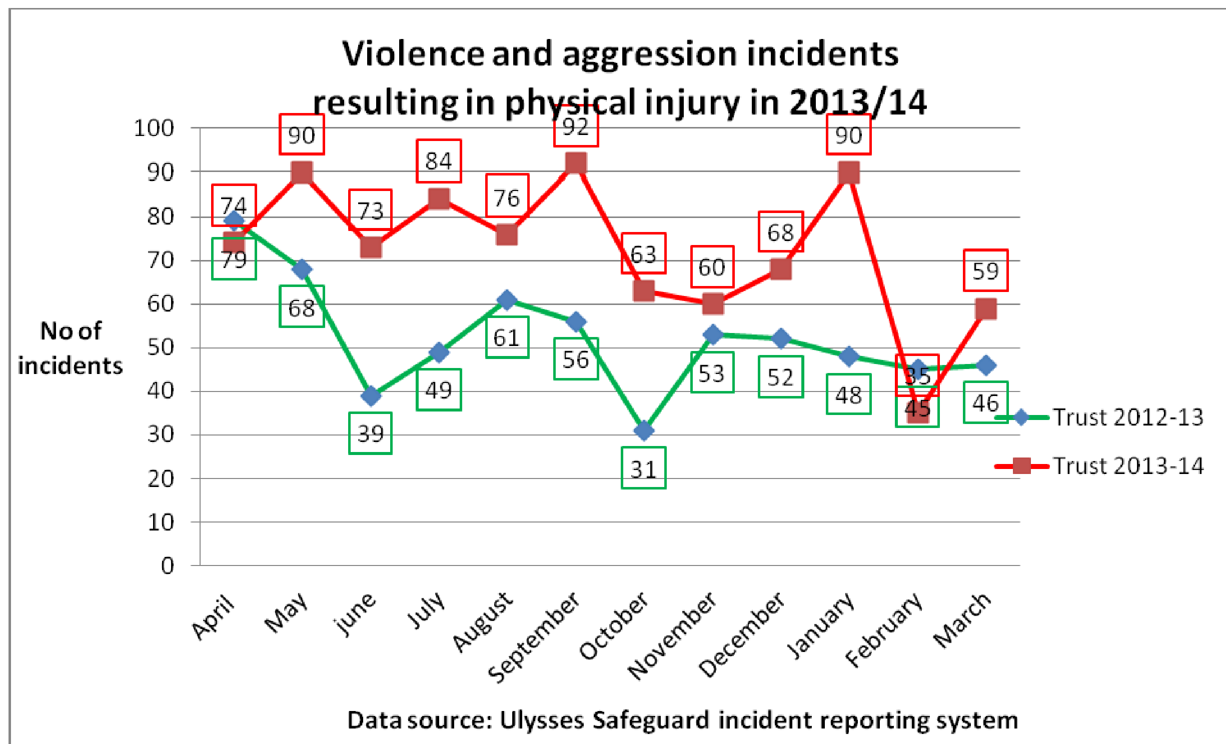
2.1 Improve therapeutic interventions in Mental Health and Learning Disabilities services to reduce patient violent and aggressive incidents which result in physical injury by 10%.

Our aim

Patients experiencing mental health distress can at times express this through violent or aggressive behaviour. Our aim is to work with them to manage their distress and avoid violent behaviour wherever possible. If it occurs we want to address it in a way that is safe for all concerned and minimises the use of coercion.

What we have achieved

We have not achieved this target. It was an ambitious one as a 14.8% reduction in violent and aggressive incidents resulting in physical injury as defined by the National Reporting and Learning System was achieved last year. We are also now including incidents occurring in the former OLDT which makes the target even more ambitious. Although the reduction target is not being met, there are downward trends in Mental Health, Learning Disabilities and OPMH services, with the exception of a spike in January 2014. These spikes can reflect the admission of an individual patient with challenging behaviour to an inpatient unit.



What we did in 2013/14 and future plans

- We reviewed the data on violent and aggressive incidents in monthly meetings to identify trends or hot spots and found no unexplained spikes or variation in incidents which would cause concern. It is anticipated that trends will remain flat on the basis of the increased acuity of patients in inpatient units.

- One OPMH ward are piloting the use of a new lighting system specifically designed to foster calmness and reduce violent and aggressive incidents. This pilot will be evaluated as to the benefits of using such lighting more widely across the trust.

- A working group has been set up in mental health services to embed recovery principles in acute care with a focus on initiatives such as increased use of peer support workers which research has shown helps reduce violent incidents and 'No Force First' principles where de-escalation techniques are used to prevent violent and aggressive incidents.

- We have developed a SAFER programme which will continue into 2014/15 and is focused on providing safe environments and minimising the use of restrictive practice. The programme has several measures and includes refining our training to reflect the current evidence base, development of 'safe wards', reduction in the use of seclusion and developing peer support workers.

- We are introducing a framework for Positive Behavioural Support which will include the introduction of Behavioural Support Plans. These will focus specific care and support to address challenging behaviour or violent and aggressive behaviour.

- We will improve environments so that we minimise the negative impact of oppressive environments on how patients behave and recover.

- We will continue to focus on the minimising of violence and aggression in our inpatient areas and have included in our priorities for 2014/15.

2.2 Prevent patients and service users deteriorating unexpectedly by using the track and trigger tool as an early warning system for 90% of appropriate patients and service users.

Our aim

Early warning systems help staff recognise the early warning signs of possible deterioration in a patient's vital signs so that prompt action can be taken to ensure appropriate treatment is given. We therefore developed a 'track and trigger' early warning system whose roll out to all services in 2012/13 took longer than anticipated and so we did not meet the quality improvement priority last year regarding its use. We want to identify early signs of deterioration so we can best help patients and so repeated the priority for 2013/14.

What we have achieved

We have achieved this target. Clinical audits have shown an increased use of the track and trigger observation charts during 2013/14 with the latest audit in November 2013 reporting 91% of appropriate patients were assessed using the track and trigger observation charts.

Clinical audit results in use of an early warning system/track and trigger system

	Sept 2011 (modified early warning system)	March 2013 (track and trigger)	Nov 2013 (track and trigger)
Community Hospitals	75%		
All services		69%	91%

There have been no reported deaths in community hospitals in 2013/14 where the early signs of deterioration have been missed.

What we did in 2013/14 and future plans

- We continued the roll out to all clinical services of 'track and trigger' observation charts to monitor patient's vital signs as part of an early warning scoring system to detect clinical deterioration.

- We have reviewed and revised the Physical Assessment and Monitoring Policy to make guidance clearer to staff, particularly for mental health and learning disabilities teams where the monitoring of the physical health needs of patients is less well established.

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- We have provided a training programme in physical assessment and monitoring for all new starters with a set of clinical competencies to be achieved within first 6 weeks. Bespoke training has been delivered to junior doctors.

- Throughout the year we monitored use of 'track and trigger' as part of the matron quality walk round and found variability across divisions in their use of the 'track and trigger' observation charts. Targeted support has been given to teams where the use of this early warning system is less well embedded. Latest matron walk round results for February and March 2014 show 93.9% and 92.0% of patients respectively have been assessed using track and trigger observation charts.

- The Trust's resuscitation group is currently reviewing the 'track and trigger' system in the light of a revised national early warning system (NEWS) and will make recommendations for revision as appropriate.

- In our priorities for improvement in 2014/15 we will look at learning from analysing deaths which will include consideration of effective use of early warning systems.

2.3 Five Outcome Frameworks will be introduced to demonstrate improved clinical outcomes for patients/service users.

Our aim
We want to move away from counting activities as a measure of performance to focus instead on what we need to do to ensure a positive clinical outcome is achieved for every patient we care for. We want to develop 'Outcome Frameworks' which gather all aspects of service delivery that need to be in place in order to ensure positive outcomes for patients. This was a new indicator for 2013/14.

What we achieved
We have achieved this target with five Outcome Frameworks developed with clinical services and populated with key information to support their planning for service improvements and improved clinical outcomes for patients.

What we did in 2013/14 and future plans

- The Service Improvement Project manager led on this project and developed a project plan to meet this indicator. She worked closely with a small number of clinical services to identify factors that are necessary to have in place in order to achieve the desired outcomes for patients. For example, the prevention of health crises for patients seen by the community care teams included measures about how well the patient was able to manage their own condition. It included information about whether the patient had been given information which was relevant and helpful, how confident the patient felt in managing their own condition and whether the patient had been involved in planning their own care.

- Information on many measures has been collated into outcome frameworks so that clinical services can now be supported to review and interpret the data and use to plan for service improvement. The frameworks will support services to plan for

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positive clinical outcomes and identify any key issues which need to be addressed to achieve the best care for patients.

- This indicator has been met and will not be included in 2014/15 priorities for improvement, however the project is continuing next year and will embed the use of existing outcome frameworks within services and develop further frameworks.

2.4 All Community Hospitals and Older People's Mental Health wards will provide dementia friendly environments.

Our aim
We want the Trust to be a dementia friendly organisation and to provide appropriate dementia friendly environments for all inpatients in Community Hospitals so that their stay in hospital is as comfortable as possible. Clinical audit in 2012 found there were some areas where we could improve to meet the needs of patients with dementia. This was a new indicator for 2013/14.

What we have achieved
We have successfully completed the project plan developed to achieve this indicator and are pleased with progress made. However we are aware of some of the actions required following a CQC inspection of an Older People's Mental Health ward and will continue to support dementia friendly initiatives.

What we did in 2013/14 and future plans

- Key staff attended King's Fund training on providing dementia friendly environments with information cascaded to clinical teams.

- We successfully piloted use of dementia leads for each ward who led on dementia friendly objectives for their area with dementia lead programme being extended to all wards.

- We have worked collaboratively with key partners to develop a dementia friendly strategy and to drive work streams in education, environment and awareness. The Trust's dementia lead is working with local county councils and acute hospitals to scope and develop training and education provision.

- Observational audits in the community hospitals found evidence of good practice in providing dementia friendly environments with clear signs in place, date information and clocks in all of the bays, and that staff were welcoming and spoke in a calm and professional manner to patients with dementia. These observational audits will be repeated in 2014/15.

- Fleet Hospital is working with Alzheimer's UK and patient/carer's associations to become part of a dementia friendly community.

- Romsey Hospital has been redecorated to be a dementia friendly environment.

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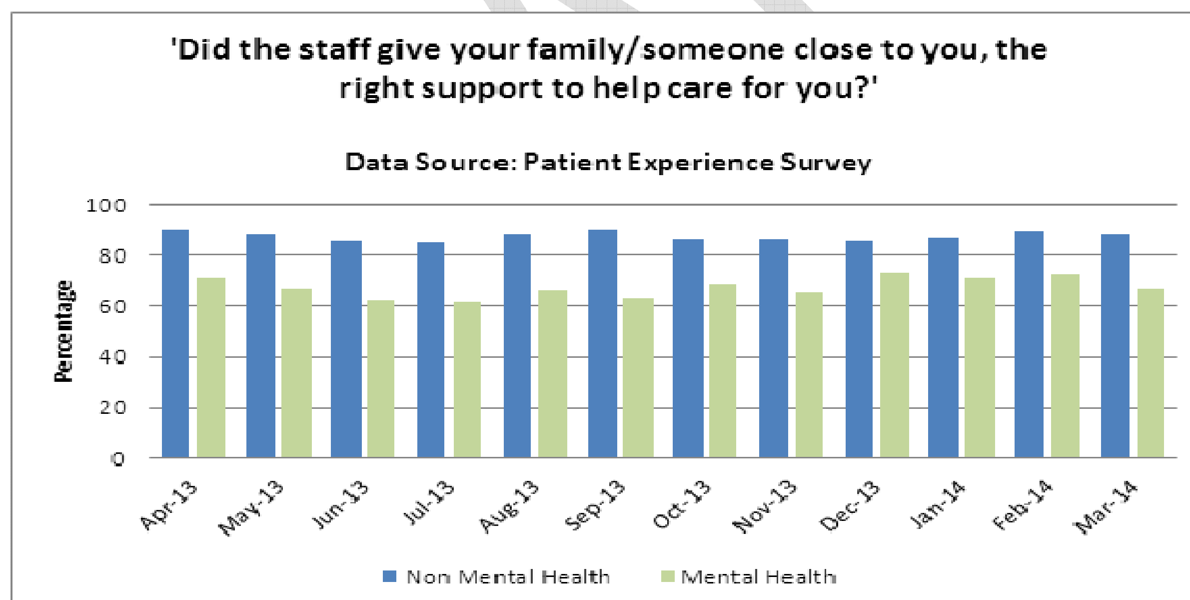
- This indicator has been met and will not be included in 2014/15 priorities for improvement, however we will continue with work already started with key partners to ensure dementia friendly initiatives are successfully continued.

Priority 3: Improving Patient Experience

3.1 95% (75% in mental health services) positive response to the question 'did the staff give your family/someone close to you the right support to help care for you?' on our patient experience surveys.

Our aim
We recognise the importance of families or someone close to the patient in helping care for them. Our patient experience surveys in 2012/13 showed lower positive responses to our support for carers than other survey questions. We wanted to improve our carer support, leading to improved experience of our service. This was a new indicator for 2013/14.

What we have achieved
We have not quite achieved the target we set ourselves with 87.6% of patients responding positively in non-mental health services and 67.5% of patients



responding positively for mental health services on patient experience surveys. Different targets for mental health services are set internally to take into account the different nature of their caseload.

What we did in 2013/14 and future plans

- We have carer forums and drop in meetings for people and their relatives with advice and information given and signposting to local voluntary support groups and national helplines.

- We involve carers as much as possible in the care planning for their relatives so that we are choosing goals that are important to the patient and their carers and are designing our services to meet their needs.

- We provide facilities for carers to stay overnight in hospital where possible when a relative is close to the end of life.

- We involve carers in planning for the discharge of their relative from inpatient settings so that the most appropriate care is available for the patient when they leave.

- A specific carer's survey was launched in February 2014 with roll out across the whole Trust over the coming months. It is a little early for results but once received the divisions will use the feedback to help shape our support for carers and patients.

- Supporting carers and listening to their feedback to improve services is one of our priorities for improvement in 2014/15.

3.2 Achieve 95% (75% for Mental Health services) excellent in the Friends and Family Test

Our aim
We believe patients should be at the heart of everything we do and should drive the design and delivery of our care to them. We want to use their feedback to identify and implement service improvements so that we are continually improving the experience people have of our services.

What we have achieved
We used the question 'How likely are you to recommend our services to friends and family if they needed similar care or treatment?' on our patient experience surveys as the measure. We have different targets for mental health services as explained above. We achieved this target with 96.1% of patients responding positively in non-mental health services and 90.6% in mental health services.

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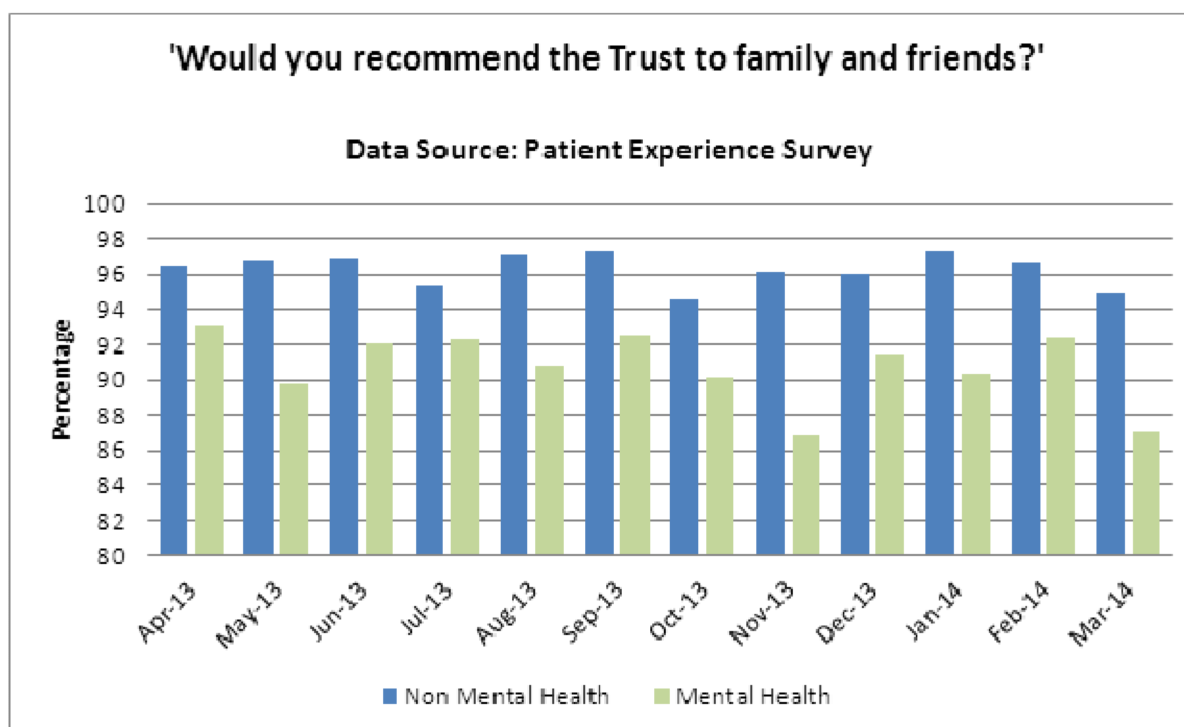

What we did in 2013/14 and future plans

- We review patient's feedback within divisional and team meetings and take action to address issues raised, for example, we bought name badges for staff as patients commented they could not read staff ID badges easily.
- We have launched new patient experience surveys for our learning disabilities and social care divisions.
- We have implemented actions to increase the numbers of surveys returned.
- We will continue to seek patient's feedback so we can improve their experience of our services and have included a similar indicator for 2014/15.

3.3 100% compliance with Duty of Candour obligations for suspected or actual patient safety incidents that result in severe harm or death

Our aim

We want to be open with patients and their carers when something has gone wrong with their care and to apologise and ensure lessons are learned. We want to be an organisation where patients have trust in the services we are providing.

What we have achieved

We have achieved this target. Quarterly audits of serious incidents have shown that staff apologise and give a full explanation to patients and their carers on those occasions, which do not happen often, where something has gone wrong with their care.

We have tried our best to contact a carer or next of kin for these discussions but on 6 occasions this year have been unable to either identify or involve a carer or next of kin.

