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HEALTH OVERVIEW AND SCRUTINY PANEL

Thursday, 27th April, 2017
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor P Baillie
Councillor Houghton
Councillor Mintoff
Councillor Noon
Councillor Savage
Councillor White

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have six 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 Adult 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 and 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.

Mobile Telephones: - Please switch your mobile telephones to silent whilst in the meeting.

Use of Social Media: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Public Representations

At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

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

COUNCIL'S PRIORITIES:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

CONDUCT OF MEETING

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 of 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.

Dates of Meetings: Municipal Year 2016/2017

2016	2017
30 June	18 January
25 August	23 February
27 October	27 April
22 December	

AGENDA

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)

(Pages 1 - 4)

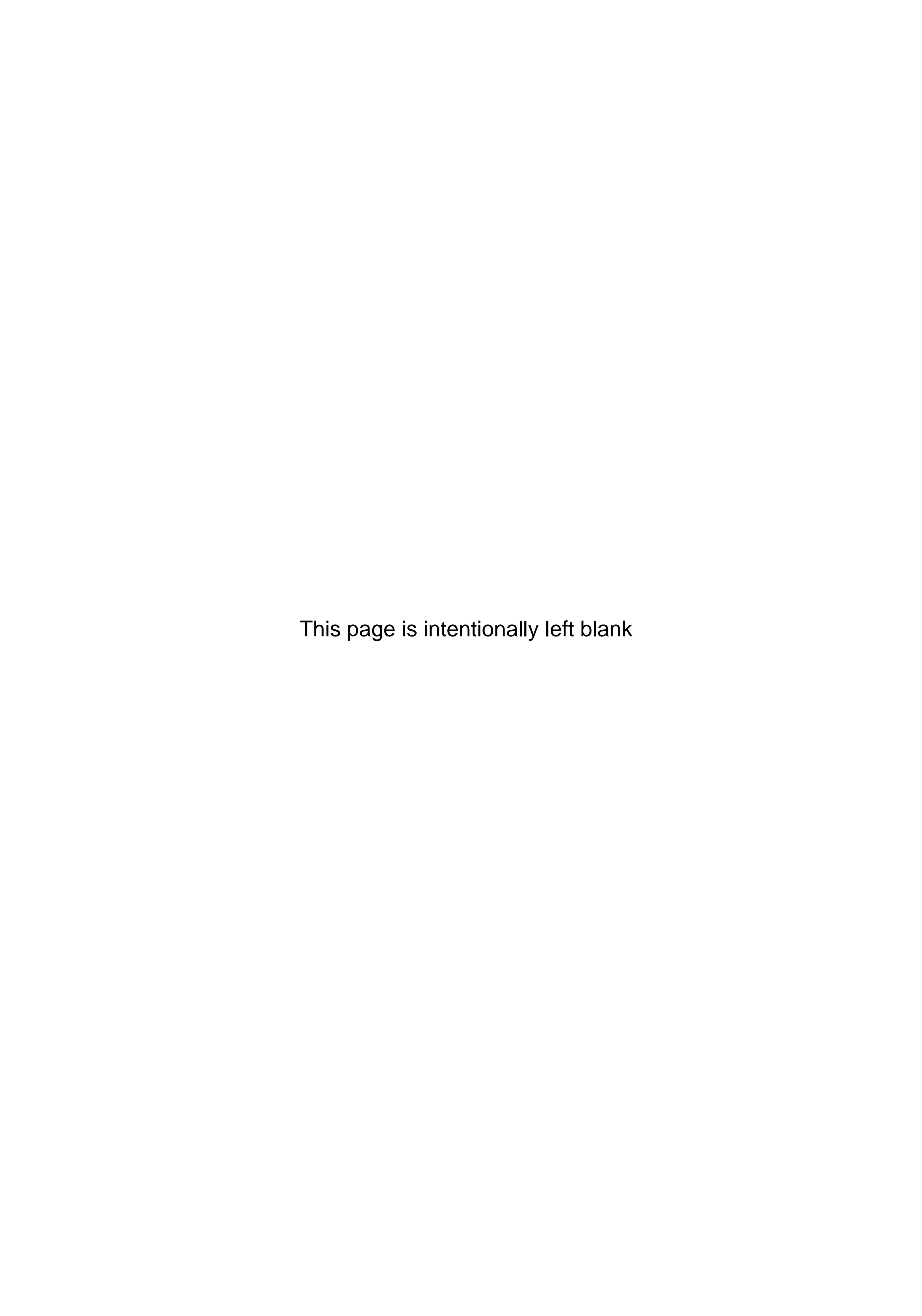
To approve and sign as a correct record the minutes of the meeting held on 23 February 2017 and to deal with any matters arising, attached.

7 SOUTHAMPTON PROVIDER DRAFT QUALITY ACCOUNTS 2016/17

(Pages 5 - 326)

Report of the Service Director, Legal and Governance introducing the 2016/17 draft Quality Accounts for NHS providers operating within Southampton.

Wednesday, 19 April 2017 SERVICE DIRECTOR, LEGAL AND GOVERNANCE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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 23 FEBRUARY 2017

Present: Councillors Bogle (Chair), Houghton, Mintoff, Noon, Savage and White

Apologies: Councillor P Baillie

19. MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

RESOLVED: that the minutes for the Panel meetings on 19th December 2016 and 18th January 2017 be approved and signed as a correct record.

20. EMERGENCY DEPARTMENT PERFORMANCE

The Panel considered the report of the Chief Executive, University Hospital Southampton Foundation Trust, providing the Panel with an update on emergency flow in University Hospital Southampton.

Fiona Dalton Chief Executive, University Hospital Southampton (UHS) and John Richards Chief Executive Officer, NHS Southampton City CCG were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters of concern including:

- The performance against targets for Emergency Department flow.
  - It was explained that overall the figures showed that performance had stabilised despite increased attendances to the Emergency Department. It was noted that locally numbers attending the emergency department had increased at a lesser rate than the national rate.
- That the Trust had received an offer of match funding from the Treasury to fund a specialist emergency department for children.
  - It was explained that it was hoped that this would alleviate pressure on the Emergency Department (ED) and enable the more effective flow of patients through the system. It was additionally noted that the establishment of the Minor Injuries Unit and arrangements in the local GP surgeries had continued to provide a ready alternative to queuing in the ED.
- That the Department had to combat different types of pressure on the service seasonally.
  - It was explained that the summer saw a higher number of attendees than winter. The Panel noted that the summer saw a higher number of accident and trauma cases that were more easily processed and discharged whilst winter saw an increase in the attendance of patients with more complex and difficult care demands, often associated with older patients. It was noted that these patients often required longer term treatment and the establishment of an effective care package prior to being able to return home.

- The Panel questioned whether the Trust were able to alleviate pressure by adjusting the numbers of patients treated by elective surgery over the winter.
    - It was explained that this was not always possible because of targets relating to treatment times. However, it was noted that as a last resort the hospital would reschedule or cancel appointments for elective surgery.
- The Panel questioned whether there were clear links in the winter to respiratory cases that could be caused by the quality of air within Southampton.
    - It was noted that it was not entirely clear why there was an increase in ED attendances this winter but it reflected a national trend.

RESOLVED that the Panel noted the improvements that had been made and requested that the issue be brought back to Panel at a future meeting.

21. UPDATE ON DISCHARGES FROM UNIVERSITY HOSPITAL SOUTHAMPTON

The Panel considered the report of the Chief Executive of University Hospital Southampton and the Acting Service Director – Adults, Housing and Communities, providing the Panel with an update on discharges from University Hospital Southampton.

Fiona Dalton Chief Executive, University Hospital Southampton (UHS), John Richards Chief Executive Officer, NHS Southampton City CCG and members of the public were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed the following issues:

- The improving performance of the Integrated Discharge Unit (IDU).
    - It was noted that there had been continued improvement in the rates of discharge for the hospital, however considerable progress still needed to be made. The Panel was told that since the development of the IDU efforts had been made to bring employees from the different organisations together as one team.
- Additional investment in the provision of domiciliary care services.
    - It was noted that additional resources had been allocated in order to provide additional care packages that would enable people to return home rather than stay in a hospital bed.
- Improvements in the monitoring of care packages.
    - It was explained that efforts had been made to improve the monitoring of health care packages and ensure that the correct level of care could be delivered for the correct period of time.
- The integration of IT systems.
    - It was noted that work was still ongoing in working towards an integration of IT systems.
- How the discharge process would be affected by the Sustainable Transformation Plan for Hampshire and the Isle of Wight.
    - It was noted that the IDU was a good example of how the systems were being pulled together to provide better care.

RESOLVED that the Panel noted the improvements that had been made and requested that the issue be brought back to Panel at a future meeting.

22. **DRAFT HEALTH AND WELLBEING STRATEGY (2017-2025)**

The Panel considered the report of the Director of Public Health seeking comments and feedback on the draft Health and Wellbeing Strategy 2017-2025.

Councillor Shields (Cabinet Member for Health and Sustainability and Chair of the Health and Wellbeing Board); the Director of Public Health and the Service Lead, Policy, Partnerships and Strategic Planning; Annabel Hodgson from Healthwatch Southampton and Joe Hannigan and Penny Turpin members of the public were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters and concerns including:
- the 5 areas of focus and priorities set out within the draft Strategy;
- the welcomed emphasis on children as a priority within the Strategy;
- the broad approach of the strategy and the need to advocate and deliver approaches even if they were politically challenging; and
- the potential to use funding collected through the Community Infrastructure Levy to contribute to health and wellbeing projects.

RESOLVED that

(i) the Panel welcomed the priorities set out in the strategy and the 5 stated areas of focus. The Panel were encouraged by the emphasis on children's health and urged the Cabinet Member to prioritise issues such as diet, dental health and obesity to improve outcomes for children in recognition that this will in time improve health outcomes across the city. The Panel recognised that this cannot be achieved in isolation and welcomed the commitment to working with schools, and other partners to help deliver improvements in children's health.

(ii) the Panel considered that wording relating to the management of risk by adolescent children be given further consideration to give it a greater resonance and make it realistic and achievable. In addition the Panel requested that emphasis on workplace wellbeing should be broadened to include employers and employees.

(iii) that the Panel requested that mental health be given a greater prominence within the strategy.

(iv) the Panel looked to the Health and Wellbeing Board to demonstrate strategic leadership, to learn from best practice from around the world to inform action, and to champion initiatives that would improve health and wellbeing outcomes in the city, even if it presents potentially challenging political conversations with residents.

23. **UPDATE ON THE IMPLEMENTATION OF SOUTHAMPTON CITY FOOT CARE PATHWAY**

The Panel considered the report of Director of Quality and Integration providing the Panel with an update on the implementation of the Foot Care Pathway.

Graham Bowen - Solent NHS Trust and Georgina Cunningham - Southampton City CCG were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed and number of matters and concerns including:

- Ongoing transformation of foot care within the City.
    - The Panel noted the improvements already made and the timelines involved.
- The support given to diabetics.
    - The Panel noted that as part of care offered to diabetics within the City patients should be offered an annual foot care assessment. It was explained that patients diagnosed with diabetes should be supported by the GP's specialist nurse.
- The timescales involved in seeing a reduction in amputations related to diabetes.
    - The Panel noted that it was likely that, given the current cohort, the statistics would show an increase in minor amputations in the short term. . It was A reduction in amputations was expected by 2018/19.
- The shortage of podiatrists within the Country.
    - It was explained that there were relatively few trained podiatrists employed by the NHS.

RESOLVED that the Panel welcomed the progress made and that they would continue to monitor performance at future meetings.

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	SOUTHAMPTON PROVIDER DRAFT QUALITY ACCOUNTS 2016/17
DATE OF DECISION:	27 APRIL 2017
REPORT OF:	SERVICE DIRECTOR - LEGAL AND GOVERNANCE

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STATEMENT OF CONFIDENTIALITY

Not applicable

BRIEF SUMMARY

This report introduces the 2016/17 draft Quality Accounts for NHS providers operating within Southampton. As part of the formal consultation process representatives from the providers will present key achievements against plans for 2016/17 and highlight priorities for 2017/18.

The Panel are requested to review the appended draft quality accounts from University Hospital Southampton NHS Foundation Trust (UHS), Care UK, Southern Health NHS Foundation Trust and Solent NHS Trust and agree any feedback for the NHS providers to consider prior to publishing final Quality Accounts by 30 June 2017.

In addition, attached as Appendix 4, is a briefing paper providing an update on Southern Health NHS Foundation Trust's Clinical Services Strategy.

RECOMMENDATIONS:

		That the Panel:
	(i)	Review the appended 2016/17 draft Quality Accounts for each of the city's NHS providers.
	(ii)	Agree a response to each Quality Account for inclusion within the final report.
	(iii)	Consider and agree if there are any matters arising within the appended documents that the Panel would like to receive further information on as part of its future work programme.

REASONS FOR REPORT RECOMMENDATIONS

1.	NHS providers are required to send their draft Quality Accounts to the Health Overview and Scrutiny Panel. The Panel have an opportunity to comment on the documents prior to publication.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)	
3.	A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.
4.	Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.
5.	The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided.
6.	The Department of Health requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year. The requirement is set out in the Health Act 2009. The documents appended to this report are therefore draft reports subject to amendments, updating to incorporate data that is not yet available, and Board approval.
7.	At the Panel meeting on the 27 April 2017 representatives from each of the NHS providers operating within Southampton will briefly outline their key achievements against plans for 2016/17 and highlight their priorities for 2016/17. The information will be presented with a specific focus on the implications for Southampton patients and residents.
8.	The Panel have an opportunity to discuss the draft Quality Accounts with the representatives from the NHS providers and to submit a response to the document for inclusion within the final version.
9.	In addition, Solent NHS Trust will update the Panel on progress implementing the CQC action plan and Southern NHS Foundation Trust will apprise the Panel of the new Clinical Services Strategy, attached as Appendix 4.
RESOURCE IMPLICATIONS	
Capital/Revenue	
10.	None.
Property/Other	
11.	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
12.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
13.	None
POLICY FRAMEWORK IMPLICATIONS	
14.	None

KEY DECISION	No	
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report	

SUPPORTING DOCUMENTATION

Appendices

1.	University Hospital Southampton NHS Foundation Trust – Draft Quality Account and Quality Report 2016/17
2.	Care UK – Draft Secondary Care Quality Account 2016/17
3.	Southern Health NHS Foundation Trust – Draft Quality Report and Quality Account 2016/17
4.	Southern Health NHS Foundation Trust – Briefing Paper on the Clinical Services Strategy
5.	Solent NHS Trust - Draft Quality Account 2016/17

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	No

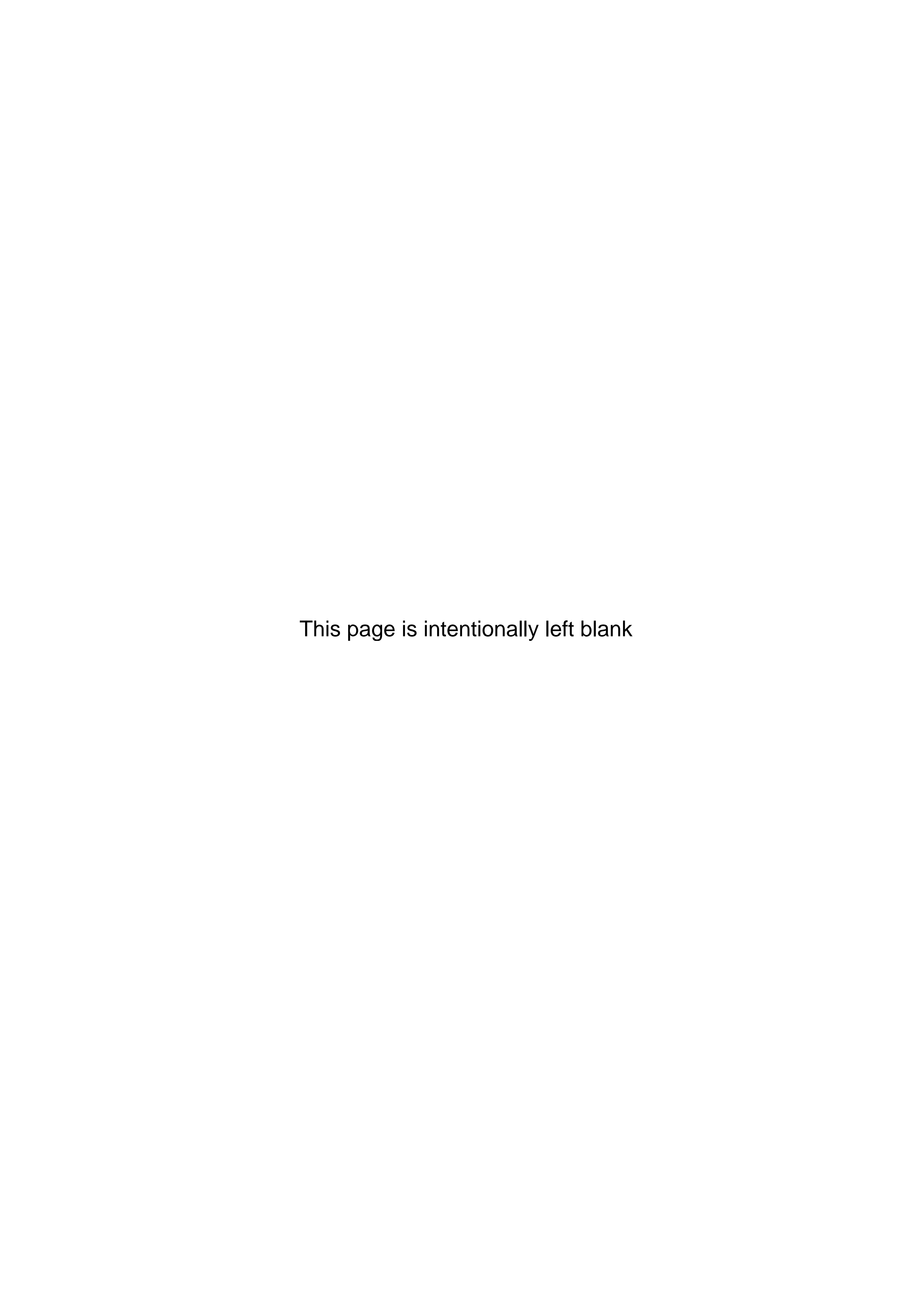
Privacy Impact Assessment

Do the implications/subject of the report require a Privacy Impact Assessment (PIA) 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

University Hospital Southampton NHS Foundation Trust

Quality Account & Quality Report 2016/2017 - DRAFT

Contents

1. Statement on quality from the Chief Executive
2. Introduction: Our approach to quality assurance
3. Progress against 2016/17
4. Priorities for improvement 2017/18
    - Deciding our quality priorities for 2017/18
    - Priority 1 : Patient Experience
    - Priority 2 : Patient Safety
    - Priority 3 : Clinical Outcomes
5. Review of quality performance
    - Participation in national and local clinical audit
    - Participation in clinical research
    - CQUIN payment framework
    - Data quality
6. Conclusion

Annex 1 : Statements from Commissioners , Health watch and Council of Governors

Appendices 1 : Patient Improvement Framework (PIF) priorities 2017/18
Appendices 2:Definitions of Pressure Ulcer grading
Appendices 3:Quality Performance data
Appendices 4:CQUINS data
Appendices 5:Clinical audit and confidential enquiries data
Appendices 6 : Outcome measures data

1. Statement from the Chief Executive

DRAFT

Our mission is to be better every day and to work with our partners at the leading edge of healthcare for the benefit of patients. The highest quality patient care remains the top priority at University Hospitals Southampton (UHS). This is reflected every year in our annual objectives and in our core values of 'patient's first, working together and always improving', however we cannot do this without our staff and we are proud that in 2016 University Hospital Southampton NHS Foundation Trust was rated as one of the top performing organisations in the country for staff engagement.

The trust was rated among the top ten in the country for staff being happy with the standard of care provided (82% against a national average of 70%) and the top 20% for staff recommending the trust as a place to work or receive treatment (4.03 against a national average of 3.76), staff who feel they are able to contribute towards improvements at work (76% against 70%) and good communication between senior management and staff (43% against 33%).

The trust also ranked among the top 20% for staff agreeing their role makes a difference to patients (92% against 90%) and organisation and management interest in and action on health and wellbeing (3.79 against 3.61), as well as staff satisfied with opportunities for flexible working (57% against 51%), satisfaction with resourcing and support (3.40 against 3.33) and recognition and value of staff by managers and the organisation (3.62 against 3.45).

In addition, the trust was among the lowest (best) 20% of trusts for percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (23% against 27%).

2015/16 has been a challenging but rewarding year and we are proud of our achievements. This quality account looks back at some of those achievements and sets out our priorities for the coming year 2017/18.

We have shown significant improvements in many areas of patient care such as end of life care (p.xxx), safe and timely discharge (p. xxx) and responding to and learning from complaints and incidents (p.xxx).

We have also been able to invest in improved and expanded facilities for patients and for research. Building work started on the new radiotherapy bunker, and the new Cancer Immunology Centre. The ongoing investment into diagnostics, in particularly radiology but also more specific schemes such as hysteroscopy, should help patients right across the hospital.

We have been successful in renewing our research funding, through both our Biomedical Research Centre and Clinical Research Facility. There was tough competition for this funding as we were competing against every other academic medical centre in the country, and the rules were clear that only "world class research" would be funded. We are proud of the Southampton research team and the knowledge that Southampton research, for instance into childhood obesity, osteoporosis and COPD, will continue to help patients receive better care across the world. Our extensive participation in research has a positive impact on patient outcome.