What we did in 2013/14 and future plans

- Every serious incident is reported by staff on the Ulysses Safeguard reporting system and investigated by a senior manager who looks at the underlying causes and contributory factors and makes recommendations for actions and learning. These aim to reduce the likelihood of a similar incident occurring in the future. Prompt questions to ascertain staff were being open and discussing with patients and carers when something has gone wrong with their care were added to the incident reporting and investigation documentation and audited on a quarterly basis by the Serious Incident Manager.

- From April 2014 the paper based audit system will be replaced by electronic reporting which will make it easier to analyse information, identify trends and share learning.

- The principles of duty of candour have been highlighted in induction training and incorporated into specific training on serious incidents.

- We will revise the existing 'Being Open' policy to encompass the principles of duty of candour and the Francis Report recommendations.

- We will continue to embed the principles of being open in everyday practice but will not include as a specific indicator in 2014/15.

Performance against key national priorities

The dashboard with relevant indicators and performance thresholds set by Monitor for 2013/14 shows the Trust was compliant with all 14 Monitor non-financial indicators by year end. 13 of these indicators were met throughout the whole year with only one indicator, percentage of patients receiving a 7 day follow up, showing inconsistent achievement. Focused work within clinical services to provide 7 day follow ups have resulted in thresholds being met December onwards.

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Improving patient and user experience : Achieving Monitor access to care and outcome standards — Version 1.1

Achieving Monitor access to care and outcome standards

Indicator	Target / Tolerance	Last 12 months	Current quarter	Last month	3 month Trend
% of patients experiencing a delayed transfer of care within a Mental Health Inpatient facility	5.0% / 7.5%	2.5%	1.8%	0.8%	▼
% of patients receiving a 7 day follow up	97.0% / 95.0%	97.0%	98.4%	97.8%	▲
% of patients receiving a 12 month review	97.0% / 95.0%	98.9%	98.3%	97.8%	▼
% gatekeeping compliance for inpatient admissions	97.0% / 95.0%	99.7%	100.0%	100.0%	▲
EIP new referrals (reported as year to date)	100.0% / n/a	187.5% YTD	186.9%	187.5%	▲
Mental Health Minimum Data Set - Identifiers	99.5% / 97.0%	99.7%	99.8%	99.8%	▲
Mental Health Minimum Data Set - Outcomes	60.0% / 50.0%	86.1%	84.5%	84.4%	▼
Community Data Set compliance	60.0% / 50.0%	99.1%	99.0%	99.1%	▼
Infection Control (Community C Difficile)	4 / n/a	3	0	0	▼
Access to Care : Learning Disabilities	Green / n/a	G	G	G	◄
Access to Care : Admitted 18 week wait	94.0% / 92.0%	97.7%	97.8%	97.8%	▲
Access to Care : Non admitted 18 week wait	97.0% / 95.0%	99.5%	99.3%	99.0%	▼
Access to Care : Incomplete pathways within 18 weeks	94.0% / 92.0%	98.8%	98.0%	97.5%	▼
A&E attendances completed within 4 hours	97.0% / 95%	98.9%	99.1%	99.0%	▲

Monthly Performance for the last 12 months: Apr 13, May 13, Jun 13, Jul 13, Aug 13, Sep 13, Oct 13, Nov 13, Dec 13, Jan 14, Feb 14, Mar 14

Created by the Southern Health Information Team

Board Leadership, assurance and governance

The Board's vision for quality is aligned with the Trust's strategic vision, core values and business strategy which is being finalised for both the two and five year operational plans to be submitted to Monitor this year.

At each board meeting, directors review measures which indicate how the organisation is performing in relation to quality, safety, clinical performance, finance and workforce. The Board has been clear throughout the year that any examples of poor quality or performance must be tackled swiftly and purposefully. Following the CQC inspections which resulted in enforcement actions to some of our inpatient sites, the Board initiated an external review by Deloitte of both corporate and quality governance structures within the Trust. Although their report is generally positive, a number of recommendations are made to strengthen the infrastructure, systems and procedures across the Trust and divisions so that poor performance and quality are identified quickly with actions taken to resolve immediately. Further details are given below.

All Non-Executive directors take an active and challenging role at the Board and board committees.

Independent Governance reviews by Deloitte

In January 2014 Deloitte concluded an independent Board Governance and Quality Governance Reviews of the Trust. Their reports convey a balanced perspective and identified many positives in relation to the organisation:

- *Board Governance* - findings from the Board Governance review were grouped around two themes: Board leadership, capability, roles and responsibilities and Board processes and systems. The report stated the most significant governance issue for the Trust being the risk associated with maintaining Board oversight and control during a period of significant change as the Trust moves towards greater divisional autonomy. It acknowledged the Trust is making significant progress but further work is required to finalise management structures, strengthen risk registers, streamline reporting, get the right balance for divisional accountability/corporate control and generally manage the cultural transition. The report recommended the Board as a whole needs greater oversight of this transformation than it has at present. Twenty-nine recommendations were made in relation to this and other issues pertaining to Board sub-committee portfolios and Executive responsibilities.

- *Quality Governance* - The report made 26 recommendations themed around each of the Monitor Quality Governance Framework domains and key risks identified included a lack of implementation of the Trust's Quality Strategy due to its recent release, the need to finalise the updated Risk Management Strategy and Policy, the completeness of divisional risk registers and lack of structured reporting in relation to the quality impact of CIPs. The report noted positively that the Quality and Safety Committee functioned well and brought effective challenge on quality however the quality governance structures and systems in the newly formed divisions were still in varying stages of development and will take time to become fully embedded.

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Deloitte also found several areas of good practice in relationship to quality and quality governance including:

- An innovative programme of combined leadership development and behaviour based appraisals which are focused upon improving patient experience, care and the working environment;
- The development of a performance management framework into Divisions which are supported by integrated performance dashboards and information;
- Staff were positive about communications at the Trust; and
- A defined divisional leadership team who are positive about the devolved accountability structure as well as the degree of collaboration and support from the Executive members of the Board.

The Trust Board accepted the Deloitte findings and recommendations and approved the management response and action plans at the Board in March 2014. Many Deloitte actions align with the outputs of the Risk Management Development Programme which was procured and commenced prior to the receipt of Deloitte's reports.

Learning Disability Services

Following the death in July 2013 of a patient in one of the Trust's non-Hampshire Learning Disability Services, the Trust commissioned an independent investigation from Verita.

In September 2013 the unit where the patient died was inspected by CQC and failed all the outcomes against which it was assessed. Since then a number of non-Hampshire Learning Disability Services have also been inspected and serious concerns identified in some of these inspections. Of the nine warning notices issued against the Trust, eight relate to the non-Hampshire Learning Disability Services.

The Verita investigation was completed in February 2014 and concluded that actions which should have been taken to manage and minimise the risk to the patient were not taken and the patient's death was therefore preventable. The Trust has publicly accepted the findings and recommendations, published the report and apologised to the family of the young man who died. Thames Valley Police are still considering the findings from the report however the Health and Safety Executive have advised they will be taking no further action.

Since the patient's death the Trust has put in place a number of measures to improve the clinical systems and processes in the non-Hampshire Learning Disability Services to safeguard patients and increase and strengthen clinical leadership in these units. MBI Health is also working with the Learning Disability Management Team to review the model of care and implement a comprehensive plan of action to further strengthen safety and quality in the coming months.

Concerns about the quality governance and assurance arrangements in the non-Hampshire Learning Disability Services and the wider Trust, have been raised by commissioners, the NHS England Regional and National Teams. The Trust has been the subject of local Quality Surveillance meetings, invited to attend two Risk Summits chaired by NHS England, and a Board to Board meeting with our largest

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commissioner, West Hampshire Clinical Commissioning Group. Throughout the Trust has been commended on its openness about the challenges it faces and for its co-operation with stakeholders in the quality surveillance process; at each meeting the Trust has shared its improvement plans in Learning Disabilities and for the wider Trust to enable these to be challenged and scrutinised and to date no significant concerns have been raised; formal feedback relating to the outcome of the last Risk Summit in March is awaited.

The Trust Chief Executive Officer and the Chief Operating Officer/Deputy Chief Executive met with the Chief Executive of the CQC and, Regional Director in March 2014. This was a constructive meeting where the Trust shared good practice as well as discussed the Trust's highest risk areas and actions being taken to address these. In February 2014 the Chief Executive Officer also met the CQC Chief Inspectors of Hospitals, Mental Health and Social Care to discuss their concerns about the number of adverse indicators that they had noted from the organisation, particularly in the non-Hampshire Learning Disability Services. The Chief Executive Officer shared the summary findings from the external governance review into Board Governance and Quality Governance processes and agreed to share the outcome of these reviews and the Trust's response to the recommendations. Professor Sir Mike Richards will be writing to the Trust formally following this meeting.

Monitor has considered all of the above intelligence and on April 23rd issued the Trust with enforcement actions due to governance failures. We take Monitor's decision very seriously and over the coming weeks our focus will be on making sure we make the improvements needed.

Quality Governance Strategy

Our Quality Strategy was approved by the Trust Board in September 2013 and has since been revised to become the Quality Governance Strategy 2014-2016 "Getting it right first time, every time". This document sets out a number of patient-centred quality improvement goals for Southern Health Foundation Trust over the next two years; at its centre is the promotion of a culture of continuous improvement where every member of staff has the pride, compassion, confidence and skills to champion the delivery of safe and effective care.

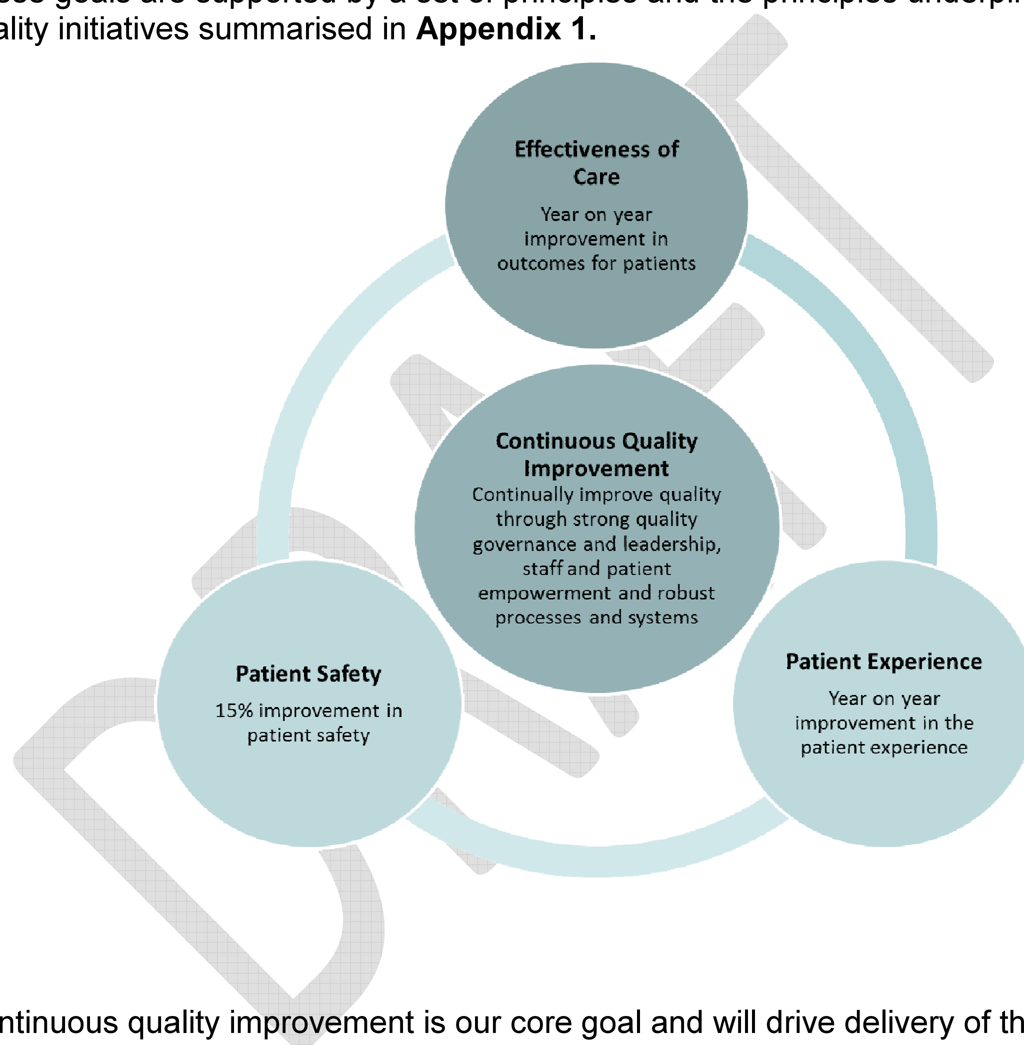
The aims of the Quality Governance Strategy are to:-

- Support the development of a culture of continuous improvement which results in higher satisfaction and experience for patients, carers and their families
- Engage every member of staff because they all must contribute to a quality experience and continuous improvement
- Set goals and priorities for improvement based on the NHS definition of quality
- Set out our approach to quality improvement which is based on evidence of what works in world class organisations
- Set out how we will measure and publish our progress

Our vision for quality ***to get it right first time, every time*** supports the Trust's overall aim of providing high quality and safe care.

This means giving the correct treatment at the appropriate time, to a high standard with minimal complications; it involves ensuring we have appropriate end-to-end care pathways with a referral system designed to allow the right patient to be seen by the right person at the right place at the right time leading to improving patient outcomes and satisfaction. It means doing this first time and every time for every patient.

To achieve this we have set ourselves four quality goals for the next three years. These goals are supported by a set of principles and the principles underpin our quality initiatives summarised in **Appendix 1.**



Continuous quality improvement is our core goal and will drive delivery of the others because process improvement and target based approaches alone have not been successful in enabling the Trust to deliver the level and scale of quality improvement it aspires to.

A cultural change which places emphasis on empowering frontline staff to make continuous changes in their clinical practice within the context of the delivery of the Clinical Strategy is needed. This will enable the Trust to aim high and deliver high and achieve maturity as recognised provider of high quality and safe care by its patients, service users, staff and stakeholders.

Organisational learning

We recognise the importance of organisational learning in developing safe effective services and the sharing of good practice. The Organisational Learning Strategy has been refreshed and will be implemented in 2014/15 across the Trust. A planned programme of work includes refinement of formal meeting and reporting structures so as to share good practice and learning opportunities, with reports being shared widely in the Trust and strengthening informal opportunities for discussion and enquiry of the data available. Divisional and frontline themes for learning and quality improvement are already being shared with Mental Health and TQtwentyone divisions each using key learning points from a review of all information about quality to share monthly top-tips posters for their staff.

We have implemented a programme of work to ensure we learn from all available information and feedback about our services, including complaints, incidents, clinical audits, CQC and mock CQC inspections and performance indicators. These have influenced the selection of some of our quality indicators for 2014/15. Information is triangulated from a wide range of indicators, to identify themes where action may be needed or good practice shared across the Trust in Trust-wide and divisional reviews.

Risk Management Development Programme

In November 2013 the Trust went out to competitive tender for independent risk management support to assist us in developing our whole-organisation approach to risk management and the Board Assurance Framework from January and throughout 2014. The programme objectives are to:

- Engage the Trust Board in the development and use of the Board Assurance Framework (BAF) for 2014/15; ensuring the BAF has the right focus and the Board is sighted on the right risks;
- Enhance the presentation and reporting of the Assurance Framework in readiness for a new BAF to Board early the 2014/15 financial year;
- Improve engagement of the Trust's clinical services in the organisations approach to risk management for the purpose of ensuring risk management is embedded in the day to day business of delivering high quality services and ensuring the risk register is relevant, reliable and fit for purpose;
- Ensure the Trust's approach to risk management and framework is robust and follows best practice by supporting the review of the Risk Management Strategy and Policy and suite of supporting documents.

The Risk Management Programme has been designed to support the Trust in addressing the challenges that have arisen during 2013/14 in relation to risk management; specifically the programme will address recommendations in the Risk Management and BAF Internal Audit and recommendations from the Deloitte Reviews.

The Chief Operating Officer/ Deputy Chief Executive is lead executive for this piece of work as it aligns with the Trust annual business cycle including strategic objective identification schedule, risk identification and risk appetite articulation for 2014/15.

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Baker Tilly were awarded the contract and commenced work in January 2014; the Project Plan was reviewed by the Audit, Assurance and Risk Committee on 6th March 2014 and a programme board convened to oversee the work and will include the Lead Director and a Non-Executive Director and programme progress and key findings will be reported to this Board. Work with clinical divisions has commenced, and the first session held with the full Trust Board to agree the high level strategic risks for 2014/15.

Workforce

We have continued to equip our leaders with the capability and confidence to deliver our Strategy and Business Plan which aims to enhance quality, safety and clinical outcomes across the organisation. Over the past 12 months the 'Going Viral' leadership programme has coached, developed and supported 481 staff to deliver the attitudes, values and behaviours expected from our workforce.

We continue to place great emphasis on ensuring our staff have the appropriate knowledge, attitude and skills to provide safe and effective care. This year has seen the development of a new analytics report (first release February 2014) which provides monthly compliance statistics on statutory and mandatory training requirements. The report is accessible via the Trust's data warehouse and enables all managers to assess their team's compliance with training requirements.

During 2013/14 our range of statutory and mandatory training sessions exceeded 30,000 attendances. Accessibility to electronic training resources as a suitable alternative to face to face attendance has continued to be promoted. Over the past 12 months our workforce accessed electronic assessments on 17,699 occasions with 87% resulting in a pass. Calculations demonstrate that this has generated a saving of £541,000 when compared to the costs associated with attendance at face to face training. These savings endorse our aim of working smartly to eliminate wasteful activities thereby enabling our staff to spend time on things that really count. The continued promotion and uptake of e-assessments during 2013/14 has contributed to the achievement of a predicted year end increase of 11.32% compliance with statutory and mandatory training.

We have recognised the diverse nature of the services we provide and have effectively utilised our Continuing Professional Development budget to meet the specialist needs of our Bands 5-9 workforce in line with divisional workforce strategies. This year we have supported our staff to access a range of educational courses which include relevant courses in neurological, physiological and psychological interventions.