We also recently received national recognition as a "global digital exemplar"; an award which we anticipate will bring an additional £10 million of national money. This will not only be through some large-scale informatics projects, but importantly improving the day to day IT equipment staff have available.

Children's services are very important to us, and thanks to a combination of NHS funds and very generous donations, we have been able to refurbish and expand Piam Brown Ward and are currently expanding Paediatric Intensive Care. We also have been raising funds and sponsorship for the new children's emergency department which has been match funded by the treasury. Both these developments sees the further expansion of our children's hospital build.

The new main entrance has also been completed, and it is worth noting it was rebuilt without spending any NHS money.

2015/16 has seen us in financial surplus. This means we can continue to look to invest in capital investment (for example, buildings or equipment). Our current financial position is enabling us to plan continued investment in our estate, particularly for the most vulnerable patients - for instance expansion and refurbishment of high dependency and intensive care facilities for patients of all ages, and theatre and interventional radiology rooms. This means that we will continue to have the facilities to look after the sickest Patients in Wessex and beyond.

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Our financial position is a result of countless acts of imagination, commitment and innovation across the trust all of which has improved our efficiency and allowed us to treat more patients, with less waste and more added value.

I am proud of our achievements and the commitment and dedication of our staff who strive continuously to provide high quality, cost effective and compassionate care. I am constantly left inspired by staff across all areas of work within this Trust, with outstanding displays of commitment, dedication and desire to provide the best possible service even at the most difficult times.

We have also done well in our 2016 in-patient survey which has highlighted many positive aspects of the patient experience. Overall: 84% rated care 7+ out of 10, 83% felt they were treated with respect and dignity and 84 % always had confidence and trust in doctors. 97% of our patients rated our environment very/fairly clean and 91% felt they always had enough privacy when being examined or treated.

Most patients are highly appreciative of the care they receive. However, it is evident that there is also room for improving the patient experience and we continue to focus on the patients experience of discharge (p. xxx) and nutritional and hydration needs (p.xxx) a

This quality account contains information on our performance in relation to quality, which, by its nature is less precise than financial information and there are acceptable differences in the way this information is measured. In addition, it has less internal and external scrutiny than the financial information presented in our annual report and accounts.

With this in mind UHS has done its best to ensure that, to my knowledge, the information in the document is accurate.

Fiona Dalton

CEO

2. Introduction: our approach to Quality Assurance

'Always improving' is embedded at UHS as one of the values in our 'forward vision' along with 'patients first' and 'working together'. These are the Trust's underpinning values, and delivering on them in relation to quality is the responsibility of Trust Board. The named executive leads for quality are the Medical Director and the Director of Nursing and Organizational Development.

Quality Improvement is just one element of a coordinated and organisation -wide approach to quality. In previous years these priorities have been outlined in a Trust- wide Patient Improvement Framework (PIF) with priorities set against outcomes, safety, experience and performance. This year we have listened to feedback from our staff and changed our approach to focus on fewer key priorities in each domain. We recognize that the quality improvement framework should focus on priorities not already led and measured in other key operational strategies and that this will strengthen our message to staff about what the priorities are. The PIF can be found in Appendices 1.

Our quality improvement framework is underpinned by strategies on safety, experience and engagement, clinical effectiveness and clinical quality and these set out our longer term aims.

To embed quality and provide assurance at ward and department level the Trust has introduced a Clinical Accreditation Scheme (CAS) a process where wards or departments are required to demonstrate adherence to standards of care to become accredited. The process for wards gaining this accreditation is through the submission of information on key quality performance indicators, patient complaints and compliments to a senior clinical panel with patient representatives who also undertake an unannounced visit of the ward or department. Successes are celebrated and areas to improve agreed where necessary.

The Trust also conducts Clinical Quality Reviews (CQR's) of nominated services in each Division based on the Care Quality Commission (CQC) inspections and identified key lines of enquiry. The objective of the CQR is to provide an internal assurance process which is proportionate, risk based, professionally informed and based on what matters to patients and staff. This information is also triangulated with feedback around areas of good practice from the division, direct observation during the review and other information collected during the CQR which provides evidence for the overall judgement framework. A formal report and action plan is generated following the review.

The Trust also monitors ward standards through the clinical quality dashboard which focuses performance against key metrics including patient safety, effectiveness, patient experience and outcomes from matron peer walkabouts.

Our commitment to safety

Healthcare carries some risk and while everyone working in the NHS works hard every day to reduce this risk, harm can still happen. Whenever possible, we must do all we can to deliver harm free care for every patient, every time, everywhere.

We will:

1. Put safety first.

Commit to reduce avoidable harm in the NHS by at least half and make public our goals and plans developed locally.

In 2015 the Trust agreed a new ambitious strategy to reduce avoidable harm to all patients within our care and go further and faster to support all clinicians to provide a high level of safe care consistently to all our patients. We fully aligned our strategy to the NHS England sign up to safety campaign and to demonstrate our commitment we have made public our 5 key pledges.

2. Continually learn.

Make our organisation more resilient to risks by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

As a Trust it is important that we learn when things go wrong, and as such we take reported incidents very seriously. Using a well-received e-reporting system for incidents (including "near misses") facilitates real time reporting and escalation in order that appropriate action is taken. It has also improved the reporting of themes down to ward level and feedback to those who have reported the incident, and allowed meaningful thematic analysis at all levels.

In the national learning reporting system, we benchmark as a top reporting Trust due to the higher as a result of the higher number of incidents reported per 100 admissions, the timeliness of reporting, and the lower numbers of incidents graded as high and moderate harm.

We focus on a culture which allows staff to 'speak up, speak out' about practice which compromises patient safety as part of the Trust raising concerns (or whistle blowing) helpline. Our staff survey shows that our staff rate us as above average in:

- Organisation treats staff involved in errors fairly – 65% against a national average for acute trusts of 54%
- Organisation encourages the reporting of errors- 90% against a national average for acute trusts of 87%

- Organisation takes action to ensure errors are not repeated-75% against a national average for acute trusts of 69%
- Staff given feedback about changes made in response to errors-64% against a national average for acute trusts of 55%
- Staff know how to report unsafe clinical practice-96% against a national average for acute trusts of 95%
- Staff would feel secure raising concerns about unsafe clinical practice-76% against a national average for acute trusts of 69%
- Staff would feel confident that the organisation would address concerns about unsafe clinical practice-66% against a national average for acute trusts of 57%

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 (pressure ulcers, patient falls, VTE [blood clot] and urinary infections due to catheters). The audit is undertaken by our staff 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 1,100 patients audited each month.

3. Be honest and transparent. Honesty and transparency with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

The duty of candour is important legislation that requires us to be open with patients and to investigate and share the findings when things have gone wrong (in cases where the harm is moderate or greater). This builds on our current policy of being open.

We have worked hard to ensure that our staff are aware of their obligations under the duty of candour, and have provided education and support to enable them to do this.

We provide training to staff of all levels both as part of their induction, education days and through rolling local programmes and cascade training.

Our ‘Being Open Policy – a Duty to be Candid’ policy outlines the steps that staff should take and the internal website provides resources and advice. We have a leaflet to explain how we investigate and learn from incidents which includes how we will be open, involve them and keep them updated. Every patient or their family are contacted by letter following a moderate high harm incident and are invited to ask any questions they would like to be answered as part of the investigation. We will also meet with patients and their families if this is their wish. We carry out regular monitoring through the relevant fields on our risk management system Ulysses to monitor compliance.

4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

UHS are working in collaboration across Wessex to improve rapid assessment and treatment of Sepsis and Acute Kidney Injury (AKI) and improving standards of care and outcomes for patients undergoing emergency laparotomy, sharing our approach and learning across the Wessex Academic Health Science Network (WAHSN). UHS is a key member of the WAHSN Patient Safety Collaborative and staff participate in shared learning activities within this Collaborative.

5. Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

In a large organization such as the NHS things will sometimes go wrong and this will have an impact on all those involved. UHS recognises the importance of ensuring that where needed the appropriate support for staff is available in an effective, efficient and timely way. We provide a range of support process for Trust staff involved in an incident, complaint or claim. Individuals have the opportunity to share their experiences and provide feedback regarding the support they have received.

Every year UHS holds a safety conference attended by over 100 delegates from our staff and partners. This is an opportunity to celebrate our successes and share our challenges. Our staff say: Comments from our staff were:

‘I attended the safety study day last week what a fantastic day inspiring speakers, great organisation, one of the best days I have attended in a long time, a credit to our Trust’

‘Excellent range of speakers, all very interesting and informative. Good to use individual cases for examples, very impressed with the patient’s own story of surviving sepsis, very powerful messages. Glad she is using her experience to help others’

This was also demonstrated via the safety pledges each delegate was asked to write following the conference. Such as:

- To create and publish a safety magazine/newsletter for theatres to educate staff on all matters of safety and safe practice
- To ensure that I have the courage to speak up when I have something to contribute to a situation and not assume that the leader has considered all risk factors
- ‘Patient First’ – my pledge is to ensure my patients remain informed and involved in their care so they feel safe in my care

All pledges are emailed to delegates to offer support in implementing them and to follow up on their progress.

Our commitment to Staff: NHS Staff Survey

The NHS Staff Survey results predominantly aim to inform us about staff experience and well-being. Nationally, the NHS Staff Survey results provide an important measure of performance against the pledges set out in the NHS Constitution. The constitution outlines the principles and values of the

NHS in England, setting out a number of pledges that define what staff should expect from NHS employers.

In 2016 our top 5 results were:

1. KF7. Percentage of staff able to contribute towards improvements at work- 76% against a national average for acute trusts of 70%

2. KF6. Percentage of staff reporting good communication between senior management and staff- 43% against a national average for acute trusts of 33%

3. KF31. Staff confidence and security in reporting unsafe clinical practice- 3.81 against a national average for acute trusts of 3.65

4. KF5. Recognition and value of staff by managers and the organisation- 3.62 against a national average for acute trusts of 3.45

5. KF15. Percentage of staff satisfied with the opportunities for flexible working- 57% against a national average for acute trusts of 51%

We also continued to perform above average for KF21 -percentage believing that trusts provide equal opportunities for career progression or promotion – 88% against a national average for acute trusts of 87%.

Table 1 – KF 21 percentage believing that trust provides equal opportunities for career progression or promotion 2016 breakdown:

UHS	Average for acute Trusts	Disabilities	Hours	Gender	Age groups
White – 89%	White – 88%	Staff with disabilities – 81%	Part time staff – 88%	Men – 86%	16 – 30yrs – 90%
BME – 78%	BME – 76%	Staff with no disability – 89%	Full time staff – 88%	Women – 89%	31 – 40yrs – 86%
					41 – 50yrs – 88%
					51+yrs – 87%

In 2016 our performance for KF 26 - percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months was unchanged from 2015 – 43% against a national average for acute trusts of 45%.

To further improve supporting our staff in 2017 UHS are developing a framework of core behaviours to support each of our values and our wider quality strategy and organizational development. The behavioural framework 'living our values' will be used in recruitment, appraisal, performance management and talent management.

Our consultation for this included multidisciplinary focus groups which were held between September and November 2016 with trained internal facilitators, lunchtime sessions which were led by the CEO and Director of Nursing, one to one interviews with senior executives (Talent Works) and other staff at Fab NHS Change Day, and online input from Survey Monkey. Approximately 300 staff have been involved in the process so far.

In collaboration with our black and minority ethnic (BME) network, we have developed a workforce race, equality and action (RACE) place against the workforce race quality standard to address inequalities for our BME staff.

Our focus makes explicit behaviours expected in 3 areas – putting patients first, working together and always improving:

- Working with colleagues to agree a shared view of what good looks like and what we need to achieve
- Joining things together across professional and organisational boundaries to make them easier, better and safer for patients and staff
- Taking a genuine interest in our colleagues and patients as people
- Sticking to our word and doing what we say we will do
- Finding creative ways to bring people together in order to build long-term relationships based on trust and respect
- Offering constructive feedback to colleagues with intent to help them improve

- Valuing each other as the most precious resource in UHS.
- Being there for each other during the low points as well as the high.
- Supporting colleagues to develop their potential and enabling everyone to be part of shaping our services.
- Listening to each other and responding to the needs of others.
- Recognising and celebrating the achievements of others.
- Appreciating our diversity and making the most of the difference between us.
- Being proud to be part of UHS and of making a difference for patients.

Over the next 12 months we will continue to promote the NHS staff survey and encourage staff to participate. Any issues or concerns identified will be reported to the board and a suitable action plan developed and implemented. We will use the feedback from the survey to support staff to improve the services we deliver and will share our findings so that we can learn from our mistakes.

Our commitment to education and training

Training health professionals in quality improvement has the potential to impact positively on attitudes, knowledge and behaviours. The health care workforce needs to be adequately prepared to ensure it continually understands and measures quality of care in terms of structure, process, and outcomes. To deliver quality care, health professionals must be able to be clear about what they are trying to accomplish, how they will know that a change has led to improvement, and what change they can make that will result in an improvement

We promote educational experiences whereby health professionals define best practices by reviewing currently available information and literature, compare these with current practice to identify gaps in performance, develop policies, procedures and standards to organize care around the best practices, and then continuously monitor them.

We already have significant quality improvement activity in education at UHS, including a training programme to develop professional ‘quality improvement’ skills across the organization, and a formal four day training programme in quality improvement techniques.

We also support learner reviews as part of the quality assurance process for learning in clinical areas, and 3 Scientific Training Programme (STP) candidates have completed their training and have been retained in the organization in paediatric cardiology, radiation protection and radiotherapy physics and pharmacy.

Leadership development and human factors are now an integral part of patient safety’s scrutiny of avoidable harm incidents and near misses. Delivering human factors education as part of our leadership development programme ensures staff involved in investigation of incidents focus on not just ‘how did it happen?’ but, importantly, also ‘how can we prevent it from happening again?’.

We are also fully engaged in apprenticeships and public sector targets for apprenticeships. Our skills for practice leads are participating in national and regional apprenticeship working groups, and post graduate medical training has seen a year on year improvement in ratings via the GMC survey with 2016 seeing 32 areas of statistically significant positive outliers (compared to 13 the year before) and a fall from 41 to 24 of outliers. Scoring especially well were Paediatric Surgery, Respiratory Medicine, Medical Oncology, Obstetric and Gynecology Post Graduate Foundation Year doctor in their first year of training (FY1) and General Practitioner Emergency Medicine.

Training provides staff with a range of recognised tools and techniques they can apply in appropriate context. In our recent staff survey the Trust has scored in the upper quartile for staff reporting engagement in change and improvement.

Our commitment to the Care Quality Commission

In preparation for the unannounced Care Quality Commission (CQC) inspection of our core services in January 2017, UHS reconvened a CQC executive steering group .The group was chaired by the Director of Nursing and included a wide range of senior membership such as the Divisional Heads of Nursing, Divisional Clinical Directors, Divisional Directors of Operations, Medical Director and representatives from education, communications, facilities, and performance.

The CQC inspection assessed the Trust against 5 key questions and the Well Led domain:
The results were as follows :

Insert outcome grid here,

3. Progress against 2016/17 priorities

This section outlines how we have performed against the delivery of our 2015/16 quality priorities. Action plans and measures were developed for each of the priorities last year, and performance has been monitored throughout the year by clinical teams and UHS committees. The section describes progress against the following priorities:

Patient Experience:

1. End of life care
2. Safe and timely discharge of all patients
3. Responding to and learning from patient feedback (complaints)

Patient Safety:

4. Acute Kidney Failure
5. Reduction in high harm pressure ulcers and high harm falls
6. Reduction of never events

Clinical Effectiveness:

7. Clinical specialties having outcome measures

8. Improvements in mortality rates/way mortality is measured and evaluated

Patient Experience

Priority 1: End of Life Care

Our aims for 2015/16 were:

1. Education and Training programme: delivering sessions on each of the five priorities for care, difficult conversation skills and advance care planning

2. Continued participation in, and inform of, the National work stream around the Emergency Care & Treatment Plan, working alongside Wessex Collaboration for Leadership in Applied Health Research & Care (CLAHRC) into the use of Treatment Escalation Plans (TEP)

3. Develop an End of Life Care competency framework based on the new recommendations set out within the latest NICE Clinical Guideline 31 (2015) ensuring that staff caring for the dying, within the acute hospital, are supported in developing the skills, knowledge and attitudes required in the delivery of excellence in end of life care.

4. Development of information for relatives and carers for those individuals who's wish it is die at home supporting them in who to contact and who will be there for support in their bereavement

5. Audit the use of the individualised end of life care plan and use the results to inform continuing improvement in the care of the dying

Our achievements for 2015/16 were:

1. Education and training on the five priorities for care within our Trust is incorporated into other existing programmes of teaching rather than stand-alone sessions. This recognises the difficulty of releasing clinical staff for non-mandated training. The key components of End of Life Care (Recognition, Communication, Involvement, Support Plan and Do) are broken down to ensure that each of these priorities are explored and explained. This is delivered in Trust induction, at ward level and within other formal development programmes such as Health Care Assistant (HCA) training and overseas nurses' sessions. All FY1 and FY2 (Post graduate Foundation Year doctor in their second year of training) doctors receive 2 sessions of teaching, one primarily about pharmacological and non-pharmacological symptom control and another about care of the dying patient including talking about bad news and the use of the Individualised End of Life Care Plan. Sage and Thyme, a level 1 communication skills training, continues to be delivered and is now accessed via the Virtual Learning Environment (VLE). Advanced communication Skills training will be run internally at UHS from March 2017 and will be free for suitable multi-disciplinary clinical staff.

2. The Trust remains engaged with the Treatment Escalation Plan (TEP) agenda and we continue to participate in and inform the national work stream together with the research conducted by the Wessex CLAHRC. The national launch of the ReSPECT initiative is on the 27th February 2017. The Trust will critically analyse this initiative with the potential to explore a unified Wessex adoption approach with partner organisations and establish the most effective implementation, communication, and training approach. Use of our local UHS Treatment Escalation Plan remains an option alongside the unified Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form if widespread use across Wessex is unachievable.

3. The development of an End of Life Care competency framework has been superseded by the national End of Life Care Core Skills Education and Training Framework currently under consultation, which, when ratified, will form the basis of future training and education delivery within the Trust. The national framework is based on a tiered approach ensuring that each staff group receive the appropriate level of training and education in End of Life Care. Local competency documents for clinical band 5 nurses have been adapted to include awareness of key national initiatives and policy documents [One Chance to Get it Right (2014), Ambitions in Palliative and End of Life Care; A national framework for local action 2015 – 2020, Every Moment Counts (2015), What's Important to me: A Review of Choice in End of Life Care (2015)] together with the UHS document the Individualised End of Life Care Plan for the last days or hours of life. This approach has supported staff in developing the skills, knowledge and attitudes required in the delivery of excellence in end of life care.

4. Within the Acute Hospital, the Hospital Palliative Care Team give out a patient and carers leaflet with contact details and information about the service we provide. Patients who are referred to the Countess Mountbatten House Community services are given a comprehensive information leaflet detailing the services available. Those patients who do not reside within the Countess Mountbatten House catchment area receive information relevant to their locality from their Community Palliative Care providers directly. Families of those patients who die within UHS, are given written information directly by the UHS bereavement team and signposted as needed to bereavement services.

5. The Trust participated in the 2015 National Care of the Dying Audit which was hosted by the Royal College of Physicians. The results, which were disseminated in reports in March 2016, showed better than average results for :

    - The Trust's usage of syringe drivers at the end of life was in line with the national average at 24%.
    - For symptom management included agitation, pain, dyspnoea, noisy breathing and other symptoms UHS is closely in line with national symptom management, scoring above average by 2-3% in all areas except the management of pain. The national average is 57% and UHS scored 55%.

- UHS performed well in the provision of a holistic assessment in the last 24 hours of life at 76% compared the national average of 66%.
- for patients who died in hospital there were consistently high levels of documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days. However for a significant proportion of patients this recognition was not made in a timely manner. Nationally this was 87%. When sudden or unexpected death was taken into account, UHS was recognising 90% of patients that would die in the coming hours or days in a timely manner.
- The Choice in End of Life Care Programme review found people identified the importance of thinking and planning for the end of life early, while people are still able to consider and express their wishes, but highlighted the difficulties of initiating these sensitive conversations. The difficulty of these conversions is reflected in the low numbers nationally at 20%. UHSFT's data showed this happened in 29% of cases reported, and this increased to 33% if adjusted for sudden and unexpected deaths. Based on the national data, it would appear that having the conversation with a relative or nominated person is far less challenging with good levels of engagement nationally and locally. Nationally this sits at 79% when adjusted to exclude sudden and unexpected deaths. UHSFT performed well in this at 95%.

It is acknowledged that in some areas in 2015/16 we did not perform so well:

- The national average for medication review in the last 24 hours of life was 65%; UHS data demonstrated 53% of patients had this review in the last 24 hours of life
- Discussion of DNACPR decision making in conjunction with the patient nationally sits at about 36%. UHS recorded 30% in the data they submitted to the National Care of the Dying audit. This data excludes sudden and unexpected deaths
- Currently UHS does not seek feedback from bereaved relatives. The national average for this is 80% demonstrating a clear need for improvement at UHS
- The perceived lack of hydration of dying patients was one of the most common complaints reported by the public to the Neuberger Review of the Liverpool Care Pathway. The new NICE Guideline NG31 on 'Clinical care of adults in the last days of life' is very clear on the importance of maintaining hydration, either by patients being allowed and supported to drink, or by clinically assisted forms of hydration. National assessment of hydration status in the last 24 hours of life was 67%. UHS recorded 60% compliance with this assessment process

The trust is currently repeating the national audit at a local level using the same methodology. The results will be compared against our previous performance and end of life care will be identified as a priority for 2017/18.

Priority 2: Promote safe and timely discharge of all patients

Planning for patient discharge is an essential element of any admission to an acute setting, but may often be left until the patient is almost ready to leave hospital. When patient discharge is effective, complications as a result of extended lengths of hospital stay are prevented, hospital beds are used efficiently and readmissions are reduced, and patient experience is improved.

Our aim in 2015/16 was to ensure discharge planning was prioritised by focusing on the essential principles that should be met to ensure that patients do not experience delays at discharge and leave feeling confident and safe to do so.

We already had an Integrated Discharge Bureau (IDB) in the Trust which aimed to provide a coordinated and seamless service to our patients to ensure a prompt and efficient discharge or transfer, whilst taking into consideration their personal preferences as much as possible.

The key elements of the IDB model are collaboration, commitment and enhanced communication throughout the discharge pathway. The IDB already has representation from five organisations working in partnership who aid the discharge process, considering choice and safety, and aiming for assessed needs to be met in a person-centred way and to empower colleagues, patients and families to work collaboratively to improve the patient experience of discharge planning

In 2016 the IDB focused on introducing new initiatives including a new managing complex discharge policy , the introduction of discharge officers , ward link competencies, Continued Healthcare Coordinators and front loading the discharge process to ensure planning begins on admission.

The UHS pharmacy department also led on a variety of projects in 2015/16 aimed at improving the quality of discharge with regards to discharge medication. This area had been highlighted as an area for improvement via incident reporting and patient feedback.

These projects included;

1. Developing a discharge checklist to ensure that patients received all the necessary medicines, ancillaries and information at the point of discharge. This includes in particular an assurance that nursing homes and rest homes will receive all the information they need at the point of discharge

2. Developing written advice about the use of taxis to transport medication to patient's home addresses post discharge. Most discharge medication is given to the patient before they leave hospital; however there are occasions when medication is sent on afterwards. We aim to reduce this practice, but to provide more governance and assurance of a safe process when it does need to occur.

3. Planning to develop the role of a discharge pharmacy officer who will be responsible for the reconciliation of the discharge medication, counselling the patient and providing a steer to patients regarding when their medicines/discharge will be ready. They will also support in the proactive management of the discharges

4. Referring patients who had been assessed as at risk from develop medicines related problems post discharge to their community pharmacy for advice. This is as a result of work published in Newcastle that highlighted improved outcomes in patients referred to their community pharmacy

5. Scoping the discharge process trying to identify alternative mechanisms of discharge for patients that perhaps have fewer care needs. This is in response to patient feedback highlighting their frustration regarding the lack of options with how their discharge medication is provided.

6. Planning working on a discharge information sheet to explain to patients what their discharge involves and the necessary steps that require completion before discharge

Whilst we have made progress, we acknowledge that there is still a great deal to do in both the quality and timeliness of patient discharge, and this is why we have chosen this as an ongoing priority for 2017/18.

Priority 3: Responding to and learning from patient feedback (complaints)

If a patient is unhappy with the care they are or have received we always seek to resolve this as early and effectively as possible to prevent the patient or family feeling the need to make a formal complaint. There are occasions when we can resolve issues by arranging a meeting with the clinicians involved to answer any questions and manage concerns. This can shorten the time taken to provide a response and resolution. We monitor the numbers and themes from these complex concerns.

If the patient or family wish to make a formal complaint, we will complete a formal investigation and provide a written response.

Complaints were identified as a key patient experience indicator in our quality account of 2015/16 , and a target set to reduce complaints (excluding complex concerns which do not require formal investigation) to below 550 for the year 2016/17.

A target to close > 93 % of complaints within a target time of 35 days was agreed. For cases where this timescale is not possible, complainants are updated and informed of the reasons, and a new closure date is negotiated and agreed. The target then converts to closure of > 93% for the newly negotiated time frame.

Table 2: % of complaints closed within agreed time frames

	Apr-16	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**2016/17 Total**
Complaints received for investigation	39	37	47	34	33	27	46	51	44	31	37	32	476
% of complai	7.69%	31.82%	37.21%	46.67%	41.86%	41.94%	45.24%	56.60%	78.43%	76.74%	72.73%	72.5%	50.78%

nts closed within original 35 days timeframe													
% complaints closed following re-negotiated timeframe	100.0	100.0	100.0	100.0	100.0	94.6	97.4	98.1	100.0	100.0	100	97.1	98.9%

Table 3- Number of complaints and complex concerns received monthly April 2016 to January 2017

2016/17	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Complaints received for investigation	39	38	47	34	33	28	47	51	47	43	37	32	476
Total Number of Complex Concerns	20	24	22	33	26	32	17	27	13	25	24	31	294

Table 4- Percentage of Dissatisfied Complaints over Total Number of Complaints

By Received Date	Number of Dissatisfied Cases	Number of Complaints	Percentage Dissatisfied
2015/16	49	431	11.37%
2016/17	44	420	10.48%

The average time to respond for 2015/16 across the year was 38 days with variation month to month from 24 to 54 days.

Year to date 2016/17 the average remains the same but variation is from 24 to 47 days and consistently in last three months we have been below our 35 day target.

The complaints team also sit on each division's governance boards to advise, inform and support their complaints management, and to help ensure learning is embedded in practice.

Learning from our complaints:

A vital part of the complaints process is to look for any learning that we can identify and seek to change our practice accordingly.

If complainants are not satisfied by our investigation and response then they can refer themselves to the Parliamentary and Health Service Ombudsman (PHSO).

In 2015/16 there were 10 complaints referred to the PHSO concerning UHS and 20% of these were either partially or fully upheld. This compares favourably with the PHSO average of 46% across all NHS trusts.

For each upheld complaint by the PHSO an action plan is developed by the Trust to rectify any failures and an apology given. In some cases a financial settlement can also be requested.

This year we have introduced a follow up phone call to complainants after the receipt of their complaint response to get feedback on their satisfaction. We have also started to engage with our local population at community events to inform diverse groups about how to raise concerns or make complaints and as an example have attended the Southampton Pride event late last year. We hope to continue to expand upon this work over the next year. We also will continue to work with our local Health Watch representatives as they support our complainants through the complaints process.

We have published the first two editions of a tri annual newsletter for UHS staff to support them in ensuring they have a good understanding of the complaints process and how to support our patients and visitors when they raise a concern.

During this past year we have worked hard to reduce our complaint response time, aiming to get this down to a period of 35 working days. This has been achieved for December 2016 and January 2017 with the response time moving from 48 days in April 2016 to 31 days in January 2017.

Failings found in consent process and record keeping in relation to procedure to remove ear wax.

Action taken

Each patient is given an information sheet which includes advice on

***Discharged too early following surgery**. We found that although discharge had been appropriate the written discharge information sheet was inadequate.*

Action taken

Information sheet reviewed and post operative follow-up phone call introduced a week following discharge.

Themes from issues raised through complaints and complex concerns are shared at the patient engagement and experience strategy group to ensure that this is part of the UHS strategy for improving patient experience.

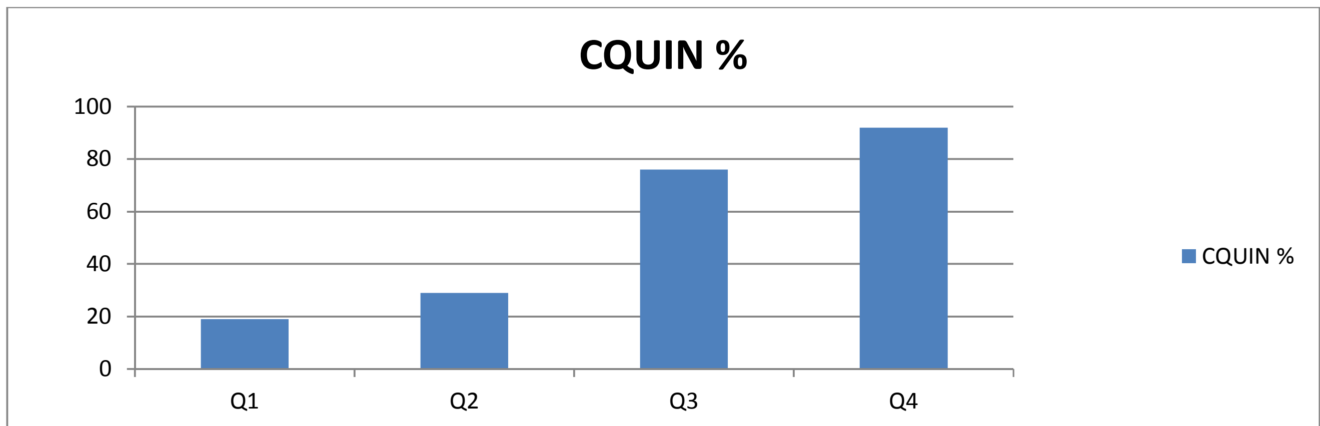
Patient Safety

Priority 1: Acute Kidney Injury (AKI)

Acute kidney injury (AKI) is common in hospitalized patients and has a poor prognosis with the mortality ranging from 10%-80%. We have been working over the last 2 years as part of our safety strategy to improve the detection, prevention and management of AKI within our trust by:

1. Ensuring information about their AKI is sent to primary care, so that these patients receive appropriate blood testing and medication following discharge from the hospital. The goal was that more than 90% of patients would have this discharge information sent to primary care by the end of 2015/2016. We measured this by auditing a random sample of 25 patients who had an AKI during their acute hospital stay every month. Four elements of information were required for the discharge information were needed for this information considered to be complete
2. Alongside the Commissioning for Quality and Innovation (CQUIN) goals we were aiming to improve the recognition and management of patients with AKIs within UHS

Table 5 - % of CQUIN achieved by Quarter 1-4



Successfully achieving the CQUIN meant we achieved a £1,240,000 cost saving to the trust.

3. An AKI working group was set up to deliver a multi professional approach to achieving this goal and an AKI Clinical Nurse Specialist (CNS) was appointed. Her role was to assist in the implementation of an electronic AKI alert that was added to the discharge summary, alongside reviewing all patients with an AKI stage 3 and being responsible for AKI education to the trust as well as to assist in reviewing all patients with an AKI stage 3 outside of critical care areas and advising on their care and management

4. Improving AKI education to the trust with a particular focus on improving the management of hydration for our inpatients and improving fluid balance documentation. We developed an e-learning AKI package which was the first of the kind in the country and likely to be taken up nationally: 400 staff members have completed this to date. Consultant-led education was given to medical students, junior doctors and on grand rounds and interdepartmental meetings including elderly care, Acute Medical Unit (AMU) , anesthetics, respiratory and cardiology

5. An AKI pharmacist was also appointed and completed cascade training with the pharmacist team. The automated section on the electronic discharge summary was launched in October 2015 and this led to a dramatic increase in completion. Clinical pharmacists took a lead role in alerting the prescribers to circumstances that might change the safe or effective dose for individual patients with an AKI alert. This includes changing doses of drugs such as the antibiotic Gentamicin to reduce renal toxicity and prevent new or worsening acute kidney injury

6. A number of pathways, guidelines and educational resources have been developed to raise awareness of AKI, improve patient management and hopefully reduce incidence of AKI including primary and secondary care pathways on map of medicine and an AKI Care Bundle for patients undergoing elective hip and knee surgery

In 2015/16 we achieved:

1. A mean reduction in length of stay for patients with an AKI 3 alert of 4 days following implementation of AKI alerts, focused AKI education and the appointment of an AKI CNS

2. A 16% reduction in number of patients with an AKI from January 2015 to September 2016 with significant and sustained falls in total numbers of alerts in medicine, orthopedics and surgery

3. A 39% reduction in number of AKI alerts (comparison of April 2015, n=2191 alerts to April 2016, n=1346 alerts)

Moving forward into 2016/17, AKI recognition and management will be a continued priority. We will focus on:

1. Trust wide rollout of hydration charts and development of an e-learning fluid balance chart package

2. Learning from AKI Mortality and Morbidity meetings and incident reports shared trust wide

3. More patients with AKI receive a urinalysis at the time of diagnosis

4. Maintaining the appropriate information sent to primary care for patients with AKI

5. Ongoing achievement of more than 90% of our patients with AKIs having information about the inpatient management of their AKI and what follow up is required sent to primary care

6. Ensuring more than 90% of patients with AKI have a urinalysis completed when their AKI is diagnosed. This is important for the correct diagnosis and management of their AKI

7. A 10% reduction in hospital acquired AKI bed days. We will achieve this through improving the management of hydration for our inpatients and improving fluid balance documentation

Priority 2: Reduce High Harm Pressure Ulcers and Falls

Our aim in 2015/16 was to continue to reduce the incidence of all pressure ulcers, with particular emphasis on high harm pressure ulcers Grade 3-4. (Definitions of grades of pressure ulcers are found in Appendices 2). We have made a clear commitment to reduce the numbers across the Trust and have achieved a year on year reduction.
We did this by:

1. The roll out and monitoring of a new UHS developed risk assessment tool to replace the risk assessment tool previously used (Braden). This tool was piloted and evaluated by staff on 2 ward areas in July 2016 and was found to be clear and simple to use, as well as increasing the accuracy of the assessment. The assessment leads ward staff to a care plan according to the level of risk to ensure that all steps in the process, appropriate to that individual are in place from admission. The new risk assessment tool, Pressure Risk Evaluation and Skin Screening tool (PRESS) and associated care plans were developed using the latest national guidelines and tailored to support staff in both the prevention and management of patient's risk of pressure damage. Learning from previous investigations had demonstrated that staff using the previous risk assessment were underestimating the risk and no care plans were consistently being

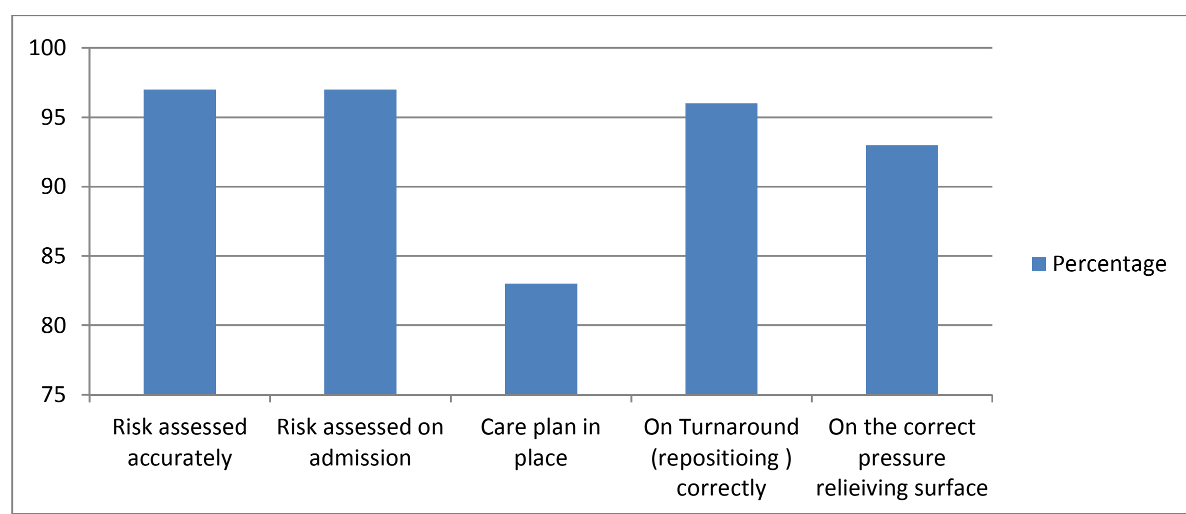
documented for individuals. The new tool and care plan process was piloted with excellent results and has now replaced the previous risk assessment in all adult in patient areas.

2. We have also focused on Grade 2 pressure ulcers and now investigate each grade 2 to identify the root causes of the damage development and to implement actions to change practice and provide support at this early stage to prevent the damage deteriorating.

3. We have focused on better measurement of the process of repositioning which is called Turnaround at UHS. A competency process was developed to ensure that after staff had attended education sessions they were also assessed as being competent with the process in their own ward areas. An audit of the process in each ward area has also been introduced to identify any areas of learning specific to that ward team and allow leaders to monitor areas progress and achievement in line with the process.

   The process is being closely monitored and an audit was undertaken at both 3 months and 6 months following implementation in late April. Results are shown in the chart below from the 3 month audit (6 month audit not currently available):

Table 6 - % compliance with key audit areas



97% of patients had an accurate risk assessment completed and completed on admission. The focus will continue over the next year to improve the use of the care plans, which was a new step in the process and so has taken longer to embed in practice.

All of the prevention initiatives available including the repositioning of patients has achieved a significant reduction in grade 2, 3 and 4 pressure ulcers so far in 2016/17:

Table 7 – All grade 2/3/4 pressure ulcers reported 2015-2017

Grade 3 and 4	2015/6		2016/17	
	Avoidable	Unavoidable	Avoidable	Unavoidable
April	2	3	1	5
May	3	3	2	3
June	4	2	1	3
July	4	5	0	7
August	5	6	1	4
September	5	3	1	3
October	4	5	1 (1 case to determine)	6
November	1	0	0	3
December	2	4	2	2
Totals	30	31	9	36
	65		45	

Grade 2 pressure ulcers	2014/15	2015/16	2016/17
April	20	12	13
May	14	19	15
June	24	19	16
July	21	11	11
August	14	21	8
September	24	20	8
October	14	10	16
November	13	15	12
December	19	18	8
Total	163	145	107

The focus on reduction will continue as a priority over the following year. There is still more work needed to ensure assessment of the risk of pressure ulcer development is completed as soon as possible on admission to enable timely intervention. The support and shared learning will continue to be cascaded to staff via the pressure ulcer strategy and working groups.

For 2016/2017 the Trust has set an internal target of a 10% reduction in all high harm falls and zero avoidable high harm. 'High harm' includes all falls that result in any fracture and/or severe head injury .An avoidable fall would be a fall where, following investigation, there is insufficient evidence that every reasonable effort was made to reduce the risk of a fall. This could include lack of initial assessment, review of risk on change of condition or following a fall and mitigation of any risk identified.

Year to date we have achieved a 14% reduction in the number of high harm falls, 56 compared to 65 in the same period the previous year. Unfortunately we have not achieved the target of zero avoidable high harm falls, and currently year to date we have reported 4. This is, however, a reduction on the previous year's total of 6.

It is a recognized risk that patients with dementia are at an increased risk of falls and harm from falls and there has been intensive support for these patient provided by the enhanced care support teams (ECST).The ECST currently support patients in Division B & D and can assess and plan care for patients with enhanced care needs (care that is assessed as being over and above the planned daily staffing levels for that area). The team consist of Band 5 registered mental health / learning disability nurses and health care support workers. They are able to assess and plan care individualised to the patient and work in close collaboration with the ward team. They can provide various levels of support to patients from care planning to providing therapeutic interventions and, if required 1:1 care.

Additional initiatives are also being developed. In 2016 medicine for older people introduced 'Bay Watch' which involves cohorting same sex patients identified as high risk for falls into one ward bay. A member of the multidisciplinary staff is present and visible in that bay all times. The staff members wear an armband to clearly show they are 'on duty' in that bay. The armband is then handed to the next staff member when care is taken over. There have been no avoidable high harm falls within medicine for older people since May 2016.

The emergency department has focused on increasing education and training for staff around the early identification of falls risk, and the coloured wrist bands highlighting risk of falls which they introduced in 2015 has started to roll out into other areas of the hospital including surgery.

Priority 3: Reduce Never Events

Never Events are a particular type of serious incident that are largely preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level.

As an organisation in 2015/2016 we carried out 125,615 procedures including surgeries. Most of the procedures that we carry out are uncomplicated, but we would like to work in an organisation that is successful in eradicating all avoidable harm to our patients.

If never events do occur we take them extremely seriously. The Trust has a never event oversight group which consists of members of the executive team, clinical teams and human factors with the aim of scrutinising any never events that occur as well as the safer invasive procedures work stream. Investigations are promptly instigated and action plans generated and completed to ensure learning occurs. Staff involved in never events are supported through the process and learning is widely shared in the organisation.

In 2015/16 UHS reported 6 never events. In 2016/17 we reported 3:

1. A wrong site brain biopsy .This resulted in no harm to the patient as the biopsy was diagnostic and could have been performed on either side.

2. A mismatch of hip components during a total hip replacement which resulted in a return to theatre for revision of the hip.

3. The insertion of an incorrect lens during cataract surgery as it had been calculated based on incorrect patients details.

These investigations are currently ongoing, but immediate actions taken include:

1. A review of the checking and documentation of hip components intraoperatively

2. A review of the checking process for lens calculations intraoperatively

These actions will link into the existing work stream within the Trust regarding safer invasive procedures.

Clinical Effectiveness

Priority 1: Every clinical specialty will identify an outcome measure

During 2016/17 all Divisions within UHS worked towards identifying clinical outcome measures for their services that can best be used to measure improvement in the care they provide. 36 specialities successfully identified outcome measures.

A considerable amount of progress has been made in identifying and reporting the number of areas in the Trust that contribute to national outcomes data collection to assess our performance against other specialist services and also areas who are collecting (or developing) local outcomes data.

We acknowledge we have not fully achieved this, and therefore this is a high priority for the coming year and will continue to be taken forward during the year 2017/2018.

Priority 2: Making appropriate improvements in mortality rates and the way mortality is measured and evaluated

The patient safety team is targeted and focused on ensuring we deliver the safest and most effective treatment we can. Measuring outcomes provides reassurance and allows us to focus our improvement efforts to deliver changes where most needed the NHS is appropriately focused on learning from events and in particular from reviewing mortality rates.