This year saw the implementation of a project to address the recommendations of the Cavendish review. We will be introducing a competency based induction framework for our support workers to ensure they have been trained to a specific set of standards and have the skills, knowledge and behaviours to provide compassionate and high quality care and support.

Safeguarding

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Safeguarding describes Southern Health's responsibility to work in partnership with other agencies to prevent abuse and neglect of vulnerable adults and children and to deal with it effectively if it does occur. The Trust is a member of Local Safeguarding Boards for Children and Adults and follows the Multi Agency procedures. The safeguarding focus within the Trust is 'Think Family' to ensure staff consider all individuals who may need safeguarding in a situation and not just the adult or child for whom the original concern was raised. The corporate safeguarding team has been further strengthened in the Trust with the appointment of a Named Doctor for Safeguarding Children and a Named Doctor for Safeguarding Adults. The corporate safeguarding team work in an integrated way to support sharing expertise and skills to benefit staff/patients/service users.

The Trust is committed to ensuring adequate preventative measures are in place to reduce the risk of abuse. This includes having appropriate policies, staff training, supervision, management and leadership arrangements in place and clearly defined professional boundaries. The 'Think Family' approach is reflected in both the Safeguarding and Communications Strategies, workforce development and responding to incidents.

An appropriately skilled workforce is considered key to reducing risk of abuse or neglect. Safeguarding training has been reviewed across the Trust to ensure effective high quality training is accessible to all staff. All incidents where safeguarding concerns are reported are investigated with the Trust focused on learning and sharing widely any lessons learned thereby reducing future risk. Trust safeguarding dashboards have been developed which enable monitoring of themes and trends and support a proactive approach.

The Trust ensures all staff see safeguarding as their responsibility and divisions have identified internal lead governance structures that feed in to Trust safeguarding assurance. Action plans developed by services to address any identified shortfalls to meet the recommendations from the Winterbourne Review and Saville case are monitored through divisional governance structures and the Trust Safeguarding Forum.

Infection Prevention and Control

We take the risk of infection very seriously and work hard to maintain our low infection rates. We have our own dedicated infection prevention and control team who work with all staff to ensure the risk of infection is kept as low as possible for all patients and service users. All staff must undertake regular training in infection prevention, control and hand hygiene. There is an extensive audit programme to monitor clinical practice and ensure high standards are maintained.

We have very low rates of healthcare acquired infection with *Clostridium difficile* infection numbers reducing year by year:

Number of positive cases of C difficile –community hospitals					
Year	2009/10	2010/11	2011/12	2012/13	2013/14
Number	27	14	7	5	3

The team monitors other infections such as MRSA, MSSA and *Escherichia coli* and also any outbreaks of infection which occur in inpatient areas. These do not happen very often, but when they do occur, we investigate to see if there was anything that could have been done differently to prevent the infection. Any learning from these incidents is shared with staff.

The team work closely with other departments such as Estates and Facilities to ensure high standards of cleanliness are maintained and also to ensure that any new builds or refurbishments comply with national guidance in infection prevention and control.

Serious incidents

These are rare and unintended events that can cause significant harm or distress. If it happens as a result of failure in care or treatment, we want to understand why and how, and to make sure it doesn't happen again. We do this by:

- Ensuring staff know what to do in the event of a serious incident by having policies and procedures in place;
- Ensuring investigating officers are fully trained to identify root causes of incidents and actions which will make a difference to patient and service user outcomes;
- Ensuring that staff involved in serious incidents attend panels with senior managers to discuss root causes, review action plans and share learning in a constructive manner;
- Ensuring through our audit of action plans that improvements have been made and learning from incidents has been embedded into practice and shared across the organisation; and
- Ensuring that staff are aware of their responsibilities in being open with patients, services users and their carers to discuss openly with them serious incidents resulting in harm when things may have gone wrong.

The table below shows the number and type of serious incidents reported by Southern Health in 2011/12, 2012/13 and in 2013/14.

Total	**2011/12**	**2012/13**	**2013/14**
Infection Control (outbreaks, C-Diff, MRSA bacteremia, legionella)	14	↓ 9	→ 9
Information Governance	2	↑ 3	↓ 0
Pressure Ulcers Grade 3 (total:avoidable/unavoidable)	141	↑ 144	↓ 143
Pressure Ulcers Grade 4 (total:avoidable/unavoidable)	95	↑ 101	↑ 134
Slip/Trips/Falls	31	→ 31	↓ 22
Unexpected Deaths	7	↓ 5	→ 5
Homicide	1	→ 1	↓ 0
Suicide by Outpatient	44	↓ 33	↑ 42
Suicide by Inpatient (includes those on home leave, AWOL)	3	↓ 1	→ 1
Attempted Suicide (self harm)	12	↓ 6	↑ 14
Serious Inpatient Incident (surgical error)	6	↓ 3	↓ 1
Safeguarding (inc: allegations against staff)	11	↓ 9	↓ 8
Grade 0 (used historically when severity of incident not	6	↓ 0	→ 0

clear initially)			
Other (AWOL, Lapsed Registration, undocumented patient outcomes, medication, choking, fire and serious assault by patient)	17	⬇ 5	⬆ 10
Total	390	⬇ 353	⬆ 389

Overall the numbers of serious incidents reported have increased by 10% in 2013/14 bringing these in line with 2011/12 figures, although it must be noted that we are now a larger Trust since the acquisition of OLDT.

There are decreasing numbers of SIRIs reported in several categories:

- Infection control
- Information Governance
- Slips/Trips/Falls (high harm)
- Unexpected deaths
- Surgical errors
- Safeguarding

There are two categories showing an increase:
Suicides – we have looked at these sad incidents and have found no trend or theme, with the increase in numbers in line with national benchmarked figures.
Grade 3 and 4 pressure ulcers – show an increase of 12% in total figures but pleasingly there has been a decrease of 3% in avoidable pressure ulcers.

The Trust has participated in NHS England initiatives for pressure ulcers and suicides. This has enabled the sharing of SIRI learning from these two key areas to support the reduction of pressure ulcers and to enable organisational bench marking for key learning from suicides.

Supporting patients and service users

All people should be treated with compassion, dignity and respect in a clean, safe and well managed environment. We view excellent customer service as integral to achieving these standards and have a dedicated Complaints and Patient Advice and Liaison Services (PALS) team who are the first point of contact for people who require advice or information about any of our services and which also manages complaints.

In 2013/14 the Trust received 470 formal complaints, 488 concerns that were dealt with informally and 1732 compliments. The majority of compliments were praising staff for their clinical care and attitude.

The most common complaint categories reflect the national picture and are the same as reported in 2011/12 and 2012/13 within the Trust:

- Clinical and nursing care 31% (145);
- Attitude 18% (84); and
- Communication 16% (75);

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We want to understand reasons and trends underlying complaints so that we can change and improve our services. We therefore analyse all complaints and found the next most common categories were:

- Access to services 8% (39);
- Appointment 4% (20); and
- Medication and Prescribing 3% (15).

The majority (25) of complaints about access to services were from Mental Health services with most reflecting a mismatch between service users and carer's expectations and the redesigned community services. The remaining 12 complaints were about a variety of issues across a number of different services with no particular themes identified.

Complaints about appointments were again across a variety of services, the majority relating to outpatient appointments and orthopaedic/physiotherapy.
Complaints about medication and prescribing have been about changes to medication, side effects and differences of opinion about which medication should be given.

Overall numbers of complaints are small with 0.03% of total contacts for the year resulting in a formal complaint compared with 0.09% leading to a compliment, therefore people are three times more likely to compliment our services.

The Complaints and PALS team work closely with clinical services to review complaints and concerns and identify themes and share learning to improve quality of services with some examples given below:

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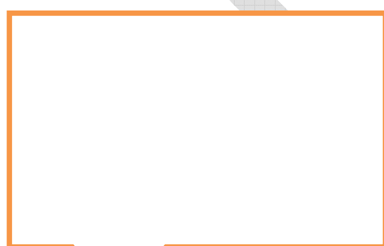
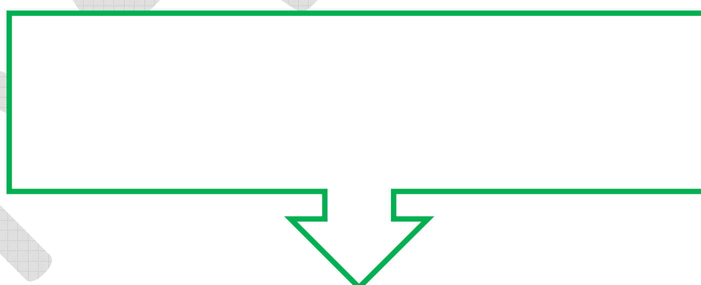
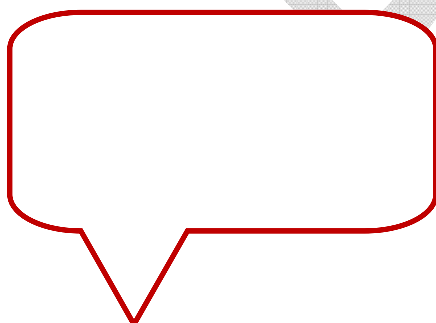
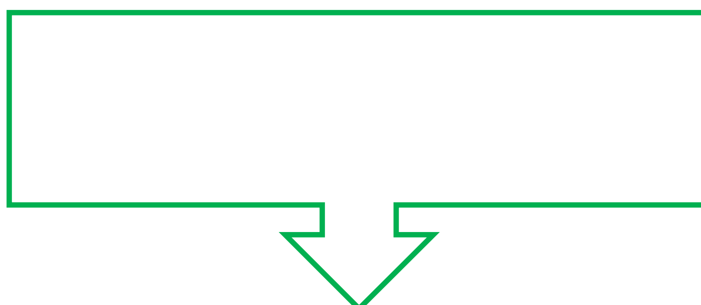




You said:

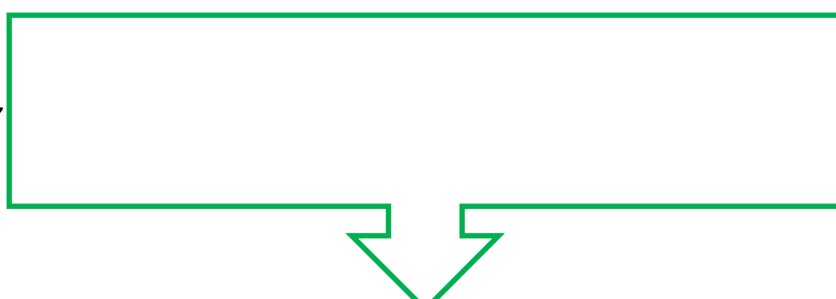
We apologised, listened and took action:





You said:

We apologised, listened and took action:



You said: We apologised, listened and took action:

In 2013/14 the Trust has been made aware of 19 complainants who have referred their complaints to the Parliamentary and Health Service Ombudsman, compared to 17 last year. Of the 19, eight have been closed with no further action and 11 are on-going.

We have reviewed the recommendations from national reviews including the National Complaints report, Berwick, Keogh and Francis reports and have already developed and started to implement a programme of actions based on their recommendations.

Conclusion

We recognise that we have faced significant quality challenges in a small number of units this year and have worked hard to rectify problems and put plans in place to drive long term sustainable improvements.

However this should not detract from the many advances we have made in the quality of services this year. We will continue to work with all our key stakeholders including patients to continue improving to achieve high quality performance in all services.

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ANNEXES

Annex 1 Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Annex 2 Statement of directors' responsibilities for the quality report

Annex 3 External Auditors' Limited Assurance Report

Annex 4 Data definitions

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Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Feedback from our local Clinical Commissioning Groups (CCGs)

To be inserted

Feedback from Healthwatch

To be inserted

Feedback from Overview and Scrutiny Committees

To be inserted

Feedback from Southern Health Governors

To be inserted

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Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- The content of the quality report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2013 to June 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to June 2014;
- Feedback from commissioners dated *xx/xx/20xx;*
- Feedback from governors dated *xx/xx/20xx;*
- Feedback from local Healthwatch organisations dated *xx/xx/20xx;*
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated *xx/xx/20xx;*
- Latest national patient survey xx/xx/20xx;
- Latest national staff survey *xx/xx/20xx;*
- The head of internal audit's annual opinion over the Trust's control environment dated *xx/xx/20xx;* and
- CQC quality and risk profiles dated *xx/xx/20xx*.

- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information in the quality report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

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

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By order of the Board
NB: sign and date in any colour except black

………………………………… Date …………………………… Chairman

………………………………… Date …………………………… Chief Executive Officer

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Annex 3: External Auditors' Limited Assurance Report

To be inserted

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Annex 4: Data definitions

PwC tested the following indicators

100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital

Detailed descriptor
The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care that are followed up within 7 days.

Data definition
All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions
- Patients who die within 7 days of discharge may be excluded;
- Where legal precedence has forced the removal of the patient from the country;
- Patients transferred to NHS psychiatric inpatient ward
- CAMHS (Child and Adolescent mental health services) are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

Accountability
Achieving at least 95% rate of patients followed up after discharge each quarter.

Minimising delayed transfer of care

Detailed descriptor
The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus).

Data definition
Number of patients (acute and non-acute, aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly Sit-Rep figures is used as the numerator. The denominator is average number of occupied bed days.

A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.

A patient is ready for transfer when:
i) a clinical decision has been made that the patient is ready for transfer AND
ii) a multi-disciplinary team decision has been made that the patient is ready for transfer AND
iii) the patient is safe to transfer.

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To be effective, the measure must apply to acute beds, and to non-acute and mental health beds. If one category of beds is excluded, the risk is that patients will be relocated to one of the 'excluded' beds rather than just discharged.

Accountability
The ambition is to maintain the lowest rate of delayed transfers of care. Good performance is demonstrated by a consistently low rate over time, and/or by a decreasing rate. Poor performance is characterised by a high rate, and/or by an increase in rate.

Local Indicator

Safety incidents involving severe harm or death

Indicator description
Patient safety incidents reported to the National Reporting and Learning Service (NRLS), where degree of harm is recorded as 'severe harm' or 'death', as a percentage of all patient safety incidents reported.

Indicator construction
Numerator: The number of patient safety incidents recorded as causing severe harm/death as described above.

The 'degree of harm' for PSIs is defined as follows;
'severe' – the patient has been permanently harmed as a result of the PSI, and
'death' – the PSI has resulted in the death of the patient.

Denominator: The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS).

Indicator format: Standard percentage.

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST: DRAFT QUALITY ACCOUNT 2013/14		
DATE OF DECISION	15 MAY 2014		
REPORT OF:	DIRECTOR OF NURSING		
CONTACT DETAILS			
AUTHOR:	Name: Judy Gillow	Tel:	023 8077 7222
	E-mail: judy.gillow@uhs.nhs.uk		
STATEMENT OF CONFIDENTIALITY			
None			

BRIEF SUMMARY

This report introduces the draft of the UHS quality account for 2013/14 which will be published in June of this year. The account reports on progress in meeting the targets set for the 2013/14 as well as looking ahead to set priorities for the year 2014/15. Judy Gillow, Director of Nursing, will present the Quality Account to the panel.

RECOMMENDATIONS:

(i) To note and provide comment with regard the UHS NHS Foundation Trust Draft Quality Account

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Panel to consider the evidence in order to agree findings and recommendations at the end of the inquiry process.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. To be assured that UHS FT are continuing to deliver high quality and relevant care for the population it serves and that the priorities it has set for the coming year are in line with commissioning and JSNA intentions.

DETAIL (Including consultation carried out)

3. The purpose of this quality report is to hold the Trust to account for the quality of the healthcare services we deliver. The Quality Account presents the Trusts achievements against the quality priorities previously set for 2013/14, alongside national priorities and the wider quality and service improvement work we have completed. The University Hospital Southampton Draft Quality Account is attached at Appendix 1.

4. The Trust also demonstrates how it will continue to enhance the quality of services we provide, and the details of quality priorities for 2014/15 which have been developed in conjunction with our staff, patients, carers and external stakeholders.

5. This year has seen unprecedented demand for our services. The Trust has struggled to meet this demand and deliver the national targets of patients waiting no longer than four hours in the emergency department and patients being treated within 18 weeks. In collaboration with partner organisations we

have been working hard to get this right for our patients and have opened additional capacity to support future delivery.

6. The UHS Trust achieved eight of the nine priorities identified last year. The one priority that was not achieved was improvements in mortality rates and has been made a priority again in 2014/15.

7. This year's patient improvement framework has been developed by listening to staff and patients to identify the most important priorities. We have then consulted on these with patient groups, our commissioners and staff.

8. The priorities for 2014/15 are set out below.

Priorities for clinical outcomes

Priority 1: Every clinical speciality will identify an outcome measure

Priority 2: Improving Hospital Standardised Mortality Rattios (HSMR)

Priority 3: Improving Hospital Standardised Mortality Ratios (HSMR)

Priorities for patient experience

Priority 1: Improving care and safeguarding vulnerable adults

Priority 2: Improve the patient experience at mealtimes

Priority 3: To provide the safe and timely discharge of patients from UHS

Priorities for patient safety

Priority 1: To continue to improve reporting of incidents and learning

Priority 2: To reduce avoidable high harm pressure ulcers and falls

Priority 3: To improve the care of the deteriorating patient.

9. Judy Gillow, Director of Nursing, will present an overview of the University Hospital Southampton NHS Foundation Trust annual report.

10. Members are asked to consider the attached report and following discussions at the meeting comment on the draft University Hospital Southampton NHS Trust Draft Quality Account. They are also asked to consider if there are any matters within the report that they wish to receive further information as part of their work programme for the next year.

RESOURCE IMPLICATIONS

Capital/Revenue

11. None

Property/Other

12. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

14. None

POLICY FRAMEWORK IMPLICATIONS

15. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	University Hospital Southampton NHS Foundation Trust, Draft Quality Account

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Agenda Item 9

University Hospital Southampton NHS Foundation Trust

Appendix 1

Our quality account and quality report

2013/14

Introduction

Chief Executive Statement

The purpose of this quality report is to hold our organisation to account for the quality of the healthcare services we deliver.

We do this by presenting our achievements against the quality priorities previously set for 2013/14, alongside national priorities and the wider quality and service improvement work we have completed. We also demonstrate how we will continue to enhance the quality of services we provide, and the details of our quality priorities for 2014/15 which have been developed in conjunction with our staff, patients, carers and external stakeholders.