It is difficult to obtain representative rates given the different populations we all serve. Although we measure and review the crude death rate its value is limited as it does not consider the case mix, in other words take into account the severity of the underlying illness or complexity of the patient

group. To improve on this we calculate the hospital standardised mortality ratio which adds complexity into the calculation.

This is an imperfect science, however it is a useful tool as it allows a degree of benchmarking but most of all allows measurement of trends and highlights potential outliers or anomalies which require evaluation.

In order to improve assurance we do not rely on this alone but consider it along with other mortality indicators and outcome measures such as Summary Hospital-level Mortality Indicator (SHMI). The Internal medical examiners group (IMEG) is particularly important. This group examines the notes and discusses the care of every patient who dies at UHS looking for both good care practice but also any areas that could be improved escalating any issues for more detailed scrutiny.

The Hospital Standardised Mortality Ratio (HSMR) is a ratio of the observed number of in-hospital deaths to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups; in a specified patient group. The expected deaths are calculated from logistical regression models taking into account and adjusting for a case mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

The UHS HSMR in 2015/16 was 102.6, while the current Year to Date (YTD) position for 2016/17 is 101.5.

The SHMI is a high level hospital mortality indicator that is published by the Department of Health on a quarterly basis. The SHMI follows a similar principle to the HSMR; however there are some differences in the case mix model. The two models should not be compared directly, but used in conjunction to monitor mortality outcomes. SHMI can also be used as a potential smoke alarm for potential deviations away from regular practice.

The SHMI data shows a consistent quarterly performance below the benchmark (benchmark = 1). Over the last 3 reporting periods the SHMI for UHS was 0.95, 0.96 and 0.96.
The data used to derive HSMR and SHMI is taken from the Hospital Episodes Statistics (HES) data therefore our ability to capture the primary diagnosis (the main condition treated by the clinicians), secondary diagnoses and co morbidities has a direct impact on HSMR and SHMI.

As part of an annual assessment the Trust undertakes an internal Information Governance audit submitted to the Department of Health. One of the Information Governance Toolkit audits looks at the information processes involved in the collection of data for clinical coding purpose ensuring information is accurate, consistent and complete. The Trust maintained its level 3 status (Highest level of attainment possible) based on the targets set by the Clinical Classification Service (CCS) regarding coding accuracy. This has been a result of continued improvements including additional information systems access and continued clinical coding awareness programs for clinical staff.

An additional priority for 2016/17 involved working with specialities, care groups and divisions to improve knowledge and understanding on HSMR. HSMR and SHMI data are monitored monthly by our central team, all outliers are investigated thoroughly and, where necessary, clinically validated to ensure clinical standards of care have not been compromised. HSMR continues to be monitored and reported to the Trust Executive Committee, Divisional management teams and divisional governance managers on a monthly basis.

Priorities for improvement 2017/18

In order to determine our priorities for improvement we have consulted with a number of stakeholders including our Trust Quality Committee (QC), our Trust Board, our Trust Executive Committee, commissioners and patient representatives through our Health Watch Group, and our Governors. The QC on behalf of the board approved the priorities and there will be regular reports on progress to the QC throughout the year.

We have developed this years' Patient Improvement Framework (PIF: found in Appendices 1) to ensure that our quality priorities are aligned with feedback from patient surveys and complaints as well as incidents, and we have taken into account our progress throughout the year against last year's priorities to help decide which priorities need an ongoing focus within this year's quality account. Priorities are built around our ambitions and intention to deliver safe, reliable and compassionate care in a transparent and measurable manner.

Each priority relates to one of the three core areas of quality:

Patient experience: meeting our patients' emotional as well as physical needs

Patient safety: having the right systems and staff in place to minimise the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes

Clinical effectiveness: providing high quality care, with world class outcomes, whilst being efficient and cost effective

This section outlines the following 2017/18 quality priorities.

Patient Experience:

1. Improving patients experience of and safety of discharge from hospital

2. Meeting patients nutritional and hydration needs
3. Improving care for vulnerable adults

Patient Safety:

1. Safer invasive procedures
2. Recognising and treating sepsis
3. Recognition and management of the deteriorating patient

Clinical Effectiveness:

1. Report outcome measures in every speciality across the hospital
2. Improve care for patients at end of life care
3. Reduce deconditioning and the impact of immobilisation on the frail elderly

Patient experience

Priority 1: Improving patients experience of and the safety of discharge from hospital

1.1 Why we have chosen this priority

The principles and benefits of safe discharge from the acute hospital setting have been discussed in section 'Progress against 2016/17 priorities Priority 2'.

We know from our in-patient surveys that we still have areas related to discharge which need improvement:

Table 7: Inpatient Survey Results 2016:

The Trust has worsened significantly on the following questions:

Lower scores are better

	2015	2016
Discharge: did not feel involved in decisions about discharge from hospital	45 %	51 %
Discharge: not given any written/printed information about what they should or should not do after leaving hospital	27 %	34 %
Discharge: not fully told side-effects of medications	55 %	64 %
Discharge: not told how to take medication clearly	23 %	30 %

1.2 What we are trying to achieve

We aim to build on the work completed in 2016/17 by setting clear patient and family expectations around discharge processes right from the beginning of the hospital admission in order to be clear about what people can expect from the start and to fully engage them with the process.

This will include:

1. Standard information to set expectations on admission
2. Standard information for the patients at each stage of the process – templates to be used on the wards
3. Clear process to be followed by the wards in conjunction with the IDB
4. Clear timelines between each stage of the process

In addition we aim to strengthen close working partnerships with other organisations, including primary care, hospital services, social services, voluntary services and the private sector to ensure that communication and consultation with the patient and his/her relatives and carers was of prime importance, commencing at pre admission, throughout their stay and following discharge.

The policy has been accepted by all the partners in the system.

1.3 What will success look like?

Metrics designed to monitor all discharges from the Trust will demonstrate improvement, and feedback via patient surveys/FFT/patient forums/Health Watch will corroborate these improvements.

Priority 2: Meeting patients nutritional and hydration needs

2.1 Why we have chosen this priority

Ensuring the nutrition and hydration needs of our patients are met has been a priority over previous years with changes and improvements identified and implemented. Patients continue to provide feedback on the meal service they receive and this area of patient care and experience remains a key focus for improvement.

Table 8: Inpatient survey results 2016

		2011	2012	2013	2014	2015	2016
22+	Hospital: food was fair or poor	54 %	53 %	50 %	49 %	44 %	49 %
23	Hospital: not offered a choice of food	19 %	19 %	17 %	16 %	15 %	19 %
24+	Hospital: did not always get enough help from staff to eat meals	47 %	44 %	46 %	35 %	34 %	43 %

(NB : the survey does not give the detail of which age groups responded to these question , however it is noted that 82.1 % of respondents were > 50 years of age , with 22.2 % being 60-19. 24% being 70-79 , 17.4 % being 80-89 and 4.3 % being over 90 years of age).

2.2 What we are trying to achieve

1. To review the process for nutrition screening, in adults and children, to ensure that patients at risk of malnutrition are identified and managed appropriately according to their individual needs

2. To review and establish compliance with Protected Meals guidelines

3. To implement a hydration assessment and chart to all adult inpatient areas

4. Work collaboratively with our new server provider to increase the percentage of patient satisfaction with food

2.3 What success will look like?

1. Patients are screened for malnutrition on admission to hospital or at pre-assessment and those at risk have an appropriate care plan implemented

2. Patients are adequately prepared for meals and receive the help they require in an environment conducive to mealtimes

3. Hydration assessments and charts are used appropriately in all adult inpatient areas

4. Progress against our performance will be reflected in the national inpatient survey 2017/18

Priority 3: Improving care for vulnerable adults

3.1 Why we have chosen this priority

‘Living a life free of harm and abuse is a fundamental right of every person. When abuse or neglect does occur, it needs to be dealt with swiftly, effectively and in ways that are proportionate to the concerns raised. In addition, the person must be at the centre of any safeguarding response and must stay as much in control of decision making as possible. The right of the individual to be heard throughout the process is a critical element in the drive to ensure more personalised care and support’. The Care Act 2014.

Health services have a duty to safeguard all patients but also provide additional measures for patients who are vulnerable and less able to protect themselves from harm or abuse. The core definition of “vulnerable adult” from the 1997 Consultation “Who Decides?” issued by the Lord Chancellor’s Department, is a person:

“Who is or may be in need of community care services by reason of disability, age or illness; and is or may be unable to take care of unable to protect him or herself against significant harm or exploitation”. This definition of an Adult covers all people over 18 years of age.

Safeguarding adults covers a spectrum of activity, from prevention through to multi-agency responses where harm and abuse occurs. Multi-agency procedures apply where there is concern of neglect, harm or abuse to a patient defined under 'No Secrets' guidance as vulnerable.

Safeguarding adults is an integral part of patient care. Duties to safeguard patients are required by professional regulators, service regulators and supported in law.

The Department of Health (DoH) document 'Safeguarding Adults: The Role of Health Service Practitioners' reminds health service practitioners of their statutory duties to safeguard adults. It aims to assist practitioners in preventing and responding to neglect, harm and abuse to patients in the most vulnerable situations.

3.2 What we are trying to achieve

The Trust’s framework for safeguarding adults is based on national guidance and from a policy perspective is jointly shared through the local safeguarding adults’ boards. This includes the national guidance detailed within the Care Act 2014, which created a new legal framework for how local authorities and other parts of the system should work together to protect adults at risk of abuse or neglect. UHS and its partnership organizations have agreed how they should work together and the roles they will play to keep adults at risk safe. This approach promotes the development of inter-agency working to make safeguarding personal and individualize care to ensure it meets each persons’ needs.

The key principles of good safeguarding include empowerment, prevention, proportionality, protection, partnership and accountability. Other important governance frameworks are also in place and ensure good levels of safeguards to keep people safe, these include; continuous learning, quality improvements, team work, professional curiosity and challenge.

UHS continues to ensure that adult safeguarding remains a high priority. Key achievements in 2015/16 have included:

1. Development and partial implementation of the learning disability strategy & investment into more learning disability clinical nurse specialist posts

2. Continual partnership working between clinical and estates teams to refurbish ‘dementia friendly’ wards & departments, Medicine for Older People (MOP) being an exemplar site

3. Development and implementation of the Enhanced Care Support Team (ECST)

4. Support for carers' through regularly held 'carers' cafés' providing expert support and guidance to people caring for our patients

5. All patients admitted to our hospital as an emergency are screened for signs of cognitive impairment and referred to their GP

6. Improved senior leadership and multi agency/disciplinary working on the pathway and resources involved in improving the safety & experience for patients presenting in mental health crisis to ED

7. PWC internal audit of adult & children's safeguarding with an outcome risk rating of 'Low' with key assurances gained of how timely and effectively concerns relating to safeguarding are identified and investigated

8. Implementation of dragon fly approach in the ED. This is a visual prompt to staff (a picture representing a dragon fly) which alerts staff to the particular needs of the patient with dementia and is currently used throughout the rest of the trust

Our priorities for next year include:

1. Meet the rising demand of patients presenting in mental health crisis – grow service, gap analysis of current service delivery against the need to identify gaps & develop a plan to address this

2. Develop robust training programs for our staff so they feel well equipped with the clinical skills for example, support patients behavior to de- escalate, refer to other specialist professional teams

3. Development a UHS Mental Health Board to address the challenges and impact for mental health patients and for staff looking after them.

4. Evaluate responsiveness & effectiveness of ECST and potentially expand service.

5. Focus on autism agenda

6. Develop leadership approach and evaluate progress with dementia strategy

7. Consider proposal for joining adults & children's safeguarding teams

8. Share & embed learning from complaints, serious incidents and serious case reviews

9. Introduce carers' passports

10. Introduce the vulnerable adult champion role

11. Development of a combined safeguarding team with associated joint governance & meeting structure

12. Provide training and awareness on mental health capacity assessment and deprivation of liberty

3.3 What will success look like?

1. Staff will be competent and confident in caring for vulnerable patients

2. Increased number of safeguarding referrals received by adult safeguarding teams and improved timeliness of response

3. Number of complaints from patients, relatives or carer's relating to safeguarding will reduce

4. Feedback from carer's / relatives will improve

5. Numbers of serious case reviews will have reduced.

How we will monitor progress for our patient experience priorities:

As national surveys are published yearly or less we measure our performance during the year using our real time patient feedback system. This provides monthly feedback which is shared with all the clinical teams. At UHS level this data is reviewed in detail at the patient experience and engagement steering group and the high level data is reported to Trust Board. We will report progress against our performance in the national survey next year.

Patient Safety

Priority 1: Recognition and management of the deteriorating patient

1.1 Why we have chosen this priority

Clinical deterioration can occur at any stage of a patients' treatment or illness, although there will be certain periods during which a patient is more vulnerable, such as the onset of illness or during medical, surgical or dental interventions. Patients who are at risk of deterioration may be identified before a serious adverse event by monitoring changes in physiological observations recorded by healthcare staff. The interpretation of these changes and timely institution of appropriate clinical management once physiological deterioration is identified is of crucial importance to minimise the likelihood of serious adverse events, including cardiac arrest and death.

UHS is committed to having standards in place for managing the risks associated with the deteriorating patient who has been identified as a recurring theme through incident reporting, serious incident investigations and complaints during 2016/17.

1.2 What we are trying to achieve

Our purpose is to prevent avoidable deterioration. Our priorities are establishing:

1. Where are we now, how are we performing?

2. Overview of current work streams, Serious Incident Requiring Investigations (SIRI), AKI, and sepsis

3. What and how are we measuring- the role of acuity audits, Modified Early Warning System (MEWS) activation data

4. Development of an annual plan for acuity improvement including roles and responsibilities, timescales and measures

5. Escalation on electronic systems (ePAMS) and paper based systems with timescales to move to all electronic systems

The existing acuity group responsible for monitoring the deteriorating patient has been reviewed and restructured to ensure that it is driven from executive level. This is to increase the trust wide profile and in acknowledgement that this affects all patients in every Division. As part of a re-launch of the group it has been renamed ROAR (recognise, observe, assess, rescue) to reflect its purpose.

The membership includes Matrons and/or Clinical Leads for each Care Group who are clearly responsible for cascading of actions and information after each meeting, the Patient Safety Team, Divisional Heads of, Nursing (DHN), Divisional Clinical Directors (DCD), AKI nurse, Sepsis nurse, Critical Care Outreach Team (CCOT), Out of Hours (OOH) team, education teams and consultants. The group's function is as a clinical reference group, providing leadership and guidance to UHS on management of the acutely unwell patients. Shared learning can be achieved through linking in directly with Quality Steering Group.

The group will meet monthly throughout 2017/18 with the above agenda, followed by a case presentation from each Division in rotation, i.e. each Division will present 3 patients per year who were unplanned Intensive Care admissions for learning.

1.3 What will success look like?

We will be able to measure and react to these metrics for improvement:

1. Measurement of baseline/ compliance/improvement.
2. Pulseless Electrical Activity (PEA) cardiac arrests

3. “False” cardiac arrest calls
4. Unplanned intensive care admissions
5. CCOT call data
6. MEWS/NEWS data
7. Development of an acuity review template
8. Development of unplanned admissions to intensive care template

These metrics may change depending on national and local priorities.

Priority 2: Safer invasive procedure

2.1 Why we have chosen this priority

A Patient Safety Alert was issued by NHS England to launch an NHS-wide programme of work based around the National Standards for Invasive Procedures (NatSSIPs) that were published on 7th September 2015.

The alert asked NHS providers to review current clinical practice and ensure the NatSSIPs are embedded into local processes by developing their own local safety standards for invasive procedures (LocSSIPs) in collaboration with staff, patients and the public.

The aim of the NatSSIPs is to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur. They set out the minimum standards considered necessary for the delivery of safe care during invasive procedures as well as underpinning aspects of education and training.

The NatSSIPs have been set and endorsed by all relevant professional bodies, including the Royal Colleges, the Care Quality Commission, the Nursing and Midwifery Council, the General Medical Council, Monitor, the Trust Development Agency, and Health Education England.

2.2 What we are trying to achieve

To embed the NatSSIPs into our own local safety standards to support staff in providing the very best care and treatment for our patients to focus on reducing not only Never Events but all avoidable harm related to invasive procedures.

2.3 What will success look like?

Our initial focus will be to build on work completed in the theatre environment in 2016/17. The World Health Organization (WHO) safer surgery checklist used within theatre has been reframed as

questions to frame practice and rebranded as ‘stop points for safety’ to allow safe, effective and consistent safety steps and move away from a tick box mentality.

In 2017/18 this will continue to roll out to all other interventional suits such as interventional radiology and interventional cardiology. There will also be the introduction of team based LocSSIPs for procedures such as central venous catheter and arterial line placement in other clinical areas such as ward areas and out- patient departments.

Compliance will be measured quarterly via number of ‘never events’, number of staff trained and percentage of each staff group trained, observational audit data and Safety culture survey. The results will be reported to the quality and governance committees, scrutinised by audit to identify missing actions or documentation with learning fed back to team meetings, and results will be disseminated throughout the Trust for wider learning.

Priority 3: Recognising and treating sepsis

3.1 Why we have chosen this priority

Sepsis occurs when the body has an abnormal response to infection. This can be life threatening and if not treated quickly sepsis can rapidly progress. Septic shock, the worst type of sepsis carries a mortality of 50%.

It is estimated that 44,000 people die in the UK from sepsis each year. For comparison approximately 18,500 patients die each year from myocardial infarction (heart attack). Sadly, diagnosing sepsis is far from straightforward and it can mimic a myriad of other conditions.

Key factors that may reduce this mortality rate are the timely recognition of the septic patient followed by rapid administration of antibiotics and other simple supportive therapies - the sepsis six care bundle.

With implementation of the basic elements of care it is believed that 12,000 lives a year could be saved. This equates to 20 lives saved per 100,000 population, 285 fewer hospital bed days and 168 fewer critical care bed days.

3.2 What we are trying to achieve

Our aim is to improve our recognition of patients at risk of sepsis and as a consequence allow the early management of septic patients. Not unsurprisingly if patients with sepsis are treated quickly mortality is reduced.

With this in mind, UHS is working towards a hospital wide, systematic approach for the identification and appropriate treatment of life-threatening infections. Whilst at the same time reduce the chance of the development of strains of bacteria that are resistant to antibiotics.

Through this we aim to reduce death and morbidity related to sepsis in all areas of the hospital. As a result, this will reduce patient length of stay, critical care length of stay and thus improve patient experience and outcome.

3.3 What success will look like?

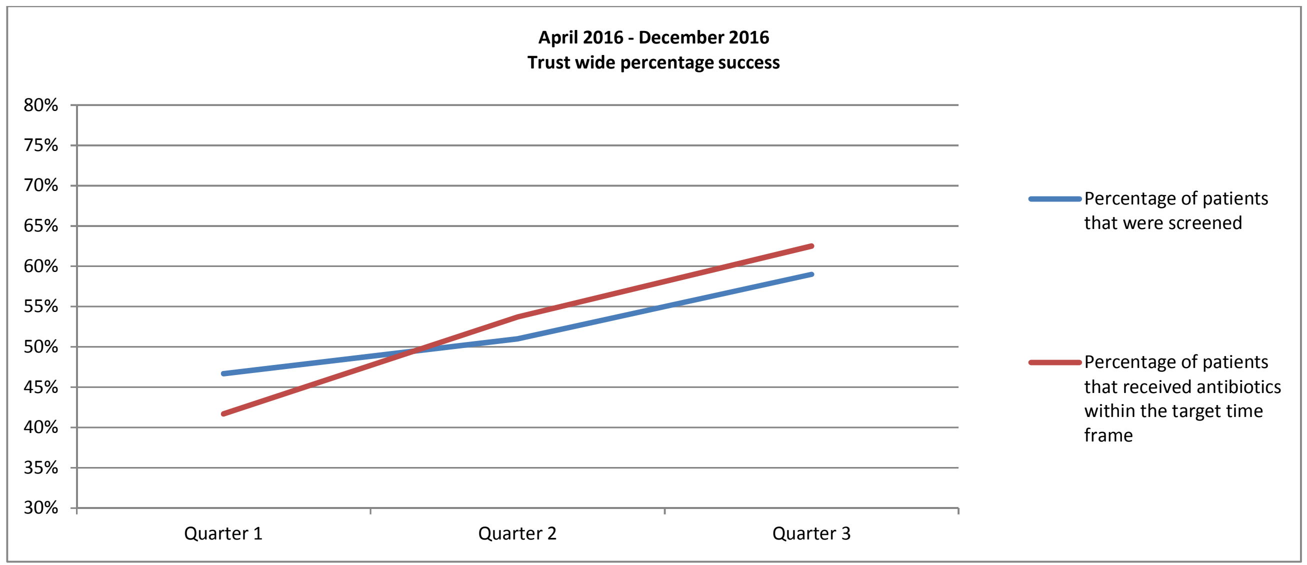
All patients deemed to be at high risk of sepsis will have appropriate screening. Following screening, if sepsis is likely they will receive timely treatment – namely the sepsis 6 care bundle of which rapid delivery of antibiotics is probably the most important element.

Our success in this hospital wide initiative will be monitored using data collected for the national sepsis CQUIN.

Current progress:

Programmes have initially rolled out to acute admitting areas and are being slowly rolled out to all acute inpatient settings. Ongoing for 2017 we aim to continue to roll out the sepsis screening programme to all adult and paediatric wards. Our progress over the last year can be seen below.

Table 8 – Roll out of the sepsis screening programme 2016-2017 (Q1-3)



(NB this data does not capture % of patients who went on to enter palliative care).

How we will monitor progress for our patient safety priorities:

Progress will be measured and monitored via clinical boards, the sepsis steering group and reported to the Quality Safety Committee.

Clinical outcomes

Priority 1: Report outcome measures in every specialty across the hospital

1.1 Why we have chosen this priority

During 2017/18 the plan is to continue developing this work stream across all clinical specialities and to establish an outcomes group to provide a greater level of scrutiny and assurance.

1.2 What we are trying to achieve

Our aims for 2017/18 are that every speciality will identify outcomes that are specific to their clinical service – these can be nationally reported or locally developed outcomes

1.3 What will success look like?

Each Care Group will be able to present their outcomes to a newly established Outcomes Scrutiny Group on an annual basis, demonstrating progress against the identified outcomes

Priority 2: Improve care for patients at End of Life

2.1 Why we have chosen this priority

We are committed to a standard whereby any person in our care at the end of their life will receive individual care based on their needs, delivered with compassion and sensitivity by our staff, and that there is regular and effective communication between staff and the dying person and those close to them. We believe these are priorities which must be embraced.

2.2 What we are trying to achieve

1. Education and training in care of the dying to be delivered for all staff caring for dying patients, to include communication skills training, and skills for supporting families and those close to dying patients

2. The decision that the patient is in the last hours or days of life should be made by the multidisciplinary team and documented by the senior doctor responsible for the patient's care. This should be discussed with the patient where possible and appropriate, and with family, carers or other advocates

3. Aim to have an adequately staffed and accessible pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met

4. Patients at the end of life will be discharged home or to an alternative place of their choice in a timely manner if that is their wish

5. To consider how the experience of relatives and carers could be incorporated in moving forwards

6. Continue to participate in and inform the National work stream around the Emergency Care & Treatment Plan, working alongside Wessex CLAHRC into the use of Treatment Escalation Plans (TEP).

7. Repeat the National Care of the Dying Audit in 2017

8. Audit the use of the individualised end of life care plan and use the results to inform continuing improvement in the care of the dying

2.3 What will success look like?

1. Staff will be competent and confidant in all aspects of end of life care

2. All end of life decisions will be made, and actions taken in accordance with the person's needs and wishes

3. The dying person, and those identified as important to them, will be involved in decisions about treatment and care in adherence with the dying persons wishes

4. The needs of families and others identified as important to the dying person will be actively explored, respected and met as far as possible

5. Sensitive communication will always take place between staff and the dying person, and those identified as important to them.

6. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion will always be in place

7. Audit results will have improved from 2016/17 results

Priority 3: Reduce the impact of deconditioning and immobilisation on the frail elderly

1.1 Why we have chosen this priority

Frail older adults have reduced functional and physiological reserves, rendering them more vulnerable to the effects of hospitalisation, which frequently results in failure to recover from the pre-hospitalisation functional loss, new disability or even continued functional decline. Alternative care models with an emphasis on multidisciplinary and continuing care units are currently being developed. Their main objective, other than the recovery of the condition that caused admission, is the prevention of functional decline. Despite the theoretical support for the idea that mobility improvement in the hospitalised patient carries multiple benefits, this idea has not been fully translated into clinical practice.

Being in bed, sedentary or just not moving leads of the impact of immobilisation of patients, this is known to increase length of stay and potentially the need for onward care.

2.2 What we are trying to achieve

At UHS we have three projects developing in 2017/18 to reduce the impact of immobilisation on the frail elderly:

1. Increasing ambulatory care at the front door: ambulatory emergency care (AEC) is an emerging, streamlined way of managing patients who would traditionally be admitted. Instead, they can be treated in an ambulatory care setting and discharged the same day – offering benefits to patients, carers, support workers and us as an organisation by releasing bed capacity within AMU and improving the delivery of the four hour ED target.

Since September 2016, the emergency medicine care group has been part of Cohort 10 of the Ambulatory Emergency Care Network, supported by NHS Elect. This is an exciting opportunity which has provided us with access to a network of sites and national experts who have developed their ambulatory care models. Resources are available to the project team to use to support the cycle of the project, including conferences, webinars, analytical tools as well templates for experience based design models.

During 2017/18 we will re-launch our present ambulatory pathways and rolling out AEC clinics seven days a week, reviewing the headache pathway with ED colleagues and looking at diabetes and superficial thrombophlebitis

2. Increasing the identification and better understanding of frailty: we are fully engaged with CEDT, Urgent Response (Solent), CAT and Social Services to begin to look at what we can develop to expedite the discharge of patients' home from CDU and in the future AMU (subject to resourcing)
3. Positively encouraging mobilisation on the wards including: Joined Ambulatory care network and frailty network led by UHS, Weekly stranded Patient reviews, creating a new care hub and walking track in elderly care and, working with the hospital therapy team.

In addition, other initiatives include:

1. Use of trained volunteers and relatives in hospital to encourage older people to be more active
2. Review the outcome of the So Move feasibility study and support continued use of the project
3. Implement the Eat Drink, Move and Pyjama Paralysis initiative in AMU and MOP wards. This is an initiative to encourage patients to dress in their own clothes to promote self-reliance in the frail elderly which has been shown to improve their independence, well-being, and reduce their length of stay.

1.3 What will success look like?

1. Reduced length of stay for patients in MOP and medicine
2. More patients being discharged back to original place of residence
3. A reduction in the number of patients needing onward care
4. Increase in the number of non-admitted cases from Acute Admissions Unit, AMU and ED
5. improvement in gait speed

How we will monitor progress for our clinical effectiveness priorities:

Performance will be measured and monitored via clinical boards, and reported to the Quality and Safety Committee. Using the Plan –Do- Study- Act (PDSA) cycle of improvement, we will continual review the potential for growth.

4.Review of quality performance

All NHS trusts are required to report their performance against a statutory set of core quality indicators in a predetermined format in their quality reports to enable readers to compare performance across organisations.

The tables in Appendices 3 provides information against a number of national priorities and measures that, in conjunction with our stakeholders, which form part of our key performance indicators which are reported monthly to trust board.

These measures cover patient safety, experience and clinical outcomes. Where possible we have included national benchmarks or targets so that progression can be seen and performance compared to other providers.

Research

Innovative thinking and research is at the heart of UHS's efforts to improve care and health. In 2016/17 we consolidated our strong R&D activity and infrastructure, with a top-5 national ranking in trial recruitment and the securing over £25 million of National Institute for Health Research (NIHR) facilities.

UHS patients have wide and rapid access to clinical trials, something underlined by the recruitment to national portfolio trials of 18583 patients, the fourth highest recruitment rate in England. Adding participants in our wider research partnerships to this takes our total recruitment to 19,984.

This performance helped secure £20M in research funding for further investment, and strengthening a key preferred partner deal that gives UHS priority on new trial contracts. Continuation of strategic partnership meetings with major pharmaceutical companies have ensured Southampton remains a key site for drug and vaccine studies.

With our partners at University of Southampton, we made successful funding submissions for a NIHR Biomedical Research Centre (BRC, £14.5 million), renewal of our NIHR Wellcome Trust Clinical Research Facility (CRF, £9.2 million) and for renewal of the Southampton Experimental Cancer Medicine Centre (ECMC). Combined, these awards secure our role in the first rank of UK clinical research sites. The BRC award consolidates our existing world-class nutrition and lifestyle BRC and respiratory NIHR Biomedical research Unit with three cross-cutting themes of microbial science, data science and behavioural science.

CQUINS

The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of NHS healthcare providers' income conditional upon achieving certain improvement goals. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers.

NHS England define CQUIN as a mechanism to secure improvements in quality of services and better outcomes for patients and drive transformational change by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

A proportion of UHS income in 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between UHS and any person or body they entered a contract, agreement or arrangement with for the provisions of relevant health services, through the CQUIN framework. Further details of the agreed goals for 2016/17 are currently being determined between UHS and clinical commissioning groups.

The conditional income in 2016/17 upon achieving quality improvements and innovation goals was £13,366,000.

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.

Our CQUIN priorities for 2016/17 can be found in Appendices 4

Data Quality

Data quality refers to the tools and processes that result in the creation of the correct, complete and valid data required to support sound decision-making.

University Hospital Southampton submitted records between April 2016 and March 2017 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As at December 2016 (latest reporting month) the percentage of records in the published data:

Which included a valid NHS number was:

- 99.2 % for admitted patient care
- 99.6 % for outpatient care
- 97 % for accident and emergency care

Which included a valid General Medical Practice Code was:

- 100 % for admitted patient car
- 99.7 % for outpatient care
- 99.9 % for accident and emergency care

University Hospital Southampton NHS Foundation Trust Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organization. The Trust met or exceeded the minimum required level of compliance assessment for all Information Quality and Records Management requirements of the Toolkit for the reporting year.

The Trust has maintained a level 3 accreditation against the NHS Litigation Authority risk management standards for Acute Trusts which contains two standards specific to records management and record keeping.

UHS recognizes that good quality health services depend on the provision of high quality information.

UHS took the following actions to improve data quality in 2016/17:

- 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.

- A data quality review programme working closely with clinical areas and clinicians 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.

- 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.

- Began a programme of education, training and data quality work to support improved collection and management of patient pathways and waiting times.

Participation in national clinical audits and confidential enquiries

A clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.

During 2016/17 60 national clinical audits and 6 national confidential enquiries covered NHS services that UHS provides.
During 2016/17 UHS participated in 96% (57) of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies that UHS participated in during 2016/17 were:

NCEPOD Mental Health Adults
NCEPOD Acute Pancreatitis
NCEPOD Acute Non Invasive Ventilation
NCEPOD Children and Young People Chronic Neurodisability
NCEPOD Children and Young People Mental Health
NCEPOD Cancer in Children, Teens and Young Adults

The national clinical audits that UHS participated in, and for which data collection was completed during 2016/17, are listed in Appendices 5 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.

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

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 reported outcome measures scores for:

(iii) Hip replacement surgery

(iv) Knee replacement surgery, during the reporting period.

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

The University Hospital Southampton NHS Foundation Trust has taken actions to improve this percentage, and so the quality of its services. The results can be found in Appendices 6

6. Conclusion

We are proud of the advances we have made in the quality of services we provide. However, our mission is to be better every day, and we recognize that maintaining high quality services relies upon continual day-to-day improvements alongside longer term strategic developments. We are not complacent and know that we are still on a journey to achieve excellence in all areas.

This Quality Report enables us to qualify our progress comprehensively and demonstrate in 2015/16 we made good progress against our quality priorities.

We see this as an essential vehicle for us to work closely with our Council of Governors, our commissioners and the local and wider community on our future quality agenda as well as celebrating our successes and progress. Working with all our key stakeholders including patients we are determined to continue improving to achieve leading healthcare for the benefit of our patients.

We are confident that we have the necessary priorities, processes and plans in place to further improve our patients' care and hospital experience as we continue striving to deliver excellence throughout 2017/18.

Pending :

Annex 1: Statements from commissioners, Health watch and Board of Governors

Appendices 1

Patient Improvement Framework

2017 - 2018

The PIF is a tool to engage and communicate with staff and patients about transformation projects to improve care planned for 2017/18. The priorities have been chosen to reflect areas that are important to our patients and staff that need transformational change and enhanced focus to realise improvements by year end.

- The PIF is not designed to replicate the detail in the trust strategy and annual plan or cover all of the key performance indicators and work streams for quality.
- The safety strategy, patient experience strategy and the clinical strategy contain detail on the plans and processes to maintain and improve quality for patients at UHS.
- It forms part of the annual quality account where each year we report on progress against last year's priorities and set priorities for the following year

Patient Improvement Framework

2017 - 2018

"Our mission is to be better every day" - Fiona Dalton, Chief Executive

Patient Experience

- Improving patients experience of discharge from hospital
- Meeting patients nutritional and hydration needs
- Improving care for vulnerable adults

Patient Safety

- Recognition and management of the deteriorating patient
- Safer Invasive procedures
- Recognising and treating sepsis

Patient Outcomes

- Report outcome measures in every specialty across the hospital
- Improve clinical data recording to ensure that the HSMR accurately reflects our performance
- Reduce deconditioning and the impact of immobilisation on the frail elderly
- Improve care for patients at end of life.

Our values	**Patients first, Working together and Always improving**
Our strategies	**Clinical, Clinical effectiveness, Patient Safety, Patient Experience, Research, Education and Training, Equality and Diversity, Workforce**
Our Assurance	**Clinical accreditation, internal quality reviews, KPI monitoring, audit**

Appendices 2

International NPUAP / EPUAP Pressure Ulcer Classification System (2009)

GradeI: Non-blanchable erythema
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. . Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.

Grade II: Partial thickness
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.
*Bruising indicates deep tissue injury.

Grade III: Full thickness skin loss
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are *not* exposed. Slough may be present but does not obscure the depth of tissue loss. *May* include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Grade IV: Full thickness tissue loss
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.

Appendices 3

We have chosen to measure our performance against the following metrics:	2013/14	2014/15	2015/16	2016/17	2016/17 benchmark
Patient Safety Indicators					
Serious Incidents Requiring Investigation (SIRI)	195	35	54	63	25 for whole year
Never Events	2	2	7	3	0
Healthcare Associated Infection MRSA bacteraemia reduction	5	5	3	1	0
Healthcare Associated Infection Census (as average of monthly %)	354%	357%	363%	361%	100%
Healthcare Associated Infection Clostridium difficile reduction	33	37	35	38	<=3 a month. 43 for whole year
Avoidable Hospital Acquired 33* Grade III and IV Pressure Ulcers	42	26	36	11	30 for whole year
Falls - Avoidable Falls	19	9	3	0	1 a month. 12 for whole year

Falls Assessment Tool (timeframe of completed within 6 hours commenced in 2016) Compliance (as average of monthly %)	95%	95.70%	71%	90.42%	>95%
Thromboprophylaxis (VTE) % Patients Assessed (CQUIN)	95.41%	95.35%	95.18%	94.87%	>=95%
Thromboprophylaxis (VTE) Pharmacological prophylaxis (as average of monthly %)	97.32%	99.46%	97.75%	95.19%	>=95%
Patient Experience Indicators					
Total Complaints	578	579	443	457	550
Percentage of complaints closed in target time (due this month) (As average of monthly %)	96.70%	93%	93%	99.08%	>=90%
National Friends & Family Test Response Rate					
UHS		27.90%			
Emergency Department		37.94%	10.76%	6.21%	>10%
Inpatients		25.15%	21.74%	20.28%	>20%
Maternity	21.70%		23.38%	29.07%	>20%

Percentage of patients recommending UHS to their friends & family					
UHS					
Emergency Department			92.26%	95.42%	>90%
Inpatients			96.16%	96.68%	>90%
Maternity			95.81%	97.66%	>90%
Monthly Real time 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 %)	13%	13.47%	13%	11.34%	<=15%
Same Sex Accommodation (Non clinically justified breaches)	16	10	5	3	0
Nutrition % of patients with Nutritional screening in 24hrs (as average of monthly %)	89.10%	89%	82%	80.47%	>=95%
Patient Outcome Indicators					
Emergency readmissions, within 28 days (as average of monthly %)	10.70%	10.40%	10.10%	10.59%	<=10%

Hospital Standardised Mortality Rate (HSMR) University Hospital Southampton NHS Foundation Trust	108.84	105.19	102.5	101.47 (Apr-Dec)	100
Hospital Standardised Mortality Rate (HSMR) Southampton General Hospital	102.53	97.64	93.63	93.14 (Apr-Dec)	<90.1
Hospital Mortality Rate (%)	1.83	1.76	1.63	1.63 (Apr-Dec)	1.61
Patient Reportedc outcome measures. PROMS hip replacement data contibuted	68.4%	74.1%	86.7%	74.0%	>=50%
Knee replacemnet data contributed	107.0%	105.9%	103.9%	104.4%	>=50%

Q.19 Readmission data from https://indicators.hscic.gov.uk/webview/ has not been updated since the last Quality Account

Q4 201617 is only Jan-Feb as March's data has yet to be submitted to DoH nationally.

Q21.1 FFT

RHM	**RESPONSE RATE**										
A&E		Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
	UHS response rate	19.60%	14.30%	8.94%	4.81%	5.23%	9.52%	6.02%	4.39%	11.96%	6.53%
	National Average	21.15%	14.55%	13.05%	12.72%	12.99%	13.19%	12.18%	12.45%	14.90%	12.73%
	Highest Trust	100.00%	45.12%	44.57%	47.22%	44.43%	45.31%	45.03%	45.46%	100.00%	45.46%
	Lowest Trust	0.03%	0.18%	0.02%	0.19%	0.07%	0.00%	0.23%	0.46%	0.02%	0.00%
RHM											
Inpatient and daycase		Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
	UHS response rate	22.66%	20.64%	21.22%	22.54%	20.79%	19.11%	19.87%	17.30%	21.74%	19.44%
	National Average	20.51%	26.08%	24.43%	24.43%	25.77%	25.12%	24.26%	24.32%	23.87%	24.92%
	Highest Trust	100.00%	100.00%	125.00%	100.00%	100.00%	100.00%	96.67%	100.00%	125.00%	100.00%
	Lowest Trust	0.06%	4.16%	4.66%	4.56%	4.75%	3.27%	1.70%	3.83%	0.06%	1.70%

RHM	**POSITIVE**										
A&E		Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
	UHS response rate	94.53%	92.27%	94.04%	93.73%	93.79%	96.34%	94.82%	96.17%	93.74%	95.38%
	National Average	90.82%	88.14%	87.07%	84.91%	85.95%	86.01%	86.04%	87.02%	87.74%	86.16%
	Highest Trust	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Lowest Trust	58.25%	62.42%	33.33%	46.33%	42.75%	44.75%	48.16%	45.49%	33.33%	42.75%
RHM											

Inpatient and daycase	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
UHS response rate	95.81%	83.04%	96.10%	96.48%	96.35%	96.23%	97.19%	96.83%	92.92%	96.63%
National Average	92.61%	95.71%	95.61%	95.70%	95.79%	95.60%	95.54%	95.75%	95.11%	95.66%
Highest Trust	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Lowest Trust	61.40%	74.44%	71.68%	72.00%	67.97%	66.86%	75.34%	75.55%	61.40%	66.86%

RHM **NEGATIVE**

A&E	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
UHS response rate	2.10%	2.72%	3.12%	2.95%	3.03%	1.89%	2.49%	1.59%	2.54%	2.26%
National Average	4.15%	6.09%	6.89%	8.37%	7.62%	7.61%	7.63%	7.01%	6.37%	7.52%
Highest Trust	29.13%	26.11%	34.78%	37.23%	37.69%	33.31%	41.03%	32.28%	37.23%	41.03%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

RHM

Inpatient and daycase	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
UHS response rate	1.33%	0.88%	1.41%	1.07%	1.08%	1.23%	0.75%	0.79%	1.18%	0.98%
National Average	3.30%	1.43%	1.48%	1.47%	1.44%	1.56%	1.53%	1.51%	1.80%	1.51%
Highest Trust	21.05%	9.34%	10.00%	11.11%	10.55%	13.01%	8.59%	9.54%	21.05%	13.01%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Q24 Cdiff per 100,000 bed days

	2015/16	2014/15	2013/14	2012/13	2011/12	2010/11
UHS	9.74	11.82	9	11.3	18.9	25.8
National Ave	14.91	15.04	14.7	17.3	22.2	29.7
Highest Trust Score	66	62.57	37.1	30.8	58.2	71.2
Lowest Trust Score	0	0	0	0	0	0
Lowest Trust Score (non-zero)	1.1	2.8	1.2	1.2	1.2	2.6

Q 25 Patient Safety Incidents

	April-15 to Sept-15			Oct-14 to Mar-15			Apr-14 to Sep-14		
	Rates Per 1000 bed days	Severe and death	severe and death %	Rates Per 1000 bed days	Severe and death	severe and death %	Rates Per 1000 bed days	Severe and death	severe and death %
UHS	31.5	54	0.91%	35.41	61	0.90%	32.3	57	0.85%
National Ave (Acute Teaching Trusts)	39.3	20	0.43%	37.15	23	0.58%	33.29	20	0.52%
Highest Trust Score (Acute teaching trusts)	74.67	89	2.92%	82.21	128	5.19%	74.96	97	3.05%
Lowest Trust Score (Acute teaching trusts)	18.07	2	0.07%	3.57	2	0.05%	0.24	0	0.00%

Oct-13 to Mar-14		
Rates Per 100 Admissions	Severe and death	severe and death %
8.35	33	0.61%
7.94	29	0.51%
12.84	46	0.88%
4.87	1	0.03%

Q 23 VTE

	2014/15/Q1	2014/15/Q2	2014/15/Q3	2014/15/Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
UHS	95.60%	95.10%	95.23%	95.38%	95.10%	95.30%	95.14%	95.17%	95.04%	95.12%	94.61%
National Ave (Acute Providers)	96.40%	96.50%	96.34%	96.30%	96.30%	96.20%	95.51%	95.45%	95.64%	95.45%	95.57%
Highest Trust Score) (Acute Providers	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Lowest Trust Score (Acute Providers)	87.20%	90.50%	81.91%	79.23%	86.10%	75.00%	78.52%	78.06%	80.61%	72.14%	76.48%

Q 12a SHMI

	January 15 - December 15		April 15 - March 16		July 15 - June 16		October 15 - September 16	
	Value	OD Banding	Value	OD Banding	Value	OD Banding	Value	OD Banding
UHS	0.95	2	0.96	2	0.96	2	0.95	2
National Ave	1	2	1	2	1	2	1	2
Highest Trust Score	1.17	1	1.18	1	1.17	1	1.16	1
Lowest Trust Score	0.67	3	0.68	3	0.69	3	0.78	3