Having started in post in October last year I have been struck by the huge sense of pride staff have in this their organisation, their motivation, their commitment to delivering excellent care and continually improve. This is vital as we know that staff happiness has a direct impact on the quality care that we provide and on outcomes for patients.

This year has seen unprecedented demand for our services. We have struggled to meet this demand and deliver the national targets of patients waiting no longer than four hours in the emergency department and patients being treated within 18 weeks. In collaboration with our partner organisations we have been working hard to get this right for our patients and have opened additional capacity to support future delivery.

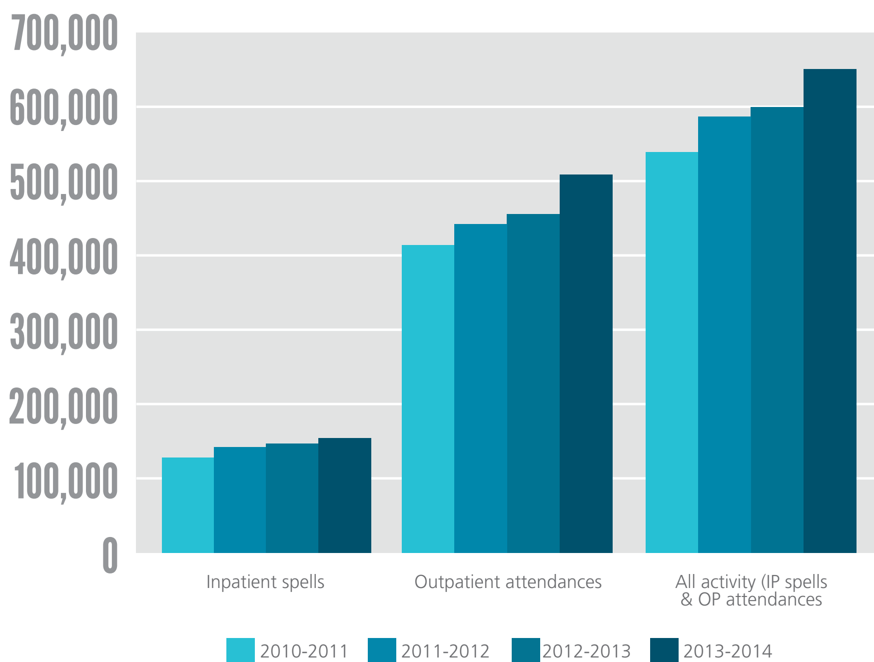
In 2013 we saw the publication of the Francis report and the Department of Health response. This was following the failings of Mid Staffordshire Hospital to its patients. We have undertaken listening exercises in our own response and have developed our own plan of action to ensure those failings do not happen here. There were many recommendations made by Francis, but an underlying theme was one of culture. We are determined to embed an open, transparent culture, where we listen and respond to staff and patients.

Given the demands on our service I am pleased that where we have focused our action in last year's priorities we have achieved a great deal. There is however more to be done to continue to improve the quality of care for patients. Whilst there are challenges ahead our focus remains on the patient, the quality of service we provide and surpassing that expectation to achieve our vision for the future.

Fiona Dalton
Chief Executive Officer

Activity levels during 2013/14

The graph below indicates the increase in demand for our services which has now been sustained over a four year period. This is reflected for inpatients (which includes those whose care does not require an overnight stay). In summary we have seen an increase of more than 10% from 2010/11 to more than 601, 000 patients.



Strategy and leadership for high quality care

Patients are at the centre of everything that we do. Our ambition is to excel in all aspects of acute health care delivery for our local community and for our wider regional tertiary population.

Our quality governance strategy provides the direction and focus for the organisation and takes a whole system approach to continually improve standards for patient safety, patient experience and outcomes.

This is supported by a range of strategies which define our priorities in more detail and our model is to deliver these through our patient improvement framework (PIF), which is reviewed and updated annually. The PIF is focused around four key principle areas:

- safety
- experience
- effectiveness and outcomes
- Performance (national quality targets).

University Hospital Southampton NHS Foundation Trust

Provides

hospital services for people with acute health problems.

Employs

around 10,000 staff

Serves

650,000 people who live in Southampton, the New Forest, Eastleigh and the Test Valley.

the residents of the Isle of Wight, channel Islands with specialist services

Delivers

a regional specialist service for southern central England

major research programmes to develop the treatments of tomorrow

training and education of our current staff as well as the healthcare workers of the future.

Hospitals

Southampton General Hospital
Princess Anne Hospital

Priorities for improving quality

This section outlines our performance in delivering the quality priorities we agreed in partnership with our stakeholders last year. It also explains how we have developed and agreed our priorities for 2014/15.

Each year we agree our patient improvement framework (PIF) priorities in consultation with frontline staff, patient representatives, our Council of Governors, Clinical Commissioning Groups and members of the Trust Board. The priorities sit in four domains, patient safety, patient experience, patient outcomes and performance. The PIF reflects national priorities, the Department of Health's operating framework and commissioning for quality, innovation and improvement (CQUIN) taregts. It also includes priorities identified by our patients in their feedback and complaints and areas where we have seen themes of things going wrong that require focus. In addition the PIF identifies priorities from previous years which have been targeted for sustainable improvement and outlines the strategies that support improvements across all of the priorities identified.

With many competing agendas for staff the PIF enables them to clearly identify our priorities for focus but does not negate the need to provide good quality care to patients delivered by the right people, in the right place and at the right time. We first developed the PIF in 2007 and have been using it every years since so our staff are familiar with it and it is embedded in our everyday practice. It helps us to clearly identify our priorities for improvement alongside our daily efforts to ensure that high quality care is provided by the right people, in the right place and at the right time.

Key performance indicators are identified in the PIF to measure improvement for each priority. These are reported on a monthly basis through the Trust's performance report and through in depth quarterly reports for patient experience, safety and outcomes which are discussed at trust executive committee, Trust Board and with our commissioners. In local areas, we display performance against our KPIs in our clinical quality dashboards to ensure there is a flow of inromation from ward to board. In ward areas we also display our responses to patient feedback demonstrating how we have acted on the things they have said about us.

"All members of staff are cheerful friendly and hard working. Quite pleasant to be here really! Certainly no complaints at all."

I was terrified going to theatre the porters were calm and reassuring. The nurse that looked after me in the pre-op room before anesthetic was excellent, caring, understanding, holding my hand and reassuring me. The anaesthetist was very nice and relaxed very professional and helpful. Having this experience helped me to recover

A review of our performance in 2013/14

We achieved eight of the nine priorities identified last year. The one priority that was not achieved was improvements in mortality rates and has been made a priority again in 2014/15.

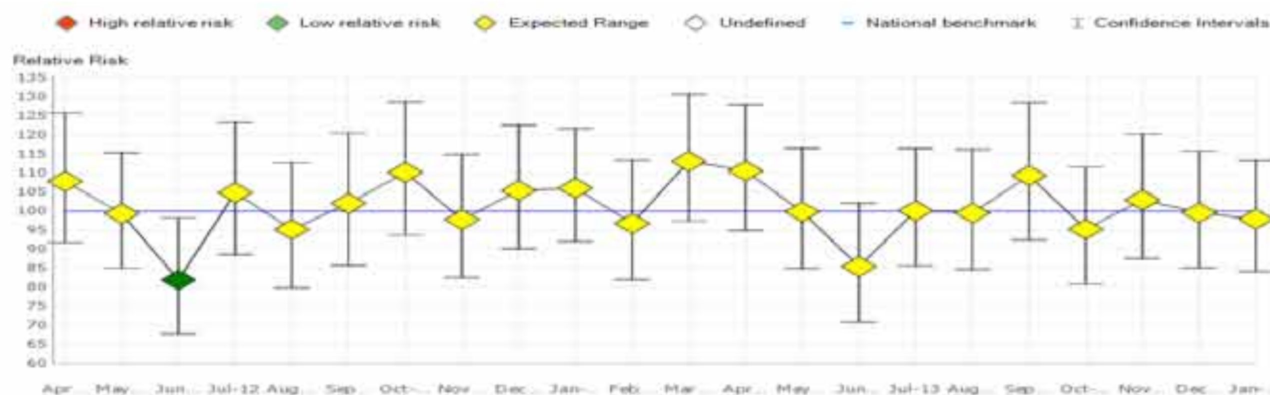
Priorities for outcomes and clinical effectiveness

Priority 1: Making improvements in mortality rates and the way mortality is measured and evaluated.

The hospital standardised mortality ratio (HSMR) is a calculation used to monitor death rates in a trust. It is based on a subset of diagnoses which give rise to around 80 per cent of in-hospital deaths. The ratio is of observed and expected deaths multiplied by 100. Thus if mortality levels are higher than would be expected, the HSMR will be greater than 100.

Measuring hospital performance is complex. Within healthcare HSMR is used as an indicator of quality that measures whether the death rate within a hospital is higher or lower than expected, compared to the death rate across England. However there are many reasons why the number of deaths in hospital varies so it should not be used in isolation, but considered with other indicators that give a well-rounded view of hospital quality and activity.

The table below shows the monthly HSMR at UHS from April 2012 – January 2014. The HSMR for the year to date (April 13 – January 14) is 100.01 and almost exactly on the midpoint of the expected range when compared to the national benchmark.



UHS HSMR has remained constant since April 2012 but has not fallen since April 2013 in line with the trust's internal assurance target. To further understand this various actions have been taken including:

- A review of the standards of care in areas of unusual/unexplained raised HSMR (to date no major avoidable cause of death has been identified)
- Clinical data validations in areas of unusual/unexplained raised HSMR when the clinical record is reviewed to check if the original data used for coding was correct (incorrect data leads to inappropriate risk stratification and so a spurious high HSMR) and if significant inaccuracies are identified the clinical coded data is changed but only in adherence to strict national coding rules (to date in some small areas of clinical practice significant coding errors have been identified and a Trust-wide education programme for the medical staff in relation to the coding process is underway
- Further strengthening of the mortality and morbidity meetings within each specialty to ensure any lessons relating to potential improvements in care are identified
- Service quality reviews where members of the Trust, clinical commissioning groups and patient representatives are invited to review the service provided by the Trust in a particular Care Group. Currently one review has been completed and a further three reviews have been scheduled to be completed by the end of 2014.
- A high level group within each of the four clinical divisions has been set up to review mortality data on a monthly basis and agree/carry out any required investigation or corrective action.

Priority 2: Improving outcomes for the deteriorating patient

Early recognition of deterioration in a patient's clinical signs can lead to an improved clinical outcome. These signs can be used to predict the occurrence of cardiac arrest. Following the national confidential enquiry into patient outcome and death (NCEPOD) report "Time to Intervene" (2012) improvement in the care of deteriorating patients was identified as a priority. Survival can be improved with close observation, earlier recognition of severity markers of risk, senior decision making and appropriate admission into critical care environments.

The Trust's overall aim was to improve early recognition and management of patients' deterioration at ward level, maintaining ward-level cardiac arrests below the outturn in 2012/13 and achieving 90% compliance with the Trusts monthly acuity audit. The table below demonstrates our significant achievement in this area during 2013/14.

Cardiac arrests at ward level – performance 2013/14

	2012/13	2013/14	
PEA	VF Asystole Total arrests	70 ROSC 45 = 64.2%	We achieved a reduction in PEA arrests of 18.7% and an improvement in ROSC of 9.6%
VF	48 ROSC 41 = 85%	23 ROSC 22 = 95.6%	We achieved a reduction in VF arrests of 52.1% and an improvement in ROSC of 10.6%
Asystole	54 ROSC 17 = 31.5%	46 ROSC 21 = 45.6%	We achieved a reduction in asystole arrests of 14.8% and an improvement in ROSC of 14.1%
Total arrests	188	139	There was a total fall in cardiac arrests of 26%

ROSC: Return of spontaneous circulation. PEA: Pulse-less electrical activity. VF: Ventricular fibrillation

The total number of cardiac arrests within UHS has decreased during 2013/2014 by 49 events, a fall of 26%. This is further classified by a reduction of pulseless electrical activity (PEA) cardiac arrests by 18.7%, ventricular fibrillation (VF) cardiac arrests by 52.1% and a reduction in asystole as the first presenting rhythm by 14.7%.

Focusing on PEA arrests, this type of cardiac arrest is the most avoidable and has the most scope to detect changes in a patient's condition prior to an event occurring. A significant achievement has been made in the reduction of PEA cardiac arrest.

A review of each PEA arrest is undertaken to share learning and raise awareness of contributing factors leading to a PEA arrest. An increase in training of the recognition of the deteriorating adult patient has been implemented and this has thought to contribute to a reduction in the number of cardiac arrests seen within the UHS.

Priority 3: Improve the care of older patients with delirium and / or dementia

An project was undertaken to create a dementia-friendly community, aiming to improve the care for older patients with delirium and dementia when they are in the acute hospital setting.

This was achieved through:

- Commencing a program to ensure that all staff in UHS receive dementia awareness training.
- Providing enhanced training and education to those delivering care
- Identifying and training "dementia champions" in all appropriate clinical areas.
- Developing carer support and information networks
- Improving the environment within the medicine for older people wards to be more "dementia friendly".
- Introduce "This is me" – a tool designed to introduce the person with dementia to care staff across services in order to support person-centered care

The training programme was received positively and 772 staff received classroom training to improve their skills and knowledge. Information was cascaded to over 5000 staff via specially produced information leaflets.

A greater understanding of the needs of people with dementia and their carers was developed – identified by the roll out of 'This is Me' tool and in the evaluation of appropriate care planning.

The ward environment on the medicine for older people's wards was reviewed and improved, making the area more appropriate for the needs of patients with dementia.

The newly established carers' cafe has been successfully running on a weekly basis with positive user feedback. It is well attended and supported by volunteers and other outside agencies. It has inspired one agency to have the confidence to set a café up on the outskirts of Southampton to support people in their local area.

The Southampton Dementia Partnership, which started after the appointment of the UHS dementia specialist nurse has evolved during the project and now meets on a quarterly basis throughout the year, sharing progress and new work streams. Specific goals have been established by the group for development in 2014. The project has been evaluated through a carer satisfaction survey and satisfaction has improved from 72% being dissatisfied/very dissatisfied at the beginning of the project, to 61% dissatisfied/very dissatisfied being at the end of the project. Aspects of care that have been identified as where patients/carers felt dissatisfied included communication between carers and clinical staff and aspects relating to fundamentals of care.

Clinical staff report feeling more confident in meeting the complex needs of people with dementia and the evaluation has enabled the acute hospital to demonstrate a robust and effective model of care for dementia patients.

The project was successful and the role of dementia nurses / pathway facilitators has enabled staff to feel supported to deliver personcentred care to people with dementia. Engagement in the agenda for improving dementia care and the enthusiasm for increased understanding and knowledge has been reflected in the numbers of staff requesting face-to-face learning both in classrooms as well as in the clinical environments.

Patient Experience

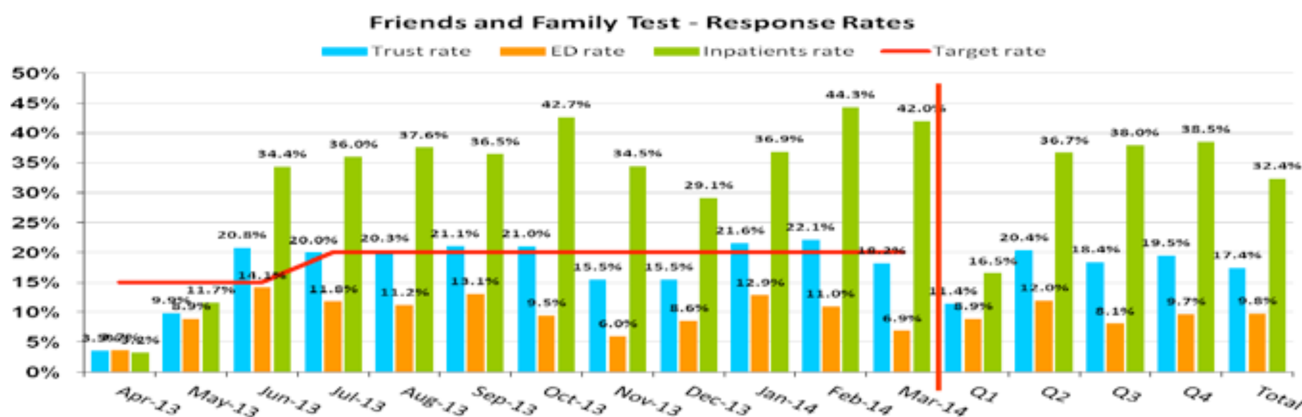
Priority 1: To implement the national friends and family test

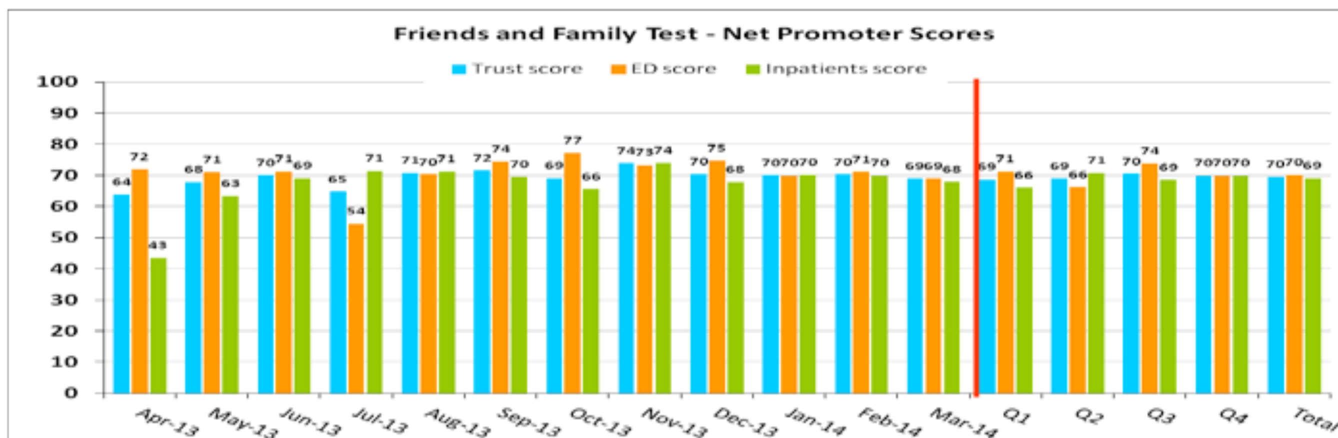
Seeking and acting on patient feedback is key to improving the quality of healthcare services. The national friends and family test (FFT) is a simple, comparable test which provides a mechanism to identify both good and poor performance across NHS organisations.

Since April 2013 patients have been able to provide feedback at UHS by answering one simple question, "How likely are you to recommend your ward to friends and family if they needed similar care or treatment?". Our aim was to implement the test within the hospital's inpatient areas and emergency department. This has been achieved and valuable information about our service is being obtained.

The response rate for providing feedback and the net promoter scores have been monitored throughout the year. Responses to the FFT have been displayed in clinical areas along with details of improvements that have been made as a result of feedback from patients. The net promoter score is a standardised national methodology, ensuring that scores are consistent and transparent. It is calculated by subtracting the number of detractor scores ("extremely unlikely" "unlikely" and "neither likely" nor unlikely") from the number of promoter scores to give a number between -100 and +100 with the higher number indicating more favourable responses. The charts below show how we have performed in the FFT in 2013/14.

Promoter Scores	Passive Scores	Detractor Scores
"Extremely likely" responses	"Likely" or "Don't Know" responses	"neither likely or unlikely", "unlikely" and "extremely unlikely" responses





Our overall response rate since FFT was introduced has increased from an initial 8.7% to 20.9% to date. The net promoter score has improved from an initial 64 to a score of 70 currently. We have achieved all of the CQUIN measures this year apart from achieving a 15% response rate in quarter one.

At a corporate level, the themes from patient feedback will be triangulated with complaints, real time patient feedback, annual inpatient surveys and net promoter scores to identify key work streams for improving patient experience, ensuring we are listening and acting upon patient feedback.

FFT targets are increasing next year and it is being rolled out to outpatients, day case units and the question will also be asked to all staff working within UHS.

Priority 2: Improving the experience women have of our maternity service

The national Care Quality Commission (CQC) Maternity Survey 2013 was undertaken at the Princess Anne Hospital. It asked women to feedback what they thought about different aspects of their care during pregnancy, labour and birth and the weeks following the birth of their baby.

The survey showed that UHS is one of the 'better performing' services in the country. We performed significantly better than average in the area of providing care to mothers in the postnatal period, in giving them information about contraception and their recovery after birth.

The maternity department was above the national average for offering choice for place of birth and enquiring about mothers' wellbeing. The feedback from mothers was that time was provided to enable questions to be asked and staff took their concerns seriously.

The national friends and family test has been introduced into maternity services, introducing real time monitoring to capture immediate feedback on women's experiences. The first three months results have been published nationally.

These results showed that when 139 women were questioned on the quality of antenatal treatment they received over the three-month period, 70% said they were 'extremely likely' to recommend staff and facilities to family and friends and 26% 'likely'.

In addition, of 134 patients asked if they would recommend postnatal services, 63% answered 'extremely likely' and 31% 'likely'

In response to the feedback from both the inpatient survey and the FFT additional actions have been put in place to continue to improve mothers' experiences:

- To ensure women understand the skill mix of staff that supports their care in the postnatal period and how to access help from their midwife and others should they require it.
- To raise awareness of the varied appropriate breastfeeding advice that women will receive as their baby grows and develops.
- To ensure that women feel confident that we are informed about their medical and obstetric history.
- To fully embed the FFT into maternity and obtain real time data and feedback from mothers throughout their maternity experience.

Priority 3: Improving handovers, comprehensive and accurate documentation

After a CQC visit in October 2012, the Trust received feedback about identified inconsistency quality issues in the patient care records in some areas. As a result of this we identified a priority to improve the quality and standard of nursing documentation during 2013/14 Enhancing the information supporting the handover of patient care would help to improve the continuity for patients as they move around the organisation.

Evidence demonstrates that good documentation of nursing and medical care promotes better patient outcomes, safety and experience, thereby enhancing team working. By clearly communicating the care needs of our patients, decision making can be optimised and a more consistent approach to the needs of patients promoted.

What we did

Nursing documentation ensures that comprehensive assessments of patients need are identified on admission, followed by daily documentation of care provided and the forward planning of patients discharge needs. A review of the nursing documentation has been undertaken and a new documentation pack is being piloted in specific areas of the Trust.

In addition a pilot is being undertaken to launch the electronic nurses worklist as an adjunct to the doctor's electronic work list initiative. This will record details of the reason for the patient's current admission, and tasks, statuses and interventions required under the care of a specific team, consultant or ward.

Educational support has been developed to run alongside the new documentation and the electronic work list to support the requirements of the documentation policy.

Through focusing on this improvement area compliance has been achieved with the CQC Quality Standards Outcome R20 for Records, NHSLA Health Record – keeping Standards, nursing and midwifery council (NMC) Guidance, Essence of Care Record keeping standards and UHS records management policy.

Patient Safety

Last year's priorities for patient safety were improving learning from patient safety incidents, implementing the safety thermometer bundle and improving care for patients with diabetes.

✓ Priority 1: Improving learning from patient safety incidents

As a Trust it important that we learn when things go wrong and as such we take reported incidents very seriously. This year we launched the "safe care in our hands" campaign which included the roll-out of e-reporting of incidents, a focus on culture and asking staff to speak up, speak out and safety walkabouts. E-reporting of incidents, including "near misses" has been well received by staff and it facilitates real time reporting and escalation in order that appropriate action is taken. Ithas also improved the reporting of themes down to ward level and feedback to those who have reported the incident.

In the national learning reporting system we were outliers when benchmarked with other Trusts in the number of incidents reported per 100 admissions, the timeliness of reporting and the numbers of incidents graded as high and moderate harm. Rolling out e-reporting is improving this position, and as part of the roll-out we have trained over 2,500 staff using this as an opportunity to raise awareness of incident reporting focusing on near misses and to train staff in the appropriate grading of incidents focusing on actual rather than potential harm.

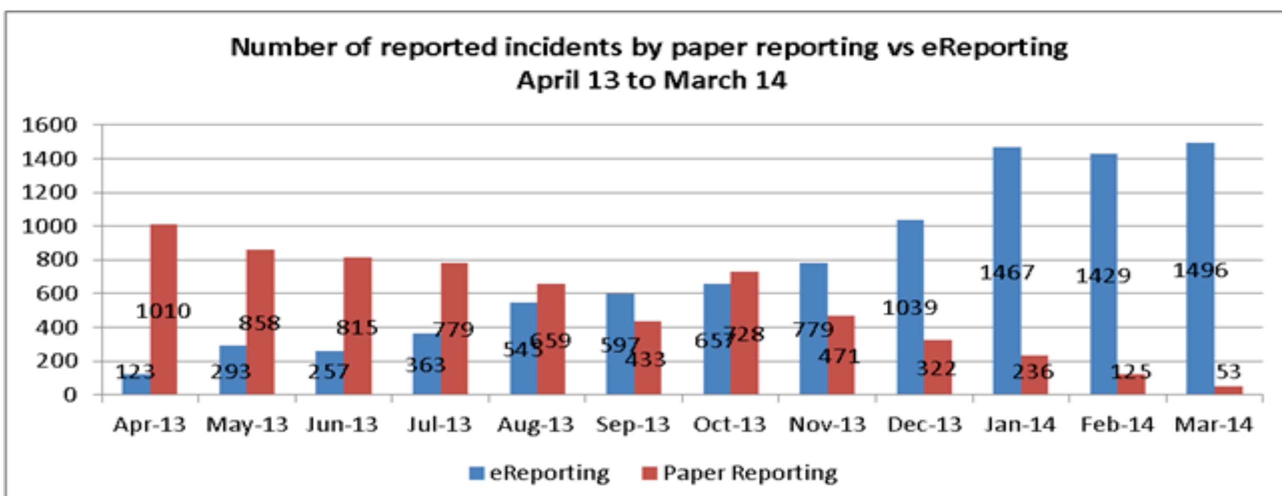
We have robust processes for the management of incidents and near misses where every incident is graded and analysed, and where required undergoes a root cause analysis report.

Over the last year the trust has reported two 'never events'. Never events are nationally defined and agreed as serious incidents that should not happen. Both events were retained swabs; one was identified eleven months after the surgery on an x-ray. The second patient was operated on following severe multiple traumas. The retained swab was identified at a second planned operation two days later. Both patients have been fully informed of the investigation and offered the opportunity to receive a full copy of the incident report. Learning from these events involves reinforcement of the core principles of safer surgery:

- Surgical and theatre teams must collaboratively ensure that all elements of the safer surgery checklist are completed.
- No x-ray detectable or accountable swabs should be used that do not form part of a formal swab count.
- All actions and behaviours in theatres, from all theatre users, allow for safe practice and communication irrespective of staff grade or seniority.

These actions form part of an audit structure to ensure that organisational learning has occurred.

Trends and themes are identified from the incidents and these are circulated across the trust for action within divisions and monitored through the clinical governance structure. In-depth reviews have been undertaken in maternity. Two themes identified were the failure to recognise and prevent deterioration in a patients condition and violence and aggression between patients to patients and patients to staff. Learning has been shared down to ward level and provides a focus for our priorities for 2014/15.



Priority 2: Implementing the safety thermometer bundle

The national safety thermometer is a prevalence audit tool that allows teams to measure harm and the proportion of patients that are "harm free" from four of the most common and preventable causes. These are pressure ulcers, patient falls, VTE (blood clot) and urinary infections due to catheters. The audit is undertaken on a monthly basis and submitted to a national database for benchmarking.

We have consistently achieved over 95% for no new harms/new harm-free care with over 1100 patients audited each month. Wards include a patient identifier where harm has occurred. This facilitates follow-up, triangulation with real time data and learning.

No harms 2013-2014

Division	Care group	No harms
Division A	Cancer care	97.05%
	Critical care	93.26%
	Surgery	98.43%
Division A total		**97.10%**
Division B	Emergency medicine	93.57%
	Specialist medicine	98.50%
Division B total		**93.95%**
Division C	Child health	98.17%
	Women and new born	99.90%
Division C total		**98.93%**
Division D	Cardiovascular and thoracic	97.81%
	Neurosciences	97.38%
	Trauma and orthopaedics	97.01%
Division D total		**97.43%**
Grand total		**96.51%**

In terms of actual incidents real progress has been made with risk assessments for VTE consistently at 95% and reducing catheter-related infections. However we failed to reduce the number of falls and pressure ulcers against our internal targets. This can, in part, be attributed to the number of frail elderly patients admitted but there is more work that we can do to reduce the incidence.

Priority 3: Improving care for patients with diabetes

What have we achieved?

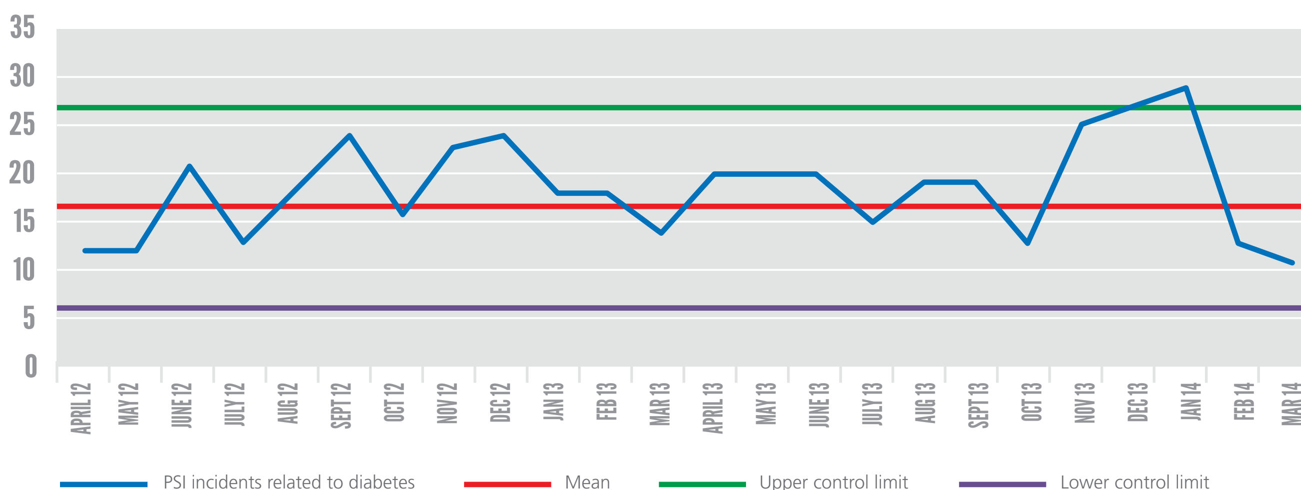
Our aim for 2013/14 was to have zero incidents classified as "never events" in relation to the prescription of insulin. This has been achieved through close monitoring of patients' prescriptions.

There are still a number of incidents/errors that relate to diabetes and reflect a focus on reporting. Overall incidents remain stable around the mean of 17. The incidents show a trend where insulin has been inappropriately omitted or not prescribed for no clear clinical reason. Omission of insulin due to communication and human errors as opposed to e-prescribing problems are also a theme. The e-reporting roll-out has increased the volume of all incidents reported and the continued focus on improving diabetes care.

The diabetes team at UHS has developed a "care bundle" for all patients with diabetes. On one single day UHS hosts 150 adults with diabetes and the aim is that the specialist diabetes team sees patients with complex problems. Those patients that have been identified to the diabetes team are discussed with team and community partners (e.g. district nurses, GP's, community matrons or diabetes team) so a shared plan of care can be produced.

Many initiatives have been put in place to ensure safer and enhanced care for diabetic patients, these include:

- Updating diabetes ketoacidosis guidelines in line with national best practice
- Diabetes link nurse: over 90% of wards have an identified named person
- Education and training. Link nurses using education/ information board on the wards, with the theme changed monthly
- diabetes.nhs.uk/safe_use_of_ insulin learning module now built into Southampton University undergraduate and post graduate medicine
- UHSFT adult impatient diabetes guideline developed
- UHSFT enteral feeding guidelines (adult) nutritional supporting diabetes



Our quality priorities for 2014/15

We have developed this year's patient improvement framework by listening to staff and patients to identify the mosy important priorities. We have then consulted on these with patient groups, our commissioners and staff. Last year's PIF adopted the domains set out in the Department of Health Operating Framework, but having listened to staff we agreed that we should go back to previous templates using the four domains of experience, safety, outcomes and performance to best maintain momentum and focus. We have also tried to be much more specific in setting measurable objectives in each of our prioties and recognised research as an important component of delivering quality services.

Priorities for clinical outcomes

Priority 1
Every clinical speciality will identify an outcome measure

We have agreed that all care groups within UHS will identify a clinical outcome mearuse for their service that can best be used to measure improvement in the care they provide. This is intended to increase ownership of clinical outcomes at a local level and respond better to patient needs. Care groups will engage with staff and patients when identifying priorities and work with patient groups to achieve a desired change in practice.

Our aim

- Each speciality has an identified outcome that is specific to clinical need
- Each speciality will monitor and report on the outcome progress
- Each care group publishes the outcome at the end of the year, demonstrating the impact it has had on patient care.
- Each speciality will participate in a National Institute of Healthcare Research (NIHR) portfolio research.

Priority 2
Improving Hospital Standardised Mortality Rattios (HSMR)

HSMR can be an indicator of things going wrong in a hospital and it is important to ensure that the data is robust and outcomes are accurately coded. The data needs to be reviewed by each speciality and take action if required. The data is monitored by the central team and reported to the Trust Board and through the clinical governance structure to ensure early interventions are undertaken.

Our aim

- To provide reports on HSMR by care group / timing
- To clinically validate data that is benchmarked as an outlier and where appropriate put actions in place to address

Priority 3
Improving Hospital Standardised Mortality Rattios (HSMR)

Diabetes is a common lifelong health condition. There are three million people diagnosed with diabetes in the UK and an estimated 850,000 people who have the condition but do not know it. Within UHS approximately 15% of inpatients will have diabetes. Patients can be admitted due to a lack of diabetic control but also diabetic patients who are ill or require surgery have different requirements. Patients with diabetes have a longer than average length of stay so appropriate management is key.

Our aim

- All patients with diabetes on the ward will be identifiable to all ward staff
- Safe practices for using insulin will be observed with a 20% reduction in incidents related to insulin administration
- No insulin never events will occur
- A more robust diabetes discharge plan will be provided
- Open a portfolio of diabetes research studies focussing on improving care

Priorities for patient experience

Priority 1
Improving care and safeguarding vulnerable adults

With an increasing elderly population which is reflected in the patient group admitted to our hospital getting the right pathway of care for these patients is vital. We are aware from feedback that we haven't always got this pathway of care right, which is why we have chosen this as a priority.

Our aim

- Develop a care pathway that meets the specific needs of the vulnerable patient. Specific focus on proactive assessment of patient needs prior to admission and comprehensive plans for discharge into the community.
- Learning from incidents and complaints relating to vulnerable adults taking a proactive approach to implementing changes that promote improved safety and experience for the patient and their carers.
- Improving communication to families on the pathway of care for their relative.

Priority 2
Improve the patient experience at mealtimes

Good nutrition and hydration are fundamental to well-being and recovery from illness or trauma. Consistently, patients are telling us that the experience of their hospital stay would be enhanced if the experience of their meals was improved. UHS recognizes the importance of having safe, high quality nutrition and hydration for all patients, regardless of age, gender, faith or cultural/social background.

Malnourished patients stay in hospital longer, are three times as likely to develop complications during surgery and have a higher mortality rate (Age Concern 2006, Mehta et al, 2013). Illness is frequently associated with under-nutrition and it has been shown that appropriate nutrition presents clinical benefit.

Our aim

- To establish a nutritional pathway for dementia patients
- To improve patient mealtime experience by ensuring compliance with protected mealtimes and ensuring assistance is provided to patients who require help with feeding.
- Implementation of the meal time assistant role to provide additional support to patients at meal times.
- Further enhancement of monitoring of the quality of food and triangulation of themes identified from patient and staff feedback. Implement appropriate actions and monitor.

I was in a mixed age ward and I don't think the nurses/ auxiliary staff helped me with small matters e.g. reading menu care/ opening sealed packets of food/ cutlery. Cutting up food/ assisting me with eating.