Q12b Palliative Care Indicator

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

	January 15 - December 15	April 15 - March 16	July 15 - June 16	October 15 - September 16
UHS	44.3	42.6	42.2	43.2
National Ave	27.6	28.5	29.2	29.8
Highest Trust Score	54.8	54.6	54.8	56.3
Lowest Trust Score	0.2	0.6	0.6	0.4

The percentage of patient admitted with palliative care coded at either diagnosis or specialty level

	January 15 - December 15	April 15 - March 16	July 15 - June 16	October 15 - September 16
UHS	2.35	2.15	2.19	2.29
National Ave	1.45	1.48	1.51	1.54
Highest Trust Score	3.46	3.28	3.61	3.67
Lowest Trust Score	0.49	0.01	0.01	0.01

18 Hip Replacement Surgery

	2016/17 Q2*
UHS	19.09
National Ave (Acute Providers)	22.02
Highest Trust Score) (Acute Providers	25.20
Lowest Trust Score (Acute Providers)	18.04

Knee Replacement Surgery

	2016/17 Q2*
UHS	Too few modelled records (<30) for NHSD to provide a health gain.
National Ave (Acute Providers)	16.88
Highest Trust Score) (Acute Providers	21.35
Lowest Trust Score (Acute Providers)	12.65

* Data is only available for April through September 2016 and is not split by quarter, the data is entered under Q2 but the data is for Q1 and Q2 combined. WeI have used the latest available updated data (Feb 2017) and the metric used is average adjusted health gain for Primary hip and knee replacements

Q 25 MRSA screening

2016/17

	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	
Eligible patients	15493	14731	13948	17172	61344
Screened for MRSA	57541	49099	56023	58772	221435
% achieved	371.40%	333.30%	401.66%	342.25%	360.97%

2015/16

	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	
Eligible patients	14943	15594	15402	16270	62209
Screened for MRSA	55759	55507	56575	57688	225529
% achieved	373.14%	355.95%	367.32%	354.57%	362.53%

Appendices 4

Clinical	CQUIN Scheme	CQUIN Target	National or Local Scheme	Financial Reward for Achieving Scheme
CCGs	Sepsis 2a	Screening all patients for sepsis screening is appropriate who arrive through the Emergency Department/ or by direct admission to any other unit	National	£335,000
CCGs	Sepsis 2b	Initiate intravenous antibiotics within one hour of presentation, for those patients who have suspected severe sepsis, Red Flag or septic shock	National	£335,000
CCGs	Staff health & Wellbeing - staffing	Introduction of health and wellbeing initiatives covering physical activities, mental health and improving access to physio for people with MSK issues	National	£669,000
CCGs	Staff health & Wellbeing – healthy food	Achieve a step change in the health of food offered on the premises and submit national data based on existing contracts with food and drink suppliers	National	£669,000
CCGs	Staff health & Wellbeing – Flu Vaccine	Achieve a 75% uptake on the flu vaccine for frontline clinical staff	National	£669,000
CCGs	Antimicrobial Stewardship 4a	Reduction in antibiotic consumption per 1,000 admissions	National	£536,000
CCGs	Antimicrobial Stewardship 4b	Empiric review of antibiotic prescription	National	£134,000
CCG's	All National CQUINs	All other local CCG's collaborative CQUIN funding split across all National CQUINS	National	£412,000
SCCCG	Outpatient Follow Up	Review current practice of routine face to face follow ups with aim to stop routine face to face follow ups and commence patient initiated follow up	Local	£373,000
SCCCG	Choose and Book	Deliver directly-bookable services to all patients referred from GP and community services	Local	£373,000
SCCCG	Frequent Attendees	Working with community partners, reduce the number of frequent attendances at ED and frequent admissions	Local	£373,000
SCCCG	Cancer 62 day pathway	In Depth review of all long waiters >104 days including an RCA and a clinical harm review	Local	£373,000

WHCCG	Non Elective Excess Bed days	A reduction in non elective excess bed days. Improved discharge planning, reduction in length of stay and improved quality care	Local	£720,000
WHCCG	Ambulatory Emergency Care	Focus on developing, implementation and strengthening of AEC protocols to deliver care outside traditional bed based hospital setting resulting in enhanced patient experience and outcomes	Local	£720,000
NHSE	Intravenous Immunoglobulin Panel (IVIg)	Implementation and management of a regional clinical IVIg panel set up by the regional centre and involving the local District General Hospitals.	Local	£535,000
NHSE	Intravenous Immunoglobulin Panel Database	Database of IVIG data	Local	£535,000
NHSE	CF Adherence	Randomised pilot trial providing services for Cystic Fibrosis patients	Local	£162,000
NHSE	Optimal Device	Maintenance and improvement in optimisation of device usage during the year of transition to a centralised national procurement and supply chain	Local	£351,000
NHSE	SACT	Dose banding principles using local and national dose banding tables	Local	£128,000
NHSE	Rheumatic MDT	Development of coordinated MDT clinics for patients with multisystem auto-immune rheumatic diseases and to ensure data collection and compliance with existing NHSE commissioning policies	Local	£166,000
NHSE	Audit of clinical intervention rates	Participate in required clinical interventions requested by NHSE	Local	£459,000
NHSE	Adult Critical Care	Baseline and thematic review of delayed discharges over 24 hours from GICU	Local	£351,000
NHSE	Dental	Data reporting standards – Identification of secondary dental activity within commissioning data sets	Local	£13,000
NHSE	Dental	To support local clinical commissioning for dental services	Local	£37,000
NHSE	Hep C Network	Infrastructure governance and partnership working across the healthcare providers	Local	£3,815,000
NHSE	Public Health	No specific CQUIN so funds spread across other NHSE CQUINs	Local	£125,000
			Total	£13,366,000

Appendices 5

	Total number of NCAs UHS were eligible to participate in (n=60)	Eligible (58)	Participated (55 = 98%)	% Actual cases submitted / expected submissions
1.	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	Continuous
2.	Adult Asthma (BTS)	✓	×	N/A
3.	BAUS Nephrectomy Audit	✓	✓	In progress
4.	BAUS Percutaneous Nephrolithotomy	✓	✓	In progress
5.	BAUS Prostatectomy Audit	✓	✓	In progress
6.	BAUS Stress Urinary Incontinence Audit	✓	✓	In progress
7.	Bowel cancer (NBOCAP)	✓	✓	100%
8.	Cardiac Rhythm Management (CRM)	✓	✓	Continuous
9.	Case Mix Programme (CMP)	✓	✓	1212 Cases (every GICU admission)
10.	Child health clinical outcome review programme (NCEPOD) Neurodisability and Mental health in 0-25 years old	✓	✓	100%
11.	College of Emergency Medicine (CEM)- Asthma (paediatric and adult) care in emergency department	✓	✓	100%
12.	College of Emergency Medicine (CEM)- severe sepsis and septic shock	✓	✓	100%
13.	College of Emergency Medicine (CEM)- Consultant sign-off	✓	✓	100%
14.	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	✓	✓	In progress
15.	Coronary Angioplasty (NICOR)	✓	✓	100%
16.	Diabetes Footcare	✓	×	N/A
17.	Diabetes in pregancy (NPID)	✓	✓	62 cases
18.	Diabetes Diabetes Transition	✓	✓	100%
19.	Diabetes Inpatient Audit (NADIA)	✓	✓	100%
20.	Diabetes (Paediatric) RCPCH NPDA	✓	✓	100%
21.	Elective surgery (National PROMs Programme) hips and knees Hip participation rate: Knee participation rate:	✓	✓	Yes, continuous 86.7% 103.9%
22.	Endocrine and Thyroid National audit	✓	✓	TBC
23.	Falls and Fragility Fractures Audit Programme (FFFAP) national hip fracture database	✓	✓	Continuous

24.	Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database	✓	✓	Continuous
25.	Falls and Fragility Fractures Audit Programme (FFFAP) national inpatient falls	✓	✓	In progress
26.	Head and Neck Cancer Audit	✓	✓	In progress
27.	Inflammatory Bowel Disease (IBD) programme - Biological therapies adult and paeds	✓	✓	In progress
28.	Learning Disability Mortality Review Programme (LeDeR)	✓	✓	15 cases
29.	Lung cancer (NLCA) (LUCADA)	✓	✓	Continuous
30.	Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	100%
31.	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality	✓	✓	100%
32.	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Mortality	✓	✓	100%
33.	Medical and Surgical Clinical Outcome review programme NCEPOD – NIV	✓	✓	100%
34.	Medical and Surgical Clinical Outcome review programme NCEPOD –Acute pancreatitis	✓	✓	100%
35.	Medical and Surgical Clinical Outcome review programme NCEPOD – Mental health Adults	✓	✓	100%
36.	National Adult Cardiac Surgery Audit	✓	✓	In progress
37.	National Audit of Dementia	✓	✓	100%
38.	National Cardiac Arrest Audit (NCAA)	✓	✓	118 Team visits which met NCAA scope
39.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary Workstream	✓	✓	In progress
40.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary Rehabilitation Audit	✓	✓	In progress
41.	National Comparative Audit of blood Transfusion- 2015 Audit of Patient Blood Management in Scheduled Surgery (NCABT)	✓	✓	29 cases
42.	2016 Audit of Red Cell and Platelet Transfusion in Haematology (NCABT)	✓	✓	40 cases
43.	National Emergency Laparotomy Audit (NELA)	✓	✓	In progress
44.	National Heart Failure Audit	✓	✓	In progress
45.	National Joint Registry (NJR)	✓	✓	95%
46.	National Ophthalmology Audit	✓	✓	In progress
47.	National Prostate Cancer Audit (NPCA) (2nd year)	✓	✓	100%
48.	National Vascular Registry (NVR)	✓	✓	In progress
49.	Neonatal Intensive and Special Care (NNAP)	✓	✓	737
50.	Neurosurgical National Audit programme	✓	✓	6,617 admissions
51.	Oesophago-gastric cancer (NAOGC) (NOGGA)	✓	✓	In progress

52.	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	In progress
53.	Paediatric Pneumonia	✓	✓	In progress
54.	Renal replacement therapy (Renal Registry)	✓	✓	100%
55.	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient Audit	✓	✓	207 expected every quarter
56.	Sentinel Stroke National Audit Programme (SSNAP) SSNAP Post Acute Organisational Audit	✓	✓	100%
57.	UK Cystic Fibrosis Registry (Adults and Paeds)	✓	✓	100%

National Clinical Audit: actions to improve quality

National audit title	Actions
1. Diabetes Inpatient Audit (NADIA)	• Nursing staff to have twice annual link nurse meetings and diabetes study days. • Bespoke ward/department based teaching to be further arranged as necessary. • Doctors to have regular diabetes education slots and lunchtime departmental teaching as required • HCP's and undergraduates education sessions to be provided upon request • Update the diabetes guide and make available on StaffNet. • DiAppBetes (smartphone application to support HCPs for diabetes care) being updated. • Inpatient diabetes E-learning tool to be made available on VLE. • Divisional Education Leads to support areas that need diabetes updates. • Push for increased foot clinic support for patients from West Hampshire.
2. 2016 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	• To reduce transfusion of platelets from two to one unit in out-patients. • Re-audit in Autumn 2017 looking at intervals between transfusions in Haematology out-patients
3. Rheumatoid and Early Inflammatory Arthritis	• Quality Standard (QS) 1 & 2 - Improvements to GP education to be made to increase awareness of early inflammatory arthritis (EIA) and to encourage rapid referral of patients suspected of having an EIA directly to the Consultant or via urgent referral through the Choose and Book service. • Looking to introduce an electronic referral form to support the current Choose and Book process. • QS3 - A Consultant-led service to be introduced. • QS4 & 5 – To introduce a formal personalised patient education portfolio with information about their condition, treatment, monitoring requirements and advice line information.

4. National Comparative Audit of Blood Transfusion (NCABT) 2015 Audit of Lower GI Bleeding and the use of blood	• Audit outcomes to be discussed at Surgery care group audit meeting and circulated to clinicians.
5. Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal mortality	• Active program is ongoing, which mirrors National initiatives to reduce stillbirth numbers. • Revise guidelines for monitoring fetal growth. • Planned revision of patient information on the importance of reduced fetal movements. • On-going internal review of all perinatal mortality with a view to learning lessons.
6. Elective surgery (National PROMs Programme) - Hips and knees	• An audit of patients reporting worse condition-specific health post-operatively is complete and a report will be circulated once it has been signed off by the lead clinician. • PROMs health gains have been used to produce a patient handout for hip replacements and to highlight areas where post-operative rehabilitation could be changed. This document is now live on the UHS website. • Work with the MSK physiotherapy department to develop targeted occupational therapy • Further analysis to be carried out.
7. UK Cystic Fibrosis Registry (Adults and Paeds)	• To increase social worker time. • Develop a strategy to address nutritional outcomes in our patients.
8. Coronary Angioplasty (NICOR)	• To continue to perform at same level of care
9. Sentinel Stroke National Audit Programme (SSNAP) SSNAP Post Acute Organisational Audit	• On-going work within the trust to work on CT time within 1 hour for all strokes admitted
10. National Joint Registry (NJR)	• A monthly report to ensure all relevant hip and knee replacements are entered onto the NJR. This was instituted in October 2015 and has decreased the number of missing records in the 15/16 data quality audit. • NJR consent forms are being sent with pre-assessment appointment letters which has help boost the percentage of patients consenting to their data being held on the NJR from 71% in 13/14 to 95% in 16/17 to date. • The Orthopaedic Department are engaged in an ongoing process of validation and implication of individual consultant level data • Other contributing factors are being identified and addressed
11. Bowel cancer (NBOCAP	• Improved completeness of submission data
12. National Vascular Registry (NVR)	• Vascular centralisation with Portsmouth Unit moving to Southampton.

13. College of Emergency Medicine (CEM) – procedural sedation	• Development of pre sedation checklist • Development of pre discharge checklist
14. Diabetes (Paediatric) PNDA	• Reviewed & amended team agreed blood glucose targets for patients at team away day on 7th June 2016 • Reviewed & amended team agreed HbA1c targets for patients at team away day on 7th June 2016
15. Medical and Surgical Clinical Outcome review programme NCEPOD – Acute pancreatitis	• To revise the Gall bladder surgery pathway. • To discuss complex pancreatitis cases in an MDT meeting.
16. National Prostate Cancer Audit (NPCA) (2nd year)	• Improvement of data completion for certain fields expected in future years following improved import processes from HICCS.

Local Clinical Audit: actions to improve quality

Audit Title	**Actions**
1. Assessment and prevention of delirium in people with Hip fracture	• Education and awareness about the 4AT poster which is to be placed on ward. • Education session for FY1 and SHO doctors working in T&O to include 4AT and audit findings.
2. 6 monthly completion of Real-Ear-to-Coupler Difference (RECD) measurements on all Permanent Childhood Hearing Impairment (PCHI) children <5 years	• Staff to continue to ensure RECD measurements are performed at each hearing aid review appointment. • To try to ensure appointments are booked no more than 6 months apart. • If RECD measurements cannot or are not performed the reason for this needs to be documented.
3. Diagnosis and management of clinically isolated syndromes that have a high risk of conversion to multiple sclerosis	• Patients presenting with asymptomatic T2 high signal lesions on imaging should be offered a referral to the multiple sclerosis disease-modifying drug clinic or MDT. • Patients presenting with asymptomatic T2 high signal lesions on imaging should be offered a follow-up MRI scan after 3-6 months. • Present the results at our regional neurology meeting. • Share results via a group email. • Ensure all MS specialists in the region are in agreement with these recommendations.
4. Drink thickening practices against the process agreed by the Nursing and Midwifery Group (NMG), and the Oropharyngeal Dysphagia Policy.	• Supply/replacement process for the new generic above bed sign to be circulated within the Trust • A crib sheet on how to use bed signs to be produced and circulated. • Bed signage to be covered in all relevant SLT/N&D training. • A rolling ward training programme on how to mix thickened drinks and to follow SLT recommendations will be rolled out.

	• Rigorous incident reporting of incorrect recommendations to be completed. • Training and process for diet grid sign off by Nurse in Charge to be revisited. • Matrons to support wards on the agreed drink round process. • Matrons to support wards on agreed process for water jug thickening. • Matrons to support wards on following the NPSA alert that tins of thickener must not be left on patient's tables without a risk assessment being carried out. • SLT to provide bespoke ward/staff training when needed.
5. Use of delirium diagnostic tool in elderly care	• To ensure the recommended tool for assessing patients with delirium is available to staff on the relevant wards.
6. Management of Diabetic Ketoacidosis in Adults at UHS	• Nursing and medical staff on AMU will be educated about the need for hourly observations on patients admitted with DKA. • To amend the DKA chart to carry a check box for foot examination. • All patients presenting with DKA and ph<6.9 on a blood gas will be referred to ITU. • Diabetes team will have a new checklist indicating ketone/sick day advice as well as post-discharge follow up.
7. Epilepsy Surgery: Outcomes and Complications	• To make alterations in surgical technique to reduce morbidity from temporal lobe resections. • To have less prolonged gaps between operations. • To send notification of adverse outcomes directly to neurosurgical management team. • To have a rapid review of post-operative outcomes to discuss complications more quickly. • A formal re-audit to be completed in 12-18 months.
8. Management of anaphylaxis in Paediatric patients presenting to PAU and ED	• To introduce a discharge proforma.
9. An audit of domperidone prescribing in children	• Educate prescribers on the importance of ECG monitoring with domperidone. • Speak to prescribers/consultants and try to come to a solution on length of time medication is taken for.
10. Emergency diabetic eye screening referrals to eye casualty	• New telephone answering service to be installed. • Protocol for referring patients to eye casualty has been redesigned to include faxing of why being referred. • Two-part referral to be amalgamated into one. • Staff to be trained on the new Optimise computer system to be able to view retinal screening images. • Access to the Optimise computer system to be given to staff once trained.
11. Ongoing pain management in the major trauma patient	• Teaching and education on pain scoring in ED to be performed in cooperation with the Acute Pain Team.

	• Teaching and education on at rest and movement pain scoring performed in cooperation with the Acute Pain Team. • Discussion with Metavision Team re: implementation of rest/movement pain score to be added in the electronic observation chart. • Introduction of regular analgesics and laxatives in the analgesia bundle; teaching and education of the ward staff including T&O doctors (at T&O induction). • Re-audit in 6 months time once above actions implemented
12. A re-audit of the prevalence of overweight and obesity amongst the local paediatric diabetes population	• Develop resources which are designed specifically to support overweight and obesity patients. • To include prescriptive kilocalorie counting diets and portion sizes in the resources. • Use alternative and more modern methods to communicate with diabetes patients, which better suit their needs. • To make appointments outside of school and parents working hours. • Increasing the use of e-mail to communicate with families about dietary intake. • To improve communication and awareness of local community run exercise and activity programmes that are accessible to the children and young people. • To look at an obesity strategy and resource that links UHS with community activities. • To be part of the Southampton City strategy board for the healthy weight campaign. • To ensure all the diabetes team continue to discuss growth charts and targets with patients and their families in clinic. • To describe in all written communication with parents their child's weight status and their target. • To consider adding nutritional requirements at the top or bottom of each dietetic report given to all patients as standard. Explaining recommended daily grams of carbohydrate and sugar. • To change the written information given to newly diagnosed diabetes patients to have more emphasis on healthy diets and bodyweight. • To keep a record of prevalence of diabulaemia on the database.
13. Perineal repair guideline – patient information leaflet audit	• To use 'Theme of the week' to remind staff to record in the case notes when they have given the perineal repair leaflet to a woman.
14. A re-audit to assess the use of a cough assessment framework in neuromuscular patients admitted with respiratory problems.	• To keep the cough assessment form in ward folders to allow quick and easy access. • Repeat teaching sessions to all teams. • Re-launch interest across all Divisions. • To complete a re-audit.

15. Children and young people diagnosed with Type I Diabetes who are Carbohydrate Counting at Level 3	• To aim for 100% carbohydrate counting at re-audit in 2018. • To review patients identified as not carbohydrate counting and aim to establish them carbohydrate counting with appropriate support. • To continue to introduce carbohydrate counting at diagnosis. • To carry out another audit in the 2017 audit cycle looking at carbohydrate counting at diagnosis and HbA1c six months on. • To work with the rest of the diabetes team to develop a strategy. • To consider and recognise at the time of diagnosis which patients and families may find carbohydrate counting challenging. • For patients and families who need additional support a home visit or school visit may be required.
16. Audit of GICU & CICU Metavision Recording of Enteral Feeds August 2016	• To document the times the feed is paused by pausing the infusion line on metavision.
17. A re-audit of patient experience of empathy in clinical encounters with therapy staff during admission to trauma & orthopaedic wards	• To ensure the feedback relates specifically to therapists the word 'Therapy' to be made clearer on the questionnaire. • An alternative version to be considered in order to include those with learning difficulties or cognitive impairments. Similarly, to enable those with communication difficulties to complete the questionnaire independently, a tablet/touch screen version could be used.
18. Is our hand trauma service hitting the British Society for Surgery of the Hand (BSSH) 2007 standards?	• To develop guideline criteria with the hand consultants for access to the hand clinic. • To develop and undertake an education programme to ED clinicians to ensure full implementation. • To discuss with consultants the development and implementation of a teaching programme for the trauma consultant teams. • To develop guideline criteria with the hand consultants for access to the hand clinic to ensure the most appropriate patients are seen by the right team. • To develop a specific pathway for priority patients from ED assessment to definitive surgery.
19. Audit of patient medical notes where the DNACPR audit form recorded that there was no discussion with the patient	• To educate the medical staff on the need to document in patient's medical notes the reasons DNACPR decisions are not communicated to patients. • To be added to the resuscitation training for medical staff.
20. Developmental Dysplasia of Hips (DDH) - Risk Factors - Timeliness of intervention	• Guideline to be reviewed and republished, ensuring the referral criteria is clear. • Risks register entry (2113) to be update to reflect the timeliness aspect of the PHE criteria. • Audit to be discussed with the DGM and CE lead for child health.