Priority 3
To provide the safe and timely discharge of patients from UHS

Well organised and timely discharge is an important part of patient care and a planned and co-ordinated approach enables patients to leave the hospital safely and efficiently.

Trust wide patient flow is also supported by efficient discharge enabling UHS to deliver a proficient, safe and appropriate admission pathway for its patients.

Patients are telling us that we do not always get our discharge process right and it is apparent that this area of care needs to be a priority for this year.

Our aim

Discharge appointments will be implemented across all care groups within UHS by July 2014

- Patient discharge information document will be in place by July 2014
- UHS operational inpatient standard four will be achieved. This standard is that "A discharge plan, electronic discharge summary and medication will be completed by 5pm the day prior to predicted discharge for the vast majority of patients"

"The discharge procedure takes too long. Surely if no medication is needed the patient can be sent the discharge summary in the post and allowed home. I was given permission to go home first thing in the morning; I was still waiting for the paper work to be signed at 3pm."

Priorities for patient safety

Priority 1
To continue to improve reporting of incidents and learning

Higher levels of incident reporting reflect an open and transparent culture where an organisation is willing to learn. This priority has been rolled over from last year, as there is still work to be done.

Our aim
To improve our benchmarked position on the national reporting and learning system for the number of reported incidents per 100 admissions, timeliness of reporting and levels of harm reported.

- To have fully rolled out e-reporting in the Trust
- To increase the levels of incident reporting.
- Reduce the levels of high harm incidents
- To demonstrate learning that has occurred from reported incidents.

Priority 2
To reduce avoidable high harm pressure ulcers and falls

Pressure ulcers and falls have a direct impact on safety and the patient experience. Reducing avoidable harm to zero is a patient safety aspiration and we need to set ourselves ambitious reduction targets to realise this aim. There is also a cost to these levels of harm, every grade 3 and 4 pressure ulcer incurs a cost of £10,000 and a high harm fall can cost £15,000 – 20,000. This money could be better invested in the provision of patient care

Our aim

- To reduce avoidable pressure ulcers (grade 2, 3 and 4) by 20%
- To reduce high harm falls by 20%
- To reduce to a statistically significant level all pressure ulcers and falls per 1,000 bed days.
- To work with the whole health economy across the patient pathway in the community and in inpatient care to reduce the prevalence of pressure ulcers.
- To embed assessment and plan of care.

Actions to achieve the aims include:

- A review of the risk assessment used, in conjunction with the nursing documentation
- Pilot the use of patient name bands to visually identify patients at risk of falls
- Detailed focus in areas with high numbers of falls/pressure ulcers
- Continued focus on education and training of clinical staff.

Priority 3
To improve the care of the deteriorating patient.

We have seen a number of incidents in 2013 /14 where there has been a failure to recognise the deterioration of a patient and while this was in the outcome domain of the patient improvement framework last year we need to have a greater focus going forward. Preventing deterioration improves safety of our patients and reduces length of stay.

Our aim

- To reduce the avoidable admissions to the critical care areas of UHS
- To reduce the number of serious incidents requiring investigation (SIRI's) relating to management of the deteriorating patient
- To improve the handover and escalation when a patient is deteriorating.

Actions to achieve the aims include:

- Relaunch of a corporate group to focus on actions to promote early recognition of the deteriorating adult patient.
- Relaunch situation, background, assessment and recognition (SBAR). A communication tool to promote accurate and concise information when a deteriorating patient has been identified.
- Develop a sepsis recognition protocol
- Develop a fluid prescribing protocol.

Participation in national clinical audit and confidential inquiries

During 2013/14 UHS participated in 97.7 % of the national clinical audits and 100 % of the national confidential enquiries (NCEPOD) of which it was eligible to participate in.

The NCEPOD that UHS was eligible to participate in during 2013/14 were:

- NCEPOD Gastrointestinal Hemorrhage (organisational audit and patients identified January 2014)
- NCEPOD Lower limb amputation (data collection completed, report to be published in autumn 2014)
- Tracheostomy (data analysis completed, report to be published June 2014)

During 2012/13 UHS participated in the following national confidential enquiries:

- NCEPOD Alcohol related liver disease (report published June 2013)
- NCEPPOD Subarachnoid Haemorrhage (report published 2013)
- MBRRACE-UK- Perinatal mortality.

The national clinical audits that UHS participated in, and for which data collection was completed during 2013/14, are listed below. In Table A the number of cases submitted to each audit or enquiry is recorded as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table A: National Clinical Audits

	Total number of NCAs UHS were eligible to complete (✔=43)	**Eligible (xx)**	**Participated (xx)**	**National audit reports reviewed (xx)**	**% actual cases submitted / expected submissions**
1	Acute coronary syndrome or Acute myocardial infarction MINAP National Institute for Cardiovascular Outcomes Research (NICOR)	✔	✔	✔	100%
2	Adult cardiac surgery audit ACS National Institute for Cardiovascular Outcomes Research (NICOR) CABG and valvular surgery	✔	✔	✔	100%
3	Adult community acquired pneumonia	Currently no update available			
4	Adult critical care (Case Mix Programme) Intensive Care National Audit and Research Centre (ICNARC)	✔	✔	✔	100%
5	Bowel cancer NBOCAP - NHS IC	✔	✔	✔	
6	Bronchiectasis The British Thoracic Society (BTS)	✗	✗	✗	No audit submitted
7	Cardiac Arrest Audit NCAA - Intensive Care National Audit and Research Centre (ICNARC)	✔	✔	✔	100%
8	Cardiac arrhythmia - National Institute for Cardiovascular Outcomes Research (NICOR)	Currently no update available			
9	Comparative blood transfusion audit - Medical use of blood	✔	✔	✗	54%
10	Congenital heart disease,(Paediatric cardiac surgery)- National Institute for Cardiovascular Outcomes Research (NICOR)	Currently no update available			
11	Coronary angioplasty - National Institute for Cardiovascular Outcomes Research (NICOR)	✔	✔	✔	100%
12	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) - NHS IC, Leeds	✔	✔	✔	100%
13	Diabetes (Paediatric) PNDA - Royal College of Child Health and Paediatrics (RCPCH)	✔	✔	✔	The deadline for submissions has not yet been reached
14	Elective surgery (National PROMs Programme) NHS IC, Leeds - HIPS	✔	✔	✔	55.6% 2011-12 latest published data
15	Elective surgery (National PROMs Programme) NHS IC, Leeds - KNEES	✔	✔	✔	104% 2011-12 latest published data
16	Emergency use of oxygen The British Thoracic Society (BTS)	Currently no update available			
17	Epilepsy 12 audit (Childhood Epilepsy) - Royal College of Child Health and Paediatrics (RCPCH)	Currently no update available			
18	Head and neck oncology - NHS IC*	Currently no update available			
19	Heart failure HF - National Institute for Cardiovascular Outcomes Research (NICOR	✔	✔	✗	

	Total number of NCAs UHS were eligible to complete (✔=43)	Eligible (xx)	Participated (xx)	National audit reports reviewed (xx)	% actual cases submitted / expected submissions
20	Hip fracture database, national	✔	✔	✔	100%
21	Inflammatory bowel disease IBD - Royal College of Physicians (RCP), CEEU	✔	✔	✗	100%
22	Inflammatory bowel disease IBD - Royal College of Physicians (RCP), CEEU	Currently no update available			
23	Lung cancer NLCA - NHS IC, Leeds	✔	✔	✔	70%
24	National audit of dementia audit NAD - Royal College of Psychiatrists (CCQI)	Currently no update available			
25	NASH National audit of seizure management (epilepsy)	✔	✔	✔	97%
26	National comparative audit of blood transfusion	Currently no update available			
27	National emergency laparotomy audit NELA	✔	✔		The deadline for submissions has not yet been reached
28	National Joint Registry NJR	Currently no update available			
29	National Vascular Registry NVR	Currently no update available			
30	Neonatal intensive and special care NNAP	✔	✔	✔	100%
31	Non-invasive ventilation - adults - British Thoracic Society (BTS)	Currently no update available			
32	Oesophago-gastric cancer - The Royal College of Surgeons of England (RCS) AUGIS	Currently no update available			
33	Pain database	Currently no update available			
34	Paediatric asthma - The British Thoracic Society (BTS)	Currently no update available			
35	Paediatric intensive care PICANet - University of Leicester	Currently no update available			
36	Paediatric pneumonia - BTS	✔	✔	✗	The deadline for submissions has not yet been reached
37	Paracetamol Overdose CEM	✔	✔		The deadline for submissions has not yet been reached
38	Prostate cancer				
39	Perinatal mortality - MBRRACE-UK	✔	✔	✗	100%
40	Pulmonary hypertension - NHS IC	Currently no update available			

	Total number of NCAs UHS were eligible to complete (✔=43)	**Eligible (xx)**	**Participated (xx)**	**National audit reports reviewed (xx)**	**% actual cases submitted / expected submissions**
41	Severe sepsis & septic shock	✔	✔		The deadline for submissions has not yet been reached
42	Sentinel Stroke National Audit Programme (SSNAP)*	✔	✔	✗ First UHS results for Q3 due spring 2014	100%
43	Severe trauma (Trauma Audit & Research Network) TARN	✔	✔	✔	100%

Note:
*UHS has registered to participate in the 2013/14 Sentinel Stroke National Audit Programme (SSNAP) the single reporting system for acute strokes.

The reports of 14 national clinical audits were reviewed by the Trust in 2013/14 and UHS intends to take the following actions to improve the quality of healthcare provided, the description of actions are in Table B.

Table B: Actions from National Clinical Audits

National audit title	Actions
Acute coronary syndrome or Acute myocardial infarction MINAP National Institute for Cardiovascular Outcomes Research (NICOR)	Quarterly meetings to constantly review possible improvements
Adult cardiac surgery audit ACS National Institute for Cardiovascular Outcomes Research (NICOR) CABG and valvular surgery	Data was presented at the recent UHS Clinical Effectiveness conference. Mechanisms in place for identifying any problems early should any change in UHS performance occur.
Severe trauma (Trauma Audit & Research Network) TARN	1. Improve the percentage of cases of major trauma seen by a consultant within 30 mins and 5 mins. appointment of more ED consultants and changes to provide 24 hr cover 2. Improve the timeliness of CT for major trauma and severe head injuries - ongoing education and simulation training within the emergency department and anaesthetics 3. Improve the percentage of cases of open fractures meeting BOAST 4 criteria, an audit is in progress. Business case being developed regarding increased plastic surgery within UHS. 4. Increased consultant presence in theatre for life and limb threatening injuries - significant improvements seen by alterations in rotas in orthopaedics and general surgery. 5. The percentage of patient completion of rehabilitation prescription is high. The provision of rehabilitation remains poor. A Trust business case is in preparation.
Lung cancer NLCA - NHS IC,	Final 2012 data not yet published. 2011 data discussed at Focus Group. Data collection needs improving, especially CNS data and collection of TNM data at MDT. Ongoing discussions with Ascribe re changes to HICCS to allow accurate data collection at MDT.
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) - NHS IC,	There were themes identified from 2012 Sept National inpatient audit that reported in Mar-April 13. Need to keep working on staff education around diabetes. Keep educating nursing and medical junior staff re: medication errors, actions on high and low blood glucose Need to focus on ways to improve diabetes foot assessments Work with catering to improve diabetes meal choices
Adult critical care (Case Mix Programme) Intensive Care National Audit and Research Centre (ICNARC)	Reviewed data analysis reports within the Care Group. Dissemination through the Patient Safety Advisory group
Cardiac Arrest Audit NCAA - Intensive Care National Audit and Research Centre (ICNARC)	Audit antecedents to cardiac arrest. Ensure quality of training in resuscitation throughout the trust. Education around DNACPR
Coronary angioplasty - National Institute for Cardiovascular Outcomes Research (NICOR)	UHS data reviewed at the Acute Coronary Syndrome committee and Mortality & Morbidity meeting and presented at Trust Clinical Effectiveness day

National audit title	Actions
Diabetes (Paediatric) PNDA - Royal College of Child Health and Paediatrics (RCPCH)	No actions needed. Ongoing service improvements documented & presented via National Peer Review Programme (DQuINS) Feb 2013 and Feb 2014
Hip fracture database, national	Appointment of two trauma surgeons. Nerve block service: initially started as a pilot 6 months ago, now it is a permanent service Four Trauma nurse specialists appointed: to support FY1 doctors on trauma wards, taking bloods, assessing acutely ill patients, completing discharge summaries etc. Two extra trauma sessions per week. Brook ward: a 16 bedded trauma rehabilitation ward
NASH National audit of seizure management (epilepsy) - (ED: Michael Kiuber) (1/3)	Ensure continuing education for new trainee clinicians and nursing staff rotating through to the ED on the following: 1. Documentation of comprehensive seizure history. 2. Documentation of alcohol intake; both chronic and recent binge. 3. Documentation of comprehensive examination. 4. Documentation of driving advice given and management plan for future seizures.
Neonatal intensive and special care NNAP - Alison O'Donnell	Measures have been put in place to improve initial consultation within 24 hours by senior staff with parents of babies admitted. Ongoing efforts to improve breastfeeding rates. Ongoing discussions to maximise the use of antenatal steroids.

Participation in Trustwide and local Clinical Audit

The reports of 36 local clinical audits were reviewed by the provider in 2013/14 and UHS intends to take the following actions to improve the quality of healthcare provided (See table C below)

Table C Actions from Local Clinical Audits

Audit title	Actions
Documentation of intra-operative estimated blood loss (EBL) in post operative note and anaesthetic chart	EBL on post operative note made a compulsory entry to sign off post operative note. Memo circulated to anaesthetists and anaesthetic trainees with results of this audit and encourage the documentation of EBL on anaesthetic chart.
Audit to assess if patients admitted with heart failure to the acute medical unit are being referred to the heart failure team	Involving heart failure services earlier in patient admission Informing new juniors on induction regarding referral to heart failure services Consider on post-take ward rounds and inclusion on nursing handovers Development of specialist Heart Failure Card
Re-audit of the elective ascitic drain audit	Further dissemination of Hepatology Junior Doctors Guide Regular teaching sessions on the management of the complications of Cirrhosis. Completion of trust protocol on performing ascitic drains.
Re-audit of employers procedure for medical exposures - procedure A - patient ID	Training on CRIS, ID documentation, Policy update, session on clinical education mornings
Infliximab in paediatric inflammatory bowel disease	1. Modify standard- Aim to screen for a pre-set list of diseases at diagnosis. Consultant digression taken into account for TB. 2. Rigorous guidelines, checklist and make a specified person responsible
intra-operative fluid management monitoring compliance	1. Update software for LiDCO and ODM 2. Posters to improve compliance with utilisation.
The timing of inpatient MRI scans on stroke unit	Clinical lead has discussed findings with stroke and radiology teams: radiology will create an extra afternoon slot where appropriate. This can be utilised by stroke team if necessary to reduce length of stay from waiting for MRI
Re-audit of missed doses thromboprophylaxis	Ensure staff aware of issue re not being able to block regular doses if stat dose given Reminder to staff re need for clear clinical reasons to be recorded for omissions
Completion of braden score	As per Surgical Care Group Tissue Viability action plan 2013
Screening for Embryonal tumours in patients with a confirmed clinical or molecular diagnosis of beckwith wiedermann syndrome (BWS)	The information generated by this pilot audit will enable progression to a National Audit assessing the screening recommendations given by Clinical Genetics Teams for patients affected with BWS.

Participation in Clinical Research

It is recognised that NHS organisations with significant research activity are able to demonstrate evidence of improved patient outcomes and health service delivery (NHS England 2014).

The number of patients receiving relevant health services provided or subcontracted by UHS in 2013/14 that were recruited to trials approved by the ethics committee during that period was around 13,000. We were the 6th highest recruiting Trust to NIHR studies in England, securing in excess of £20 million in funding to support research. We invested in and increased research in many clinical areas including cancer, ophthalmology, cystic fibrosis and gastroenterology. One of our patients was the first person be recruited to a global research study and thus the first person in the world to have access to potentially ground breaking new treatment.

In partnership with the University of Southampton we were awarded £9m funding over five years for the Collaboration in Leadership in Applied Health Research and Care (CLAHRC). The CLAHRC will deliver patient focussed research in areas including ageing and dementia, fundamental care in hospital, respiratory disease and patient engagement with self-directed support for long-term condition management.

We delivered a new clinical research website **www.uhs.nhs.uk/ClinicalResearchinSouthampton** and launched a public engagement programme including our event series in Winchester, Southampton and onsite.

In 2013/14 our commitment to high quality delivery of research was recognised through two major awards:

- Winners, NIHR National New Media Award for a video showcasing the work of Professor Nicholas Clarke tackling infant hip dysplasia
- Finalists in Clinical Trials Administrator category, Pharmatimes Clinical Research of the Year Awards

Data quality

UHS recognises that good quality health services depend on the provision of high quality information and high quality record keeping. Through robust record keeping patients can be assured that clinical records are anonymous and confidential.

UHS submitted records between April 2013 and March 2014 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As at February 2014, (Month 11, latest National figures available) the percentage of records in the published data:

which included a valid NHS number was:
- 98.3% for admitted patient care;
- 98.8% for outpatient care; and
- 97.3% for accident and emergency care.

which included a valid General Medical Practice Code was:
- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

UHS information governance assessment report overall score for 2013/14 was 71% and was graded satisfactory. The attainment levels assessed within the information governance toolkit provide an overall measure of the quality of information handling, and information systems, standards and processes within an organisation. The Trust met or exceeded the minimum required level of compliance assessment for all requirements of the toolkit for the reporting year.

UHS continue to focus on enhancing data quality and took the following actions in 2013/14:

- Revised the UHS Data Quality Strategy and Policy that details the expectations, processes and principles that support the collection and management of information to achieve high standards. Strategic data quality objectives and related national work are detailed.
- Continued performance management of data quality via Trust and Divisional meetings, the Clinical Coding function, and the IM&T Information Team. These groups use audit reports of patient data and key performance indicators on internal and external timeliness, validity and completion, including Dr Foster comparative analysis information. Areas of poor performance are identified, investigated and plans agreed for improvement.
- Delivery and development of a comprehensive data quality review programme working closely with clinical areas to review the quality, timeliness and accuracy of patient level data collection.
- Continued work to reduce data quality problems at the point of data entry through improved system design, changes to software, and targeted support for system users.
- Worked towards delivering real time admission, discharge and transfer recording across more ward areas, thereby supporting improved patient tracking and bed management. A new bed management system is currently

being implemented.