	• Trust Screening Lead to be made aware of the current non-compliance. • To inform the DCD of the current non-compliance. • Continue to audit to include Q1, Q2 and Q3.
21. Anticoagulation after Hip or Knee Surgery in Patients on Long-Term Anticoagulation	• Presentation of results at T&O Care Group, M&M & Audits Meeting. • Informing the T&O Consultants and Registrars who were not present at the meeting about the results of the audit and about the necessity to document Anticoagulation plans in the operation notes accurately.
22. Documentation Of post take ward round in trauma orthopaedics	• Suggest implementing a set format for post take ward round documentation.
23. Comparison of traditional Norwood procedure and its Sano modification: outcome and indication	• Results of our experience to be discussed between Paediatric Cardiac Surgeons, PICU and Cardiologist Consultants. • To agree whether to continue with Norwood and Sano modification during stage 1, moving the conduit shunt to the right pulmonary artery.
24. An audit on handover practice in Oncology	• To create a handover checklist poster. • To create signs on door during handover to minimise distraction during handover, remind other HCP not to interrupt. • To create a permanent bleep for the second twilight SHO on-call. • To create a clear structure for handover including a clear triage system for sick patients. • To put an up-to-date on-call rota in all handover rooms. • To standardise criteria for handing patients over on weekend. • To specify roles of job during on-calls. • To schedule allocated time for handover- normal days and pre-weekend. • To create a job folder for writing routine jobs done and ensure job book available on each ward for nurses to complete. • Identifying SpR/SHO on-call for the day and create a briefing for every morning. • Whatsapp group for easier communication if running late/unable to attend handover. • To ensure adequate training for new staff to manage common emergencies in the department..
25. Re-offer of virology screening (Antenatal Screening)	• Further communication with midwifery staff by newsletter.
26. Intermittent Auscultation (IA) Audit	• To feedback and educate through the education team regarding documentation of the presence of accelerations and absence of decelerations for both low risk women and women transferred to continuous fetal monitoring.

	• To feedback and educate through the education team regarding documentation of the reason for transfer to continuous fetal monitoring. • To feedback and educate through the education team regarding undertaking and documenting the maternal pulse as per the guidance. • To remove from the Care Group Risk Register entry (1624) as improved compliance. • Discuss with the consultant Midwives the options and benefits for a 'fresh ears' approach with intermittent auscultation.
27. MEOWS audit	• To add MEOWs activation hotline ext, bleeps for the Coordinator and SHO on handover sheet. • For the Theme of the week, to add education on MEOWs activation, scores.
28. Shoulder dystocia re-audit	• To encourage use and completion of shoulder dystocia proforma in paper notes by raising awareness among multidisciplinary team, via: presenting audit at MDT meeting, PROMPT course, and theme of the week. • To promote use of checklist for babies with suspected brachial plexus Injury at PROMPT course. • To raise awareness of entering babies with brachial plexus injury or upper limb fracture details on HICSS or SEND at PROMPT course.
29. High dependency care audit	• To promote documentation standards for admission and discharge on Theme of the Week. • To review guideline. • Ongoing education to be completed during HDU study days.
30. Complications from Botox in Squint	• To ensure patients having Botulinum Toxin follow-up within 6 weeks to ensure measurements are taken at time of maximum efficiency. • To make an improvement to EMG machine to enable greater accuracy with injection. • To continue to record the results of future injections to see if any alterations in practice reduce complication rate and improve success rate. • To maintain the recent increase in number of clinics to meet the demand of patients requiring treatment.
31. Retinal detachment audit	• Audit to be repeated every three months to ensure fellows are adequately monitored and to guide clinical supervision.
32. Outcomes of DCR surgery at UHS	• To discuss audit outcomes with managers to increase theatre capacity.
33. Audit to review DNACPR sheet within patients medical notes to review if signed by Consultant	• To reiteration the need for DNACPR forms to be verified by Consultants within 48 Hours. • To complete spot-checks of DNACPR forms on Matron walkabouts.

34. Re-audit of the documentation of critical care rehabilitation for those patients admitted to general intensive care	• Investigate the potential to fund a rehab coordinator post (Job description has been written, awaiting funding). • To develop current information pack (ICU Steps) given to patients on ICU admission to include details about rehab pathway. • To include information regarding potential discharges from the unit in the daily therapist handover meeting. • To include information to review patients prior to discharge will now be in the daily therapist handover meeting. • To develop information pack to give to patients on discharge from GICU in order to provide information to patients and with contact details for follow up clinics. • Reminders to complete CPAx and Barthel scores to be included in the daily therapist handover meeting. • Reminders to review goals to be included in the daily therapist handover meeting.
35. Broken down Perineum - The rate and causes of cases where women return to the Maternity Assessment Unit with complications with Perineal wound healing	• To raise awareness of the information to be given to patients about PR checking before and after suturing. • To be a Theme of the week.
36. MUST & Food Chart Audit in Trauma and Orthopaedics	• To arrange a meeting to discuss training needs that need to be implemented from the audit findings.
37. AMU handover/safety audit	• To discuss with CE lead to break down the work list to Elderly care and AMU patients. • To present audit report in AMU teaching and Governance meeting.
38. Completion of recommended onward referrals following diagnosis of a permanent childhood hearing impairment (PCHI)	• To report audit findings at the next paediatric meeting on 16th December 2016.
39. Documentation Reliability of Transthoracic Echocardiography in Diagnosing Morphology of Bicuspid Aortic Valve Disease	• To contact HICCS to assess possibility and request for mandatory data entry point for aortic morphology (with set criteria) for those undergoing aortic surgery. • To contact the department in charge of developing the echo reporting software to assess possibility and request for mandatory data entry point for aortic morphology (with set criteria) for all echo reports.
40. Management of low Hb on Neuro-intensive Care Unit (ICU)	• To increase awareness of new guidelines within the multidisciplinary teaching. • To update online Neuro ICU guidelines.
41. Giant cell arteritis audit	• To ensure that all patients that have CXR are treated with aspirin (where no contraindication).

42. An audit of Speech & Language Therapy (SLT) and ward compliance with the Oropharyngeal Dysphagia Policy on acute paediatric wards	• To feedback the audit results to the SLT team. • To circulate the report to ward leaders/matrons/division leads via email. • To meet with ward managers and matrons of the respective ward areas to share audit data and together create an action plan for improvement. • To feedback audit results to relevant trust forums/meetings i.e. NMG • To provide training to wards as appropriate. • To provide extra bed-signs to areas that requires them.
43. Completion of Peripheral Cannula Care Record	• To reiterate to all medical/nursing staff the need to record insertion date, VIPS scores and removal dates. • To ensure all medical/nursing staff to include reason if cannula has been insitu for more than 72 hours. • To reinforce the above actions to medical staff via email. • To reinforce the above actions to nursing staff via band 7 meeting. • To ensure all Nursing staffs (via band 7s) are asked to continue to submit AERS for forms not initiated/ completed.
44. Audit of completeness and accuracy of genotyping results in adult cystic fibrosis (CF)	• To add section to annual review to check whether genotype result has been seen. If not available to request result from genetics department or retest. • CF consultant to check all patients genotype at annual review and send extended genotyping where indicated. • The patient registry data to be updated with results available from extended Genotyping.
45. Developmental Dysplasia of Hips (DDH) - Risk Factors - Timeliness of intervention re-audit	• To communication with the PSC to reiterate appointments should be booked within 6 weeks of age.
46. Essence of Care - Promoting Health & Wellbeing audit	**Intensive Care actions** • To change the doctor's documentation on CIS to include health risk factors. • CAM score (to evaluate patients agitation) to be introduced through a focused education programme in CICU. • To use NICU Agitation - Sedation escalation tool using Richmond Agitation Sedation score (RASS) - continuous education and training to all staff. • Sleep assessment documentation to be placed on CIS. • To commence a sleep project to reduce noise at night. • To purchase an audiometer for the unit to assess noise at night.
47. Trustwide record keeping audit including ED	• To distribute audit results to all clinicians and governance teams at UHS. • To educate clinicians and new doctors on the importance of detail about timing and ability to identify clinicians involved with patients.

	• Consultants to ensure they educate all members of clinical team when reviewing notes, and also to ensure their trainees documentation is up to standard. • Top tips for doctor to ensure they document allergy status. • Awareness for consultant to check the junior doctors are documenting allergy status.
48. Essence of Care Bowel Bladder and Continence Audit	**Actions from Surgical Wards** • Share findings and results of audit with Senior Nursing Team on surgical ward areas. • To continue with education to new staff and current staff re: completion of patient elimination assessments for both bowel and bladder. • To meet with Ward Leader on ASU/ASA and F5 to educate nursing staff on completion of elimination assessments.. • To work with Nursing leads in bowel and bladder care to produce new Trust guidelines and to continue to scope compliance against care plans for both bowel and bladder assessments. • To work with nursing teams to educate them to complete care plans for catheter removal. • To confirm that all surgical wards have hand wipes available for patient use. **Actions from Critical Care** • To add a separate form to the nursing task for flexiseal observations to make it more accessible to document care actions. • Bedside flexiseal training sessions to be provided on GICU by the company representative. • CICU will get the flexiseal company representative to provide updates and training. • To produce new "Do Not Enter" signs. • Prompts to be made via email / Hawkeye and forums to increase compliance of the "Do Not Enter" signs use during patient care. • Staff nurse on GICU to liaise with Trust lead nurse specialist for infection prevention to investigate implementing a nurse–led protocol for Trial With-Out Cather (TWOC) specific for critical care. • To increase education on documentation of care plans for urinary care and the TWOC flow chart for the Trust. • To ensure nurses refer to Tissue Viability service (TVS) when skin damage is identified and ensure correct care plan is in place. • Educate staff on correct monitoring treatment and documentation of skin damage. **Actions from Elderly and Acute Medicine Wards** • Privacy signs to be attached to all curtains during toileting patients at bedside. • To ensure all curtains are well fitted.

	• Staff to leave patients alone whilst going to the toilet as long as it is clinically safe to do so. • All patients to be given a call bell when they are left alone whilst toileting. • All patients to be offered to be taken to the toilet rather than using the commode / bedpan as long it is clinically safe to do so. • All staff to be reminded of and educated in the importance of giving patients a choice. • To ensure patients are offered the facility to clean their hands before and after going to the toilet. • To ensure all patients are appropriately referred to community continence services prior to discharge and information to be made available to these patients. • To ensure nursing staff record an accurate plan of care for bowel, bladder and continence that should be discussed with the patient and evaluated and updated as necessary. • To ensure all patients with a catheter to receive appropriate catheter care and for this to be documented regularly and clearly.
49. Saving Lives HII 1 Central Venous Catheter Care	• All Care Group Managers / Care Group Clinical Leads to support the Clinical teams, follow up on actions and monitor those areas with sub optimal performance. • Care Group Managers / Care Group Clinical Leads to ensure that all areas submit audits as per the Infection Prevention annual audit programme.
50. Saving Lives HII 2 Peripheral Intravenous Cannula Care	• All Care Group Managers / Care Group Clinical Leads to support the Clinical teams, follow up on actions and monitor those areas with sub optimal performance. • Care Group Managers / Care Group Clinical Leads to ensure that all areas submit audits as per the Infection Prevention annual audit programme.
51. Saving Lives HII 3 Renal Dialysis Catheter Car	• Divisions and Care Groups to review and discuss this report with areas taking action in order to address those areas with sub optimal performance.
52. Saving Lives HII 5 Ventilated Patients	• Produce action plan to address non compliance (Emergency Medicine Respiratory High Dependency Unit) and provide evidence of implementation • To re-audit within 1 month ensuring compliance addressed through action plan.
53. Saving Lives HII 6 Urinary Catheter Care	• 13 Areas that scored below 85% to produce an action plan to address non compliance and provide evidence of implementation • To refer to training areas that scored low on compliance with Non Touch technique. • To re-audit within 1 month ensuring compliance addressed through action plan.

54. Saving Lives HII 8 Cleaning and decontamination	• CICU and D8 to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance is addressed through action plan.
55. Multi Professional Hand Hygiene Audit – IN Patient Areas	• Divisions and Care Groups to review and discuss this report with clinical teams. • Areas to take action in order to address those areas with sub optimal performance. • A review by all Care Group Managers / Care Group Clinical Leads is required to ensure that all teams required to submit audits do so as per the infection prevention annual audit programme. • Areas showing compliance with hand hygiene are to ensure work is ongoing in order to sustain compliance. • Action plans and notification of re-audit submissions should be emailed to Infection Prevention Team.
56. Hand washing facilities	• Areas to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan.
57. Environmental audits kitchen	• CMH and Endoscopy to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan.
58. Environmental audits linen	• Audiology to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan
59. Isolation audit	• AMU and Paediatrics Medical Unit G2 to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan • Care Group Managers / Care Group Clinical Leads are required to support the Clinical teams, follow up on actions and monitor those areas with sub optimal performance. • A review by Care Group Managers / Care Group Clinical Leads is required to ensure that all medical teams are required to submit audits do so as per the infection prevention annual audit programme. • Areas showing compliance with hand hygiene are to ensure work is ongoing in order to sustain compliance
60. Standard Precautions audit	• C7 Haematology day unit, Pulmonary function and complete Fertility to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan
61. Auditing ward compliance with the UHS	• To feedback findings to Speech and Language Team.

Oropharyngeal Dysphagia policy on adult wards	• To circulate report to ward leads / matrons / divisional leads, etc, via email. • Areas to be encouraged to complete audit as it is difficult to feed back to specific wards due to small sample size. • Managers from areas of concern to be provided with verbal / written feedback. • Audit findings to be discussed at the Catering Operational meeting.

62. Use of Chaperones when examining or carrying out intimate cares on children or young people (aged 0-18yrs) in both inpatient and outpatient settings	• To review and update the Policy to ensure:
	  ◦ There is clarity of terms 'formal' and 'informal' chaperone.
	  ◦ What documentation is required to be completed and when.
	  ◦ How to report the inappropriate use of a chaperone.

63. To look at the effectiveness of the new portable CT scanner	• To encourage use of the portable CT scanner. • To increase the number of staff who can use the portable scanner.
64. An audit of record keeping of strong potassium products in both designated Critical and non critical care areas.	• To discuss whether CCU needs a potassium record book for their own area or is it acceptable that they can use CHDU book. • Cardiac pharmacy team to investigate and discuss with ward manager about keeping appropriate records up to date. • Critical care pharmacist to investigate and discuss with ward manager about keeping appropriate complete records of pre-filled syringes. • Critical care pharmacist to investigate and discuss with ward manager about keeping records up to date on pre-filled syringes and 20% injection. • To consider blue and pink side having a record book each. • Ward pharmacist to investigate and discuss with the ward manager about the missing Piam Brown record book. • Ward pharmacist to investigate and discuss with ward manager about the missing Gynae Theatre record book. • To raise awareness and re-education of the supply and administration requirements of strong potassium products to non-designated critical care areas. • To address the pharmacy involvement around supply and record keeping. • To re-iterate the requirements of the policy that need to be adhered to with regards to administration records.
65. Pharmacy compliance with UHS Controlled Drugs Policy	• To review Pharmacy CD policy. • To review frequency of RSH CD stock checks. • To develop a more efficient way of ordering stock CDs at RSH. • Need to improve specific processes within the dispensary before the next audit.

66. Wessex N.I.C.E (Neuro-intensive Care Emergencies) Course simulation-based training	• To run course over 2 afternoons per month, instead of 1 whole day.
67. Noise levels in Neuro-intensive Care	• Source new noise monitors and re-audit. • To discuss results with GICU staff. • To re-audit more widely during both day and night time.
68. Audit to evaluate current practice on Ritaximals infusion by ensuring pre treatment screening is completed before infusion.	• To improve Ig check by ensuring staff are aware of completing the check before rituximab is given, as below standard of 60%.

Appendices 6

Adjusted health gain

	Reporting Period

	Apr 2015 - Mar 2016 (Provisional, published Feb 17)		Apr 2014 - Mar 2015 (Final, published Aug 16)		Apr 2013 - Mar 2014 (Published Aug 15)		Apr 2012 - Mar 2013 (Published Aug 14)	
	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.
Hips	20.829	21.617	21.199	21.443	21.671	21.380	20.707	21.299
Knees	15.037	16.368	15.721	16.116	14.975	16.273	15.448	15.996

Participation rates

	Reporting Period							
	Apr 2015 - Mar 2016 (Provisional, published Feb 17)		Apr 2014 - Mar 2015 (Final, published Aug 16)		Apr 2013 - Mar 2014 (Published Aug 15)		Apr 2012 - Mar 2013 (Published Aug 14)	
	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.
Overall	89.5%	74.9%	86.4%	75.6%	82.4%	77.2%	70.1%	75.5%
Hips	86.7%	86.2%	74.1%	85.8%	68.4%	87.0%	55.6%	83.2%
Knees	103.9%	96.0%	105.9%*	95.0%	107.0%*	95.0%	104.0%*	90.4%

Appendices 7

Registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of health and adult social

care in England. It ensures that health and social care services provide people with safe, effective, compassionate, high quality care and encourages care services to improve.

Registration with the 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

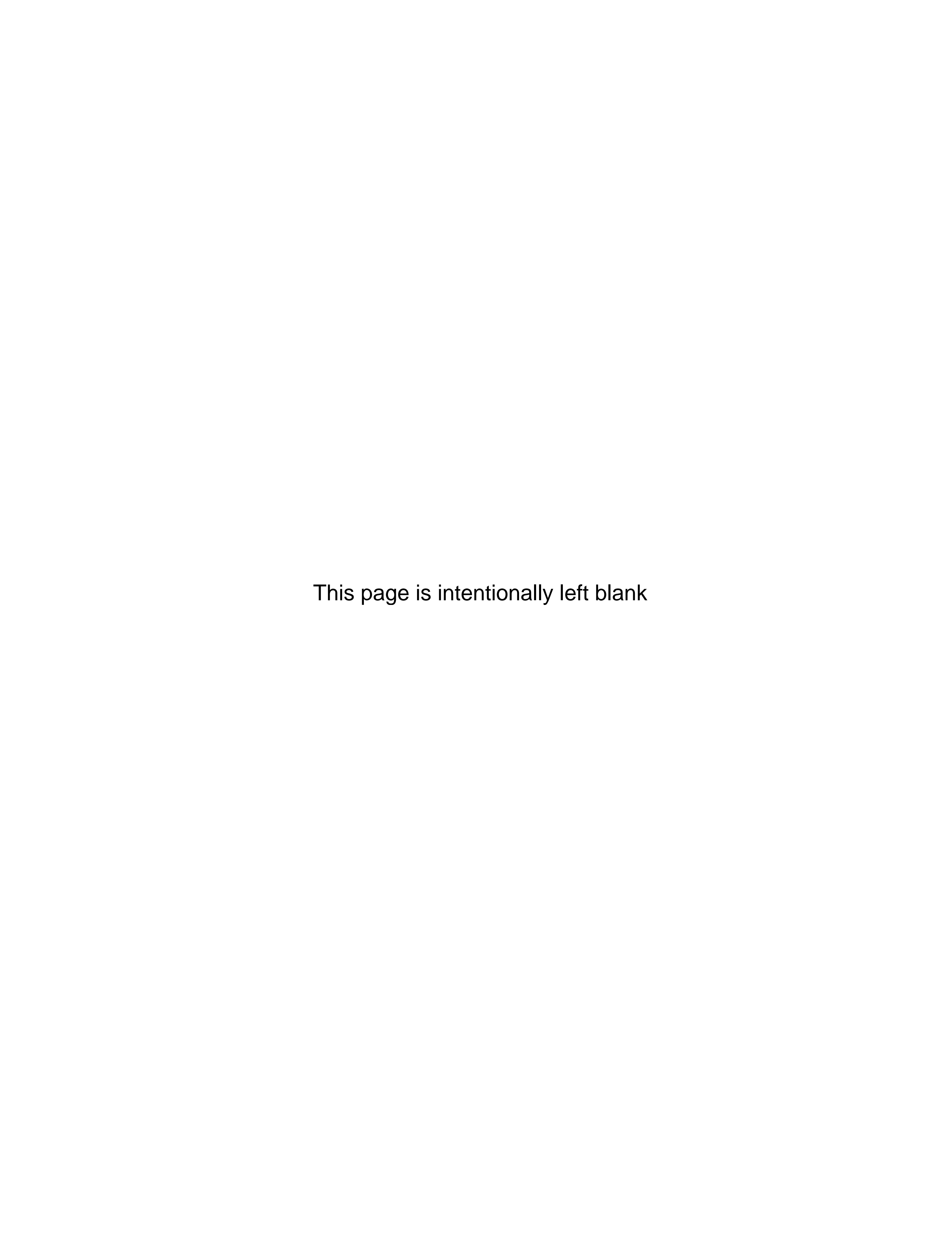
Regulated activity: Diagnostic and screening services
Provider conditions: This regulated activity may only be carried on at the following locations:
• Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
• Princess Anne Hospital, Coxford Road, Southampton, SO16 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 and the Care Quality Commission has not taken enforcement action against University Hospital Southampton NHS Foundation Trust during 2014-2017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Secondary Care Quality Account 2016-2017

Commitment to quality

Our locations

Community Diagnostics	
1	Community Diagnostics Head Office, Salford
2	East Lancashire Community DXA Service, Accrington
3	Blackburn with Darwen Community DXA Service, Darwen
4	East Lancashire Community DXA Service, Burnley
5	Calderdale DXA Service, Boothtown
6	Greater Manchester DXA Service, Rochdale
7	Greater Machester DXA Service, Ashton under Lyme
8	Norfolk Community DXA Service, Kings Lynn
9	Norfolk Community DXA Service, Docking
10	Norfolk Community DXA Service, Swaffham
11	North East Essex DXA Service, Colchester
12	Wirral Community DXA Service, Wallasey
13	Wirral Community DXA Service, Wirral
Clinical Assessment and Treatment Services	
14	Rochdale Opthalmology Service, Heywood
15	Rochdale Opthalmology Head Office, Rochdale
16	Rochdale Opthalmology Service, Rochdale

NHS Treatment Centres	
17	Barlborough NHS Treatment Centre, Barlborough
18	North East London NHS Treatment Centre, Ilford
19	Will Adams NHS Treatment Centre, Gillingham
20	Devizes NHS Treatment Centre, Devizes
21	Emersons Greem NHS Treatment Centre, Bristol
22	Shepton Mallet NHS Treatment Centre, Shepton Mallet
23	Southampton NHS Treatment Centre & MIIU, Southampton
24	Havant NHS Diagnostic Centre, Havant
25	St Mary's NHS Treatment Centre & MIIU, Portsmouth
26	Peninsula NHS Treatment Centre, Plymouth
Satellite Clinics	
28	Barlborough Satellite Clinc, Louth
29	Barlborough Satellite Clinc, Boston
30	Barlborough Satellite Clinc, Lincoln
31	Shepton Mallet Satellie Clinic, Frome
32	Shepton Mallet Satellie Clinic, South Petherton
Macular Services	
33	North West Macular Service, Preston
34	North West Macular Service, Preston
35	North West Macular Service, Chorley

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Foreword
by Jim Easton

We provide a uniquely diverse range of healthcare services for NHS patients, commissioned by, or working with, our NHS partners. Throughout our business, you will find colleagues who continuously demonstrate Care UK's values by delivering effective care that achieves the best possible outcome for each patient.