- Supported training and education programmes for all staff involved in data collection, including Information Governance training and the provision of information collection guidance.
- Maintained a programme of regular internal audit, including data quality, record keeping, health records management, information governance and clinical coding audit.
- Continued to maintain and develop improved compliance with the Information Governance Toolkit standards.

UHS was not subject to the national Payment by Results clinical coding audit during 2013/14. However results of the 2012/13 audit were shared with the data quality steering group in July 2013. This group also continue to receive regular clinical coding audit reports from a rolling programme of internal audit and assurance that UHS supports.

Review of services

During 2013/14 the UHS provided and/or sub-contracted XXX relevant health services (from Total Trust activity by specialty cumulative 2013/14 contractual report).

More information about these can be found on our website www.uhs.nhs.uk. UHS has reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2013/14 represents xx % of the total income generated from the provision of NHS services by UHS for 2013/14.

Proportion of income for achieving commissioning for quality, innovation payment framework (CQUIN).

A proportion of UHS income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between UHS and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN framework. Further details of the agreed goals for 2014/15 are being determined between UHS and clinical commissioning groups.

The monetary total for the amount of income in 2013/14 conditional upon achieving quality improvement and innovation goals was £xxx and a monetary total for the associated payment received in 2012/13 was £xxx M.

We have used the CQUIN framework to actively engage in and agree quality improvements working with our commissioners, to improve patient pathways across our local and wider health economy. Reflecting our wide patient catchment area, we agreed two CQUIN programmes in cooperation. These were one standard contract CQUIN held jointly between all our CCG commissioners and one specialist services commissioning group CQUIN programme.

Our CQUIN priorities for 2013/14

NHSE/CCGs	Innovation Health and Wealth - Intra-operative Fluids Management (IOFM)	Demonstrate to commissioners that 2013/14 trajectories for the technology are in place which are consistent with National Technology Assessment Centre (NTAC) guidance	National	
NHSE/CCGs	Innovation Health and Wealth - International & Commercial Activity	Demonstrate that clear plans are in place to exploit the value of commercial intellectual property - either standalone or in collaboration with Academic Health Science Network	National	
NHSE/CCGs	Safety thermometer	Safety thermometer	National	424
NHSE/CCGs	Safety thermometer	Safety thermometer	National	131
NHSE/CCGs	VTE part a risk assessment	VTE part a risk assessment	National	278
NHSE/CCGs	VTE part b root cause analysis	VTE part b root cause analysis	National	278

NHSE/CCGs	Friends and Family	Phased expansion	National	167
NHSE/CCGs	Friends and Family	Increase response rate	National	222
NHSE/CCGs	Friends and Family	Improved performance on the staff Friends and Family Test	National	167
NHSE/CCGs	Dementia	Improving dementia care	National	555
CCGs	LTC	LTC - Self management/ patient experience	Local	467
CCGs	LTC	Shared Decision making	Local	820
CCGs	Health Improvement / Elective Care	Health Improvement / Elective XSBD	Local	586
CCGs	Non Elective (NEL) / Urgent Care	XBD reduction - target based on NEL performance v plan - ACTIVITY	Local	844
CCGs	NEL/Urgent Care	XBD reduction - target based on NEL performance v plan - MILESTONES	Local	281
CCGs	NEL/Urgent Care	Multi Agency shared care planning	Local	563
CCGs	NEL/Urgent Care	AEC management	Local	563
NHSE	IVIG Database	Completeness of data submitted to the national IVIg database.	Local	368
NHSE	IVIG Panel	Implementation and maintenance of a regional clinical IVIg panel set up by the regional centre and involving all the local DGHs.	Local	368
NHSE	Haemophilia (trough levels)	Proportion of patients on prophylaxis who have had documented trough levels in the past 12 months which are between 1-2%.	Local	369
NHSE	Haemophilia (Haemtrak)	Number of registered moderate and severe paediatric and adult haemophilia A and B patients submitting information records via Haemtrack, either through an electronic means or via paper records entered onto the haemtrack database by the provider unit, during the period 1.4.13 – 31.3.14.	Local	369
NHSE	Neonatal Total Parental Nutrition (TPN)	Number of babies <30+0 weeks gestation or <1500g birth weight in the hospital or transferred in on day 1 of life who start TPN by day 2 of life (excluding babies who undergo surgery on day 1 or 2 of life)	Local	369
NHSE	Complex Discharge Pathways	To identify babies with a gestational age under 36 weeks who may be suitable for short-term nasogastric tube feeding at home whilst breast or bottle feeding is established and to provide an outreach service to allow this to happen	Local	369

NHSE	Clinical Dashboards	To embed and demonstrate routine use of the use of specialised services clinical dashboards	Local	491
NHSE	Cardiac Surgery	The proportion of patients referred as urgent, to have cardiac surgery* as an in-patient (with or without transfer) within 7 days of fit for surgery by cardiac surgeon.	Local	369
NHSE	MTC	Number of patients who have one or more long bones stabilised within 24 hours of injury	Local	369
NHSE	PCD	Highly specialised services clinical outcome collaborative audit workshop	Local	491
				10,844

Registration with the Care Quality Commission

Care Quality Commission:
UHS is required to register with the Care Quality Commission and its current registration status for locations and services is as below.

Regulated activity: Surgical procedures
Provider conditions: This regulated activity may only be carried on at the following locations:
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD.

Regulated activity: Treatment of disease, disorder or injury
Provider conditions: This regulated activity may only be carried on at the following locations:
- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD.

Regulated activity: Maternity and midwifery services
Provider conditions: This regulated activity may only be carried on at the following locations:
- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton, SO40 7AR
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA

Regulated activity: Diagnostic and screening services
Provider conditions: This regulated activity may only be carried on at the following locations:
- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD
- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton, SO40 7AR

Regulated activity: Transport services, triage and medical advice provided remotely
Provider conditions: This regulated activity may only be carried on at the following locations:
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD.

Regulated activity: Assessment or medical treatment for persons detained under the 1983 (Mental Health) Act
Provider conditions: This regulated activity may only be carried on at the following locations:
- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

UHS has no conditions on registration. The Care Quality Commission has not taken enforcement action against University Hospital Southampton NHS Foundation Trust during 2013/14.

UHS has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

UHS participated in a child protection Serious Case Review (Southampton Child F) dated 18/06/2012.

The CQC undertook a review of compliance at the Southampton General Hospital (SGH) site in April 2013 and reported that the Trust was fully compliant with the five standards. Patients were positive about their experiences. They said they were happy with the way they were cared for. One person stated" This is a brilliant hospital: I would recommend it to any of my friends and family as a good place to be cared for".

SGH - Standards Reviewed	CQC Judgement
Care and welfare of people who use services	Met this standard
Management of medicines	Met this standard
Staffing	Met this standard
Assessing and monitoring the quality of service provision	Met this standard
Records	Met this standard

In December 2013 the CQC also undertook their first mental health inspection at the SGH site. By law, the CQC is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. Mental Health Act Commissioners do this on behalf of CQC, by interviewing detained patients or those who have their rights restricted under the Act and discussing their experience. They also talk to relatives, carers, staff, advocates and managers, and they review records and documents.

Whilst aspects of this visit were positive the CQC found some areas for improvement and the Trust produced a statement of the actions that they will take as a result of the monitoring visit. These actions will be completed by the end of 2013/14.

Our standard core indicators of quality

From 2012/13 all trusts are required to report against a core set of indicators relevant to the services they provide, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012, this data is presented in the same way in all quality accounts published in England. This allows the reader to make a fair comparison between hospitals if they choose to.

As required by point 26 of the NHS (Quality Accounts) Amendment Regulations 2012, where the necessary data is made available by the Health and Social Care Information Centre, a comparison is made of the numbers, percentages, values, scores or rates of each of the NHS foundation trust's indicators with

a) the national average for the same; and

b) those NHS trusts and NHS foundation trusts with the highest and lowest of the same.

Our hospital mortality rating

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to—

a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and

b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period is included to give context

University Hospital Southampton NHS Foundation Trust considers that this data is as described for the following reasons, taken from national dataset using data provided.

A) The value and banding of the summary hospital-level mortality indicator ("SHMI")

	Reporting Period					
	P01648 - July 2012 - June 2013 uploaded Jan-14 next version due Apr-14		P01638 - April 2012 - March 2013 uploaded Oct-13 next version due Jan-14		P01619 - Jan 2012 - Dec 2012 uploaded Jul-13 next version due Oct-13	
	Value	OD Banding	Value	OD Banding	Value	OD Banding
UHS	0.9856	2	0.9751	2	0.9517	2
National Ave	1.0007	2	0.9273	2	1.0009	2
Highest Trust Score	1.1563	1	1.1697	1	1.1919	1
Lowest Trust Score	0.6259	3	0.6523	3	0.7031	3

http://nww.indicators.ic.nhs.uk/webview/
OD Banding: 1 Greater than OD_UL, 2 between OD_LL & OD UL, 3 Less than OD_LL

The figures below provide some context in understanding how the Trust's integrated hospice (Countess Mountbatten House) impacts on the provision of Specialist Palliative Medicine/Care within the Trust. The treatment rate (specialist palliative medicine/care) in the three quarters has risen by 1.47% in the Trust compared to a national rise of 8.57% and the Diagnosis Rate (provision of specialist palliative care) has risen by 0.88% at the Trust compared to the national rise of 6.22%.

b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level

Treatment Rate	% of observed deaths with treatment specialty code 315
Diagnosis Rate	% of observed deaths with any diagnosis code of Z515
Combined Rate	% of observed deaths with treatment specialty code 315 or any diagnosis code of Z515

http://nww.indicators.ic.nhs.uk/webview/

	Reporting Period								
	P01650 - July 2012 – Jun 2013 uploaded Jan-14 next version due Apr-14			P01640 - April 2012 - Mar2013 uploaded Oct-13 next version due Jan-14			P01621 - Jan 2012 - Dec 2012 uploaded Jul-13 next version due Oct-13		
	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate
UHS	13.8	22.9	25.0	13.3	22.1	24.0	13.6	22.7	24.5
National Ave	1.52	20.50	20.64	1.48	20.25	20.38	1.40	19.30	19.47
Highest Trust Score	17.4	44.1	44.1	16.9	43.9	44.0	16.0	42.7	42.7
Lowest Trust Score	0	0	0	0	0.1	0.1	0	0.2	0.2

Our Patient Reported Outcomes Measures (PROMS) following hip or knee replacement surgery

Adjusted health gain

	Reporting Period					
	Apr 2013 - Sept 2013 (Provisional, published Feb 14)		Apr 2012 - Mar 2013 (Published Oct13)		Apr 2011 - Mar 2012 (Published Oct13)	
	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.
National Ave	0.387*	0.447*	0.413	0.438	0.417	0.416
Highest Trust Score	0.304*	0.339*	0.339	0.319	0.290	0.302

Participation rates

	Reporting Period					
	Apr 2013 - Sept 2013 (Provisional, published Feb 14)		Apr 2012 - Mar 2013 (Published Oct13)		Apr 2011 - Mar 2012 (Published Oct13)	
	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.
Overall	74%	72.7%	70.1%	74.9%	79.7%	74.7%
Hips	53.9%	-	55.6%	-	67.6%	-
Knees	111.7%**	-	104%**	-	99.7%	-

Data source http://www.hscic.gov.uk/proms 25.04.2014

Varicose vein and groin hernia data not recorded as the numbers of procedures at UHS are very low.
*Adjusted health gain data unavailable due to low numbers, therefore figures reflect unadjusted health gain data
**Participation rates above 100% occurs when the number of questionnaires returned for a period exceeds the number of cases undertaken.

Our readmission rate for children and adults

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged:

(i) 0 to 15

(ii) 16 or over

who are readmitted to a hospital which forms part of the trust within 28days of being discharged from the hospital which forms part of the trust during the reporting period.

Readmissions within 28 days <16

	Reporting Period (all uploaded Dec-12 next Dec-13)		
	Apr 2011 - Mar 2012 standardised to persons 2007/08	Apr 2010 - Mar 2011 standardised to persons 2007/08	Apr 2009 - Mar 2010 standardised to persons 2007/08
	Indirectly age, sex, method of admission, diagnosis, procedure standardised percent		
UHS	10.81	10.40	10.40
National Ave	10.26	10.45	10.43
Highest Trust Score	14.94	16.05	23.01
Lowest Trust Score	0	0	0
Lowest Trust Score (non-zero)	3.75	4.04	4.29

Readmissions within 28 days 16+

	Reporting Period (all uploaded Dec-12 next Dec-13)		
	Apr 2011 - Mar 2012 standardised to persons 2007/08	Apr 2010 - Mar 2011 standardised to persons 2007/08	Apr 2009 - Mar 2010 standardised to persons 2007/08
	Indirectly age, sex, method of admission, diagnosis, procedure standardised percent		
UHS	11.51	11.34	11.09
National Ave	11.45	11.43	11.18
Highest Trust Score	41.65	22.76	21.83
Lowest Trust Score	0	0	0
Lowest Trust Score (non-zero)	3.35	2.44	3.36

Note: This is the most recent data available.

The Trusts responsiveness to the personal needs of its patients during the reporting period.

Unsure what this relates to?

The percentage of our staff who would recommend this trust as a provider of care, to their family and friends

Supporting and listening to our staff that work within UHS is essential to ensure we provide a safe, effective and quality service. From the national staff survey we have improved on the percentage of staff who would recommend the Trust as a provider of care to their family and friends.

UHS staff were asked:
"Staff recommendation of the Trust as a place to work or receive treatment".

For 2012/13 the response rate was 3.64% and in 2013/14 there was a slight increase to 3.79%, which is also higher than the national average.

Question	UHS 2013	National Average for all Acute Trusts 2013	UHS 2012
Q12c – I would recommend my organisation as a place to work	63%	59%	64%
Q12d – If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	71%	64%	67%
KF24 – Staff recommendation of the Trust as a place to work or receive treatment	3.79 (on a scale of 1-5)	3.68	3.64%

The staff survey will continue in 2014/15 and in addition the Friends and Family test question will be asked to all staff working with UHS.

Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism

	Reporting Period			
	2013/14 Q4	2013/14 Q3	2013/14 Q2	2013/14 Q1
UHS	95.82%	95.37%	95.23%	95.38%
National Ave (Acute Providers)	Not yet avaiable	95.84%	95.74%	95.45%
Highest Trust Score (Acute Providers)	Not yet avaiable	100.00%	100.0%	100.0%
Lowest Trust Score (Acute Providers)	Not yet avaiable	77.70%	81.70%	78.78%

Rate per 100,000 bed days of cases of C.difficile infection reported in our trust

	Reporting Period		
	2012/13	2011/12	2010/11
UHS	11.3	18.9	25.8
National Ave	17.3	22.2	29.7
Highest Trust Score	30.8	58.2	71.2
Lowest Trust Score	0	0	0
Lowest Trust Score (non-zero)	1.2	1.2	2.6

The rate per 100 admissions, of patient safety incidents reported in our trust

	Oct 12 to Mar 13			Apr 12 to Sep 12			Oct 11 to Mar 12		
	Rates per 100 admissions	Severe and death	Severe and death %	Rates per 100 admissions	Severe and death	Severe and death %	Rates per 100 admissions	Severe and death	Severe and death %
UHS	5.69	53	1.44	6.42	22	0.5	6.2	33	0.8
National Ave (Acute Teaching Trusts)	7.72	23	0.44	7.03	28	0.5	6.9	31	0.6
Highest Trust Score (Acute Teaching Trusts)	13.7	74	1.44	12.12	86	1.6	10.7	144	2.8
Lowest Trust Score (Acute Teaching Trusts)	3.21	2	0.06	2.77	1	0	0.94	0	0

Other information about the quality of care offered by University Hospital Southampton NHS Foundation Trust

The information below summarises our achievement for performance across all of the performance indicators chosen in our patient improvement framework since 2008/09 and the Monitor Compliance Framework requirements. These are reported fully each month in our trust board performance reports.

Key Performance Indicators					
Key targets	**2011/12**	**2012/13**	**2013/14**	**2013/14**	**Comment**
Targets				**Targets**	
A&E patients, % admitted, transferred or discharged < 4 hours (UHS & Partners)	95.10%	94.30%	93.30%	>= 95%	
18 weeks – Admitted patients treated within 18 weeks	90.00%	92.38%	88.62%	Maintain >= 90%	
18 weeks – Non admitted patients treated within 18 weeks	95.00%	95.24%	88.56%	Maintain >= 95%	
18 weeks - Patients currently waiting on an 18 week pathway within 18 weeks (Incomplete pathways)	Not measured	91.45%	90.57%	Achieve 92%	
6 weeks - Maximum waiting times for 15 key diagnostics tests	0.07%	0.06%	0.03%	<1%	
Cancers: 2 week wait (Urgent GP/ GDP referral) to first hospital assessment	95.80%	95.35%	94.20%	93.00%	
All breast symptoms: referral to first hospital assessment	98.50%	96.83%	94.74%	93.00%	
Cancers: 31 days (Decision to treat) to first treatment	97.70%	98.53%	96.25%	96.00%	
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (drugs)	99.90%	99.69%	99.90%	98.00%	
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (surgery)	96.50%	97.73%	97.61%	94.00%	
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (radiotherapy)	98.90%	99.03%	99.47%	94.00%	
Cancers: 62 days Urgent GP referral to treatment	88.20%	90.11%	88.10%	85.00%	

Outcomes, experience and safety performance indicators

These are both national and local mandated indicators of quality

Outcomes Performance Indicators

Key targets	2011/12	2012/13	2013/14	2013/14 Target	Met/ not met	Comment
Hospital Standardised Mortality Rate (HSMR) University Hospital Southampton NHS Foundation Trust	98.54	102.04	100.01 (Incomplete Year)	<96.8	✗	And also prioritised for 2014/15
Hospital Standardised Mortality Rate (HSMR) Southampton General Hospital	91.44	95.27	94.23 (Incomplete Year)	<90.1	✗	And also prioritised for 2014/15
Hospital Mortality Rate	1.71%	1.84%	1.82 (Incomplete Year)	<1.65%	✗	Monitored as part of early alert system
Emergency Re-admissions Within 28 days (as average of monthly %)	11.0%	10.3%	10.7%	7.5%	✗	UHS KPI 13/14 is based on published Monitor guidance. Target rebased
Patient Reported outcome measures: PROMS Hip replacement data Contributed Knee replacement data contributed	 67.6% 99.7%	 55.6% 104%	 53.9%* 117%*	 80% 80%		*2013/14 data only available for April – Sept 2013 (Published Feb 2014)

Patient Experience Indicators (These are both national and local mandated indicators of quality)

Key targets	**2011/12**	**2012/13**	**2013/14**	**2013/14 Target**	**Met/ not met**	**End of Year**
Total Complaints	687	585	578	<=600	✔	Achieved
Percentage of complaints closed in target time (due this month) (As average of monthly %)	87%	92%	96.7%	>=90%	✔	Achieved
Monthly Picker Survey Recommend hospital to family and friends (as average of monthly %)	94.3%	94.3%	N/A	>=85%		This question is no longer included in the real time picker survey and has been superseded by the National Friends and Family Test.
National Friends & Family Test						
Response Rate			21.7%	20%	✔	Achieved
Net Promoter Score*			70	75		Prioritised 14/15
Monthly Picker Survey Have you ever shared a sleeping area with patients of the opposite sex during this stay in hospital? (Those who gave an answer, as average of monthly %)	11.1%	7%	13%	<=5%	✗	Further work is underway to understand and improve the mismatch between perceived and actual experience.
Same Sex Accommodation (Non Clinically Justified Breaches)	85	10	16	<= 360 (<=30 per month)	✔	Achieved
Nutrition % Patients with MUST Screening in 24 hours (as average of monthly %)	89.4%	91.9%		>=98%	✗	Prioritized for 2013/14

From the performance indicators for patient experience there is a mismatch between perceived and actual experience by patients associated with mixed sex accommodation. Within UHS patients are cared for in single sex bays their care pathway may include a clinical area where male and females share sleeping accommodation such as within an intensive care or acute care unit. Due too this patients often report that they have shared sleeping accommodation when it is appropriate for their care.

Patient Safety Indicators

Key targets	2011/12	2012/13	2013/14	2013/14 Target	Met/ not met	Comment
Serious Incidents Requiring Investigation (SIRI)	159	127	195	<=156	✗	We have exceeded the target due to changes in reporting since November 2013. Both avoidable and unavoidable harm falls and grade 3/4 HAPU are now reported
Never Events	3	2	2	=0	✗	Please refer to supporting information for more details.
Healthcare Associated Infection MRSA bacteraemia reduction	4	3	5	<=4	✗	DoH target is 0 cases for 13/14. Monitor performance limit is for no more than 4 cases for 2013/14
Healthcare Associated Infection Census") (as average of monthly %)	388%	375%	354%	>=100%	✔	Achieved
Healthcare Associated Infection Clostridium difficile reduction	66	40	33	43	✔	Achieved
Avoidable Hospital Acquired 33* Grade III and IV Pressure Ulcers	33*	41	42	<=24	✗	Prioritized for 2014/15. 21 still to be confirmed 25/04/14
Falls Avoidable Falls	13	5	19	<8	✗	Prioritized for 2014 /15 Reporting has improved Each fall is reviewed in depth, for root cause and learning. 9 remain to be confirmed if avoidable or unavoidable
Falls Assessment tool) Compliance (as average of monthly %)	94.7%	94.5%	95%	>=95%	✔	Achieved
Thromboprophylaxis (VTE) % Patients Assessed (CQUIN)	91.21%	95.31%	95.41%	>=95%	✔	Achieved
Thromboprophylaxis (VTE) Pharmacological prophylaxis (as average of monthly %)	93.6%	96.16%	97.32	>=95%	✔	Achieved

Conclusion

Statement of Directors' responsibilities in respect of the quality report

The Trust Board is committed to
continuously improving quality, and
sees this as a top priority. It means
being a world-class provider o
patient experience, patient sa
and clinical outcomes. We are
proud of the achievements of
staff, many of whom have be
recognised nationally for exce
in care.

We have a proactive and rigo
approach to achievement, usi
Patient Improvement Framew
(PIF) to prioritise and drive
excellence in the Trust.

We take our part in supportin
health priorities community-
wide, working closely with ou
commissioners to develop and
achieve the 'Commissioning f
Quality and Innovation (CQUI
programme for local and nati
quality improvement goals.

The directors are required und
Health Act 2009 and the Nati
Health Service Quality Accoun
Regulations to prepare Quality
Accounts for each financial year.
Monitor has issued guidance to
NHS foundation trust boards on the
form and content of annual quality
reports (which incorporate the
above legal requirements) and on
the arrangements that foundation
trust boards should put in place
to support the data quality for the
preparation of the quality report.
In preparing the Quality Report,
directors are required to take steps
to satisfy themselves that:

The content of the Quality Report
meets the requirements set out in
the NHS Foundation Trust Annual
Reporting Manual 2012/13;

old

statement

environment dated 20/05/2013
CQC quality and risk profiles dated
31/03/2013
External assurance opinion on the
quality report 25/05/2013

The Quality Report presents a
balanced picture of the NHS
foundation trust's performance over
the period covered;
The performance information
reported in the Quality Report is
reliable and accurate;
There are proper internal controls
over the collection and reporting
of the measures of performance
included in the Quality Report, and
these controls are subject to review
to confirm that they are working

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By order of the Board

Date: xx/05/2014

Chairman

Date: xx/05/2014

Chief Executive

Response to the Quality Account from Southampton City and West Hampshire clinical commissioning groups

Southampton City and West Hampshire Clinical Commissioning Groups (CCGs) would like to thank University Hospital Southampton NHS Foundation Trust (UHSFT) for the opportunity to review and provide a statement response to their 2013/14 Quality Account. The Trust need to be congratulated on improving the outcomes for the deteriorating patient with the reduction in the number of cardiac arrests, the successful hospital project to improve the care of older patients with delirium and/or dementia and the continued improvement in patient experience demonstrated through the implementation of the Friends and Family test and the national Care Quality Commission (CQC) survey results. It is encouraging to read of the systems being developed by the Trust to improve the reporting, management processes and organisational learning from patient safety incidents.

Both CCGs support the priorities identified for 2014/15 especially the continued focus on reducing hospital acquired pressure ulcers and harm as a result of a fall.

Reviewing the quality account commissioners confirm that as far as it can be ascertained the quality account complies with the national requirements for such a report and the following are of specific note:

- The report provides information across the three domains of quality – patient safety, clinical effectiveness and patient experience.
- The mandated elements are incorporated into the report.
- There is evidence within the report that the Trust has used both internal and external assurance mechanisms.
- Commissioners are satisfied with the accuracy of the quality account, as far as they can be based on the information available to them.
- It is also of note that the Trust has included details of the collaborative activities undertaken with The Patient's Association and The University of Southampton following the publication and national discussion around compassionate care.

It is disappointing to note that the Trust has had another two never events this year. However the CCGs have seen the reports relating to the incidents and undertaken visits to UHSFT for additional assurance and as such are confident that measures have been put in place to prevent them happening again. As both these events related to surgery, the Trust has continued with its safer surgery action plan which commissioners will continue to monitor via monthly Clinical Quality Review Meetings.

The CCGs are surprised that the Trust has not chosen to include priorities with a continued focus on the quality of emergency services with the continued pressure these services have been experiencing and around the Trauma and Orthopaedics (T&O) service which has taken part in an internal quality review process and concerns raised by the Deanery with regards to the support for trainee doctors.

Commissioners also think that some priorities the Trust has set for 2014/15 are not defined sufficiently to support monitoring and clarity of achievement, this may be a presentational issue however the Trust should consider reviewing these. For example:

- Patient Outcomes, Priority 3: Improving care for patients with diabetes – commissioners are not clear what is meant by 'a diabetes discharge plan will be provided' does this mean a shared discharge plan as agreed with the patient for their reference as well or something else.
- Patient Experience, Priority 1: Improving care and safeguarding vulnerable adults – in relation to the '25% reduction in the number of complaint and incidents' it would help to have some clarity as to the baseline figures to consider if the reduction percentage is realistic and achievable.
- Patient Experience, Priority 2: To improve the patient mealtime experiences – commissioners would like to see within the aims details of actions to continue to review and improve the quality and variety of menu choices.

It is of note the number of clinical audits the Trust is participating in, which appears to reflect the diversity of services provided and the summaries provided of actions undertaken from the 36 local clinical audits reviewed.

Overall Southampton City and West Hampshire Clinical Commissioning Groups are satisfied that the plans outlined in the Trust's quality account will maintain and further improve the quality of services delivered to patients.

Awaiting Confirmation of Signatories

Response to the Quality Account from our Council of Governors

On behalf of the Council of Governors I am pleased to comment on the Trusts Quality Account for 2013/14.

The report reflects the challenges faced by the Trust in terms of resource versus demand, which do not get any easier year on year. Despite this the Trust has been able to celebrate many successes, which reflects the tremendous expertise, commitment and sheer hard work from the staff at every level and group within the hospital.

It is pleasing to see that feed-back from patients and families has been acted upon and changes implemented, in particular those from complaints and incidents that required investigation.

Several issues raised by Governors have been considered and are included in the work streams and priorities for next year, in particular patient nutrition.

The work that has been introduced in the ward areas to improve, patient safety, experience and outcomes is to be commended and as Governors we look forward to seeing this initiative rolled out to all areas treating patients whether in-patients or out-patients.

The biggest challenge has been to address the failure to meet the A&E targets. Despite several action plans this problem is yet to be resolved. It is encouraging to see there are intentions to work more collaboratively with external partners, especially social care service and offers some optimism for improvement.

The report states the intentions to achieve national targets, however we believe that the Trust should be more ambitious and strive for better, as those stated are generally a minimum standard only.

Patient access times are already a challenge and Governors will want to see that the actions intended to keep control on this are working.

We understand that this report has to be compiled in accordance with external guidelines, however we feel strongly that in its present format this document is cumbersome and less than straightforward to interpret by the less than expert eye. We ask that consideration is given to reviewing the present format and pressure put upon those who can influence this.

In the meantime we strongly request that a more user friendly document is made available to the residents of Southampton and beyond, which enables them to draw their own conclusions about whether the University Hospital of Southampton is safe, provides a good outcome for their needs and ensures a positive experience.

On behalf of the Council of Governors I would like to thank those involved in producing the document for giving us the opportunity to comment

Margaret Wheatcroft

Lead Governor

Response to the Quality Account from Southampton Healthwatch

Healthwatch Southampton is pleased once again to comment on the quality account of the Trust for the year. Southampton Link continued to provide the public engagement activities of Healthwatch until July 2013 and a number of members are now involved with the Strategy group of Healthwatch, so are in a position to comment on the full year's activities.

We are aware that of necessity, the quality account of a major NHS provider is a long and complex document containing a number of mandatory statements. Nevertheless we are content that the Trust has made a good attempt to ensure that it is clearly presented and understandable to the patients and public. Our overall impression is that it gives good coverage of the trust's services and as far as we can judge there are no significant omissions.

We welcome the appointment of the new Chief Executive and endorse her comment about the pride and commitment of the staff. Members of LINk/Healthwatch are involved in the clinical accreditation scheme and for this and other reasons have visited many wards and departments. We have found that staff, at all levels and over a wide range of roles, show a genuine desire to improve patient satisfaction.

In her statement the Chief Executive refers to deliver the national targets of patients waiting no longer than four hours in the emergency department and patients being treated within 18 weeks. We are pleased that the Trust has 'opened additional capacity to support future delivery' but we would have wished to see more detail and plans to tackle this within the quality account particularly as this has been an issue for the past two years. It is essential that every effort is made to further improve the situation.

Overall, a review of the 'key targets' for clinical outcomes, patient safety and patient experience is very positive with the Trust having achieved 8 of the 9 targets. In particular we are pleased that the Trust has given significant prominence to the 'Friends and family' test and the display of the results on each ward. However it is disappointing that the Trust has again reported two 'never events' and the number of avoidable hospital acquired pressure ulcers and avoidable falls continues to be of concern. The one priority not achieved was "Making improvements in mortality rates and the way mortality is measured and evaluated". This is of concern as in setting the priorities for 2014/15 the Trust confirms that this "can be an indicator of things going wrong in a hospital and it is important to ensure that the data is robust and outcomes accurately coded and then utilise the data to review by speciality and by day of treatment". The Trust has correctly identified this as a priority for 2014/15; we would wish to see the Trust rated better than its current rating for HSMR.

As an acute hospital and regional provider, UHS faces a year on year increase in patient levels and it is hoped that they are able to achieve their targets for 2014/15.

We are pleased to report that the trust has reaffirmed that it wishes to involve Healthwatch on a number of issues and maintain the relationship previously enjoyed with LINk for the benefit of patients.

Harry Dymond

Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2013 to June 2014
  - papers relating to Quality reported to the Board over the period April 2013 to June 2014
  - feedback from commissioners dated [XX/XX/20XX]
  - feedback from governors dated [XX/XX/20XX]
  - feedback from local Healthwatch organisations dated [XX/XX/20XX]
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [XX/XX/20XX]
  - [latest] national patient survey [XX/XX/20XX]
  - [latest] national staff survey [XX/XX/20XX]
  - the head of internal audit's annual opinion over the trust's control environment dated [XX/XX/20XX]
  - CQC quality and risk profiles dated [XX/XX/20XX].
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

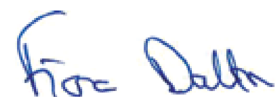
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Date: xx/05/2014

Chairman

Date: xx/05/2014



Chief Executive

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:	SOLENT NHS TRUST: DRAFT QUALITY ACCOUNT 2013/14		
DATE OF DECISION	15 MAY 2014		
REPORT OF:	DIRECTOR NURSING AND QUALITY		
CONTACT DETAILS			
AUTHOR:	Name: Judy Hillier	Tel:	023 8060 8900
	E-mail: Judy.Hillier@solent.nhs.uk		
STATEMENT OF CONFIDENTIALITY			
None			

BRIEF SUMMARY

This report introduces the draft Solent NHS Trust Quality Account for 2013/14. The account reports on progress in meeting the targets set for the 2013/14 as well as looking ahead to set priorities for the year 2014/15. Judy Hillier, Director of Nursing and Quality, will present the Quality Account to the Panel.

RECOMMENDATIONS:

(i) To note and provide comment with regard the Solent NHS Trust Draft Quality Account

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Panel to consider the evidence in order to agree findings and recommendations at the end of the inquiry process.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. To be assured that Solent NHS Trust are continuing to deliver high quality and relevant care for the population it serves and that the priorities it has set for the coming year are in line with commissioning and JSNA intentions.

DETAIL (Including consultation carried out)

3. Due to timetable issues the Solent NHS Trust's Quality Account is not currently available for publication. A supplementary paper will be published detailing the Trust's quality account for the Panel to enable them to consider the matter fully at the meeting on the 15th May 2014. A summary of the findings can be found as Appendix 1 of the report.

4. Judy Hillier, Director of Nursing and Quality, will present an overview of Solent NHS Trust's Quality Account to the Panel, with a particular focus on issues for Southampton patients.

5. Members are asked to consider the attached report and following discussions at the meeting comment on the draft University Hospital Southampton NHS Trust Draft Quality Account. They are also asked to consider if there are any matters within the report that they wish to receive further information as part of their work programme for the next year.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None

Property/Other

7. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

9. None

POLICY FRAMEWORK IMPLICATIONS

10. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Solent NHS Trust Quality Account – Executive Summary

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Solent NHS
NHS Trust

Executive Summary Report for Southampton HOSP and HWWB

Title of Paper	Solent NHS Trust Quality Account – Executive Summary				
Author(s)	Ellen McNicholas Deputy Director of Nursing and Allied Health Professionals		**Executive Sponsor**	Judy Hillier Director of Nursing and Quality	
Link to strategic Objective(s)	x	Improving outcomes	x Working in partnership	x	Ensuring sustainability
Date of Paper	7th May 2014		**Committees presented**		
Action requested of the Board	x	To receive	For decision		
References					

The purpose of this paper is to provide a summary of the Quality Account for 2014-15 for Solent NHS Trust for consideration and comment, with emphasis on the achievement against last year's priorities and the identification of the Priorities for the year moving forward.

The purpose of the Quality Account is to share information about the quality of our services, and our plans to improve even further, with patients their families and carers. The public and patients can also view quality across NHS organisations by viewing the Quality Accounts on the NHS Choices website: www.nhs.uk

The quality account includes information mandated by NHS Act 2009, and in the terms set out in the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 and the NHS (Quality Accounts) Amendments Regulations 2012 (collectively "the Quality Accounts Regulations").

In addition to ensuring that we have included all of the mandatory elements of the Quality Account, we are engaging with staff, patients, Trust members, commissioners, carers groups and our Local Involvement Networks to ensure that the Account gives an insight into the organisation and reflects the priorities that are important to us all. As a result, we have identified specific and measurable improvement initiatives in each of our priority areas.

For the panel today we are providing this summary of the priorities for your consideration and comment. Each of the identified Priorities for both the historical 2013/14 achievements and the future 2014/15 actions have relevance for the residents of Southampton, except those referring to adult mental health. Solent does not deliver adult mental health care for Southampton City residents.

The following chart lists the draft priorities for 2014/15. Full details of achievement against the present year priorities can be found in the draft Quality Account document, to follow.

2014/15 Priorities	
	Patient Safety
1	To reduce to zero the number of avoidable pressure ulcers (including reducing overall rate of community acquired pressure ulcers)
2	Improve the detection and management of medical deteriorating patients in our care (reduction in incidents)
3	Ensure appropriate staffing levels
	Patient Experience
4	Ensure communications to staff, service user, carers and patients are available in 'easy read' and other 'accessible formats'
5	Incrementally roll out real time capture of patient and service user experience
6	Promoting 'recovery' and ensuring the inclusion of the service user in care planning
	Clinical Effectiveness
7	Reduce the number of amputations in patients with diabetes
8	Reduce the number of clients who are unable to access a walk-in sexual health appointment on the day
9	Improve the physical health of mental health service users

Recommendation

The Panel is invited to comment on the 2014/15 Priorities as outlined above. Formal comments made will be included, by Solent NHS Trust, in the final published report.