The Quality Account forms part of our annual report to the public about the quality of our services. It describes our key achievements during 2016/17 and our priorities for quality improvement during the forthcoming year. In developing our Quality Account we have identified and shared information across the organisation, with our patients, doctors, nurses, therapists and management.

Quality improvements have been underpinned by our clinical governance systems and processes, both of which are fundamental to the delivery of high quality care.

Looking to the future, I am confident that we have the necessary priorities, processes and plans in place to further improve our patients' care and hospital experience as we continue striving to deliver excellence.

We remain committed to improving quality across all of our services, and aim to be in the top 10% of all NHS providers for the key quality measures of the services we provide.

This Quality Account

This Quality Account sets out our performance on a range of key measures for our patients, the wider public, commissioners and partners.

It demonstrates what we have achieved in the past year, and plan to achieve in the coming year, within our Secondary Care Division, which currently provides NHS services across:

- Elective Surgery Independent Sector Treatment Centres
- Minor Injury Units/Walk-in Centres

In line with Department of Health guidance 2010-2011, this document focuses mainly upon the following areas:

- Independent Sector Treatment Centres (ISTCs)

Care UK operates:

- Nine Treatment Centres on behalf of the NHS
- Two minor injury units
- One Ophthalmology surgery unit

In the year April 2016 to March 2017 Care UK's Treatment Centres carried out:

- 56673 day case procedures
- 8201 inpatient procedures
- 189478 outpatient consultations, including telephone consultations

Achievements 2016-2017

Over the past year, our achievements have included the first CQC rating of outstanding within the Independent elective surgery sector at our Peninsula Treatment Centre in Plymouth, and in Rochdale Ophthalmology Centre.

In addition we are delighted to report that Shepton Mallet Treatment Centre has been awarded an overall outstanding rating in all domains.

Care UK have had no cases of MRSA bacteraemia or C.difficile in our elective surgery patients since 2011, no cases have been reported of E.coli bacteraemia nor MSSA bacteraemia since national surveillance for these infections began.

Priorities 2017-2018

Our priorities for the coming year are outlined within this Quality Account and once again reflect the five key lines of enquiry set by the Care Quality Commission:

- Safe
- Effective
- Caring
- Responsive
- Well-led

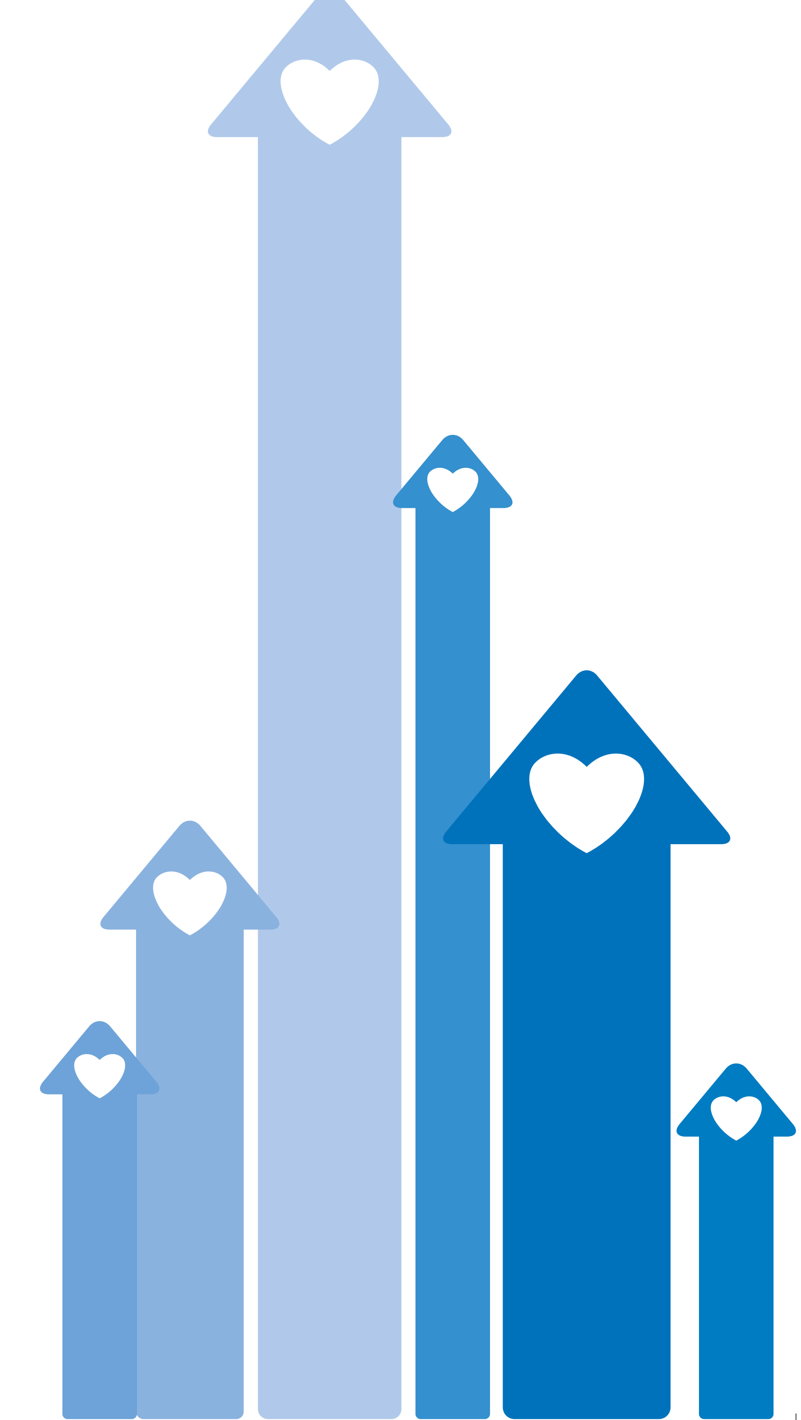
This provides a well-rounded view of the factors that influence quality, and I am confident that, as we continue to listen and respond to our patients and service users, invest in our employees and keep quality-focused in all that we do, we will provide a positive experience for those we are here to care for and help recover.

To the best of my knowledge, the information in this report is accurate.

Jim Easton
Managing Director, Health Care

Part One

Quality Priorities



What is a Quality Account?

Quality Accounts were introduced under the Health Act (2009) to strengthen healthcare providers' board-level accountability for quality, and place quality reporting on an equal footing with financial reporting.

Quality Accounts are both retrospective and forward-looking.

They look back on the previous year's information about service quality to explain where a provider is doing well and where improvement is needed.

Crucially, they also look forward, to explain what a provider has identified (through evidence and/or engagement) as the priorities for improvement over the coming year and how these priorities will be achieved and measured.

The legal duty to publish an annual Quality Account applies to all providers of NHS-funded healthcare services (whether they are NHS, independent or voluntary sector organisations). Only those providing primary care services or NHS continuing care are currently exempt under the regulations.

At Care UK we remain committed to transparency in all our reporting and follow the NHS guidance, as applicable, for our Quality Account.

This encompasses our adoption of the single common definition of quality that encompasses three equally important parts:

- Care that is clinically effective - not just in the eyes of clinicians but in the eyes of patients themselves;
- Care that is safe; and,
- Care that provides as positive an experience for patients as possible

Care UK vision and values

Our values are:

- our customers are at the heart of everything we do
- every one of us makes a difference
- together we make things better

Each of us is committed to the highest standards of quality and best practice, to meeting and exceeding our compliance to all standards across the healthcare sector.

Our vision is **'fulfilling lives'**, and each of us works to achieve this every day.

By supporting our teams to focus on three key aims we will fulfil our vision. These are to:

Focus on quality
We want to be renowned for providing high quality services. We must always seek to be the best provider of each of our services, meeting and, ideally, exceeding our service commitments. Constantly engaging with commissioners and patients to understand and meet their needs will help us to achieve this aim.

Lead change
The way healthcare is organised across the NHS is often inefficient for commissioners and frustrating for patients. As a major organisation delivering healthcare and social care, we have an unrivalled opportunity, even a responsibility, to work with commissioners to spearhead a more integrated approach.

Drive innovation
We have a key part to play in driving innovation, efficiency and effectiveness. We can do this by:

- Attracting, engaging, training and rewarding talented, compassionate and caring employees
- Investing in the development of new services aimed at providing the right care in the right place at the right time, integrated for convenience to patients
- Continuing to work closely with partners, suppliers and the many organisations and people we connect with to identify new ways of working.

Introduction

Care UK is an independent provider of healthcare services across England, on behalf of the NHS. Our NHS Treatment Centres provide inpatient, outpatient and day surgery for a range of planned surgery, endoscopy procedures, diagnostic tests and post-operative rehabilitation. Our Treatment Centre facilities are modern and purpose-built and are situated close to public transport links or in redesigned buildings close to, or within, NHS hospitals

Care UK is committed to improving the quality of our services we provide to our patients, their families and carers.

Our 2016/17 quality account is an annual report of:

- How we have performed over the last year against the priorities which we set out in last years' quality account
- Statements about quality of the NHS services provided
- Feedback of the quality account provided by our commissioners, Healthwatch and patient groups
- Our priorities setting out clearly how we are going to improve in the coming year.

As you read this report we hope that it will explain what we believe that great care looks like and what you can expect if you need use our services.

Quality priorities 2017-2018

Healthcare quality priorities.

Care UK's Secondary Care Health Care Division has identified five new quality improvement priorities for 2017-2018.

These will be monitored through our internal reporting programme, shared with commissioners as part of our joint quality reviews and achievements monitored through our internal governance structures at a local and national level.

Achievements and outcomes will be reported in next year's Quality Account.

The identification and development of our new quality priorities involved numerous stakeholders, and took into account patient feedback, complaints, incidents that occurred throughout the past year, as well as new national guidance.

In addition to focusing on the identified national quality priorities, local services will work with commissioners and patient groups to identify pertinent priorities linked to the local healthcare landscape.

Our overall aim is always to provide the best possible experience for those choosing to use Care UK's services.

Quality priority domain	Priority detail	Measure
Safe	The implementation of an electronic audit tool to measure cleaning standards and control within treatment centres.	An electronic audit tool will be developed and implemented enabling audit outcomes of cleaning standards and control to be recorded and evaluated electronically and key points of shared learning disseminated more efficiently.
Caring	Dignity champions will be implemented in each service.	All services have a dedicated dignity champion in role.
Responsive	The implementation of the National eDischarge template and population relevant fields.	All sites with edischarge template in place and relevant fields able to be populated electronically.
Effective	Improvements in the identification and dissemination of shared learning from serious incidents ensuring all valuable, safety-critical learning opportunities have been achieved across all services.	• Local action plans are developed following investigation. The action plans are implemented within defined timeframes locally and monitored accordingly • Serious Incident investigation outcomes will be disseminated broadly across all services, helping to improve shared learning and understanding of how incidents occur and importantly to reduce incidences of any future SI's from occurring.
Well-led	To improve the uptake of the winter flu vaccination and immunisation of all clinical staff across treatment centres.	Priority target - An increase of 5% of staff who are vaccinated against flu.

Safe

Priority - The implementation of an electronic audit tool to measure cleaning standards and control within treatment centres.

What are we trying to improve?

To demonstrate clean and safe services are in place with evidence of maintenance of standards across services

What will success look like?

An electronic audit tool will be developed and implemented enabling audit outcomes of cleaning standards and control to be recorded and evaluated electronically with key points of shared learning disseminated more efficiently. This will allow effective benchmarking across treatment centres via monthly monitoring and dashboards.

How will we monitor progress?

The audit scores and associated action plans will be reviewed as part of the monthly performance reviews with exceptions in services identified and monitored by the Secondary Care Quality and Governance Assurance Committee.

Caring

Priority - Identification of Dignity champions in each service.

What are we trying to improve?

To promote dignity and respect for all patients. This priority links with the dementia strategy to ensure that individual patient and carer needs are identified and managed appropriately.

What will success look like?

An annual dignity audit will be developed and completed by services which will enable the Treatment Centres to create a local action plan to address relevant areas. Each service will identify a dignity champion who will provide support to the local teams whilst linking with Dignity Champions across the organization to ensure best practice is shared.

How will we monitor progress?

The identified action plan will be monitored and managed within the monthly local quality assurance meetings. Any identified needs within services will be discussed at the quarterly Professional Leads meetings

Responsive

Priority - The implementation of the National edischarge template and population relevant fields.

What are we trying to improve?

To ensure the safe onward care of patients within healthcare services. To promote clearer communication routes with other providers to provide seamless care and support improved communication, clinical workflow and more effective transfers of care for our patients

What will success look like?

That all services will have electronic discharge summaries in place with relevant fields populated to share with healthcare agencies in line with National requirements.

How will we monitor progress?

Effective implementation of e discharge templates will be monitored via the monthly performance meetings with exceptions reported via the Quarterly Secondary Care Quality and Governance Assurance Committee meetings.

Effective

Priority - The improvement in the identification and dissemination of shared learning from serious incidents across services.

What are we trying to improve?
To provide robust evidence of the dissemination and implementation of learning across services. This will be in addition to the identification of embedded learning within operational and clinical practice.

What will success look like?
That local action plans are developed following an investigation and these action plans are implemented within defined timeframes locally and monitored accordingly. Serious Incident investigation outcomes are disseminated broadly across all services, helping to improve shared learning and understanding of how incidents occur and importantly to reduce incidences of any future serious incidents from occurring.

How will we monitor progress?
Reduction of repeated serious incidents across services.

Well-led

Priority - To improve the uptake of the winter flu vaccination and immunisation of all clinical employees across treatment centres.

What are we trying to improve?
Through increased vaccination of our frontline employees we hope to minimise the risk of vulnerable patients contracting the virus whilst in our facilities. We also hope to see a decrease in employee absence due to the influenza virus; this will in turn help improve continuity of care.

What will success look like?
Priority target - An increase of 5% of employees who are vaccinated against flu.

How will we monitor progress?
Flu champions in each service will monitor influenza immunization of employees locally. These figures will be reported monthly via monthly performance meetings.

68
120
70
105
ComfortCuff
NHS
care
Annabelle Rath

Part Two

Review of priorities for improvement 2016-2017

Page 115

Reporting back on 2016-2017 quality priorities

In our 2016-2017 Quality Account we set out our priorities for improving the quality of our services during 2016-2017, and, have provided updates and a review of our progress for each priority below.

Quality priority domain	Priority detail	Measure
Safe	1. Establish a frailty scoring system and associated outcomes framework for patients aged over 75 years undergoing planned inpatient surgery 2. Implement the National Safety Standards for Invasive Procedures (NATSSIPs) programme 3. Improve our reporting mechanisms for medication interventions and subsequent action planning	1. All sites to complete a frailty score for patients over 75 who are undergoing elective inpatient procedures. 100% of patients with scores over 7 will have care plans in place 2. Local services to have LOCSSIPs in place in line with NATSSIPs requirements identified centrally 3. All medication interventions to be recorded at all sites and action plans discussed at Quality Governance meetings
Caring	1. To continue to improve Friends and Family Test response rates from outpatients 2. Maintain a supportive environment for those living with dementia by implementing a dementia strategy and introducing dementia champions for all services	1. To achieve a 60% response rate for 1st outpatient attendances 2. Dementia champions identified within all services to support the roll out of key priorities within the dementia strategy
Responsive	1. Continue to respond consistently to patients’ complaints and feedback 2. To deliver services free from discrimination and meet the needs of the Equality Act (2010)	1. The introduction of ‘You said, we did’ feedback mechanisms within all services so that is visible to patients in key patient areas 2. Continuation of our staff survey to identify areas for improvement. Implement the Workforce Race Equality Standard (WRES) and EDS2
Effective	1. The implementation of electronic discharge (EDS) via our patient administration system (PAS) for improved continuity of care and to reduce unplanned follow up in primary care 2. To implement an antibiotic stewardship programme and strategy across secondary care	1. All Treatment Centres to have electronic discharge capabilities within their services 2. All services to have an antibiotic stewardship lead to support the delivery of key priorities within the strategy
Well-led	1. Prepare secondary care diagnostic imaging services for Imaging Services Accreditation Scheme (ISAS) accreditation 2. To develop and implement a training programme for clinical staff in middle management roles	1. Develop a framework to support the ISAS application (through gathering supportive evidence, process review etc.) 2. Identification and enrolment of key managers to undertake a bespoke 12 month training programme

Safe - Priority one:

Establish a frailty scoring system and associated outcomes framework for patients aged over 75 years undergoing planned inpatient surgery.

- All sites complete a frailty score for patients over 75 who are undergoing elective inpatient procedures.
- 100% of identified patients with scores over 7 have care plans in place, with all inpatient services having implemented the Edmonton frailty assessment. Shepton Mallet Treatment Centre complete an alternative assessment tool in line with local Health Care services.
- At the pre-assessment stage of the patient pathway, guidance notes have been prepared and circulated to staff to support their learning of how to use the Frailty Scoring System (FSS) for patients over 75.
- Resources for patients and staff have been developed to explain the rationale for the assessment scoring and expectations for patients.

Safe - Priority two:

Implement the National Safety Standards for Invasive Procedures (NATSSIPs) programme.

All Treatment Centres have completed a review of patient pathways developing and implementing local safety standards for invasive procedures (LocSSIPs) based on the national guidelines. These standards have been reviewed and ratified by the senior management team locally.

4 national LocSSIPs have been identified to be implemented at the relevant Treatment Centres delivering care.

- The use of YAG laser in Ophthalmology
- Dental - to include marking of teeth for removal on the sterile field. This follows shared learning identified as part of a Never Event investigation
- Prosthesis checking to ensure the correct sized prosthesis inserted This follows shared learning identified as part of a Never Event investigation
- Tourniquet removal process as identified as part of a Never Event investigation.

Local SSIPs have been written and are supported by local Standard Operating Procedures to cover all recommendations held within national document.

Audits of implementation of Local SSIPs have been completed resulting in an action plan and gap analysis with recorded actions.

Safe - Priority three:

Improve our reporting mechanisms for medication interventions and subsequent action planning.

Using Datix, we have manufactured a central platform for recording all medicine (pharmacy) related interventions.

The communication and implementation programme has aligned the action planning from these interventions to the local Clinical Governance forums.

Centrally, these interventions have been collated across Secondary Care, to allow benchmarking and limit setting for local sites against this national data.

Caring - Priority one:

To continue to improve Friends and Family Test response rates from outpatients.

We highlighted that we would strive for a response rate of 60% or higher amongst those attending booked first outpatients appointments.

The table below demonstrates the achievement across services.

There has been some improvement in certain areas although not in a consistent manner.

Changes with standard operation procedures have been incorporated with clear lines of responsibility for the distribution of questionnaires to patients and the subsequent electronic download of data.

All services have developed action plans to address the trends identified from patient experience feedback.

Outpatient	Devizes	St Mary's	Will Adams	Barlborough	Emersons	NEL	Peninsula	Shepton	Southampton	Average
April 2016	70%	61%	55%	80%	33%	52%	53%	73%	88%	62.78%
May 2016	78%	61%	55%	78%	38%	85%	44%	73%	75%	65.22%
June 2016	59%	54%	45%	34%	41%	59%	64%	43%	83%	53.56%
July 2016	51%	54%	28%	76%	31%	42%	27%	50%	75%	48.22%
August 2016	67%	55%	35%	82%	33%	40%	31%	46%	80%	52.11%
Sept 2016	72%	100%	48%	68%	27%	17%	46%	44%	31%	50.33%
October 2016	82%	36%	51%	69%	23%	34%	63%	36%	51%	49.44%
November	86%	48%	54%	74%	40%	44%	30%	49%	61%	54.00%
Dec 2016	86%	33%	55%	59%	40%	43%	19%	12%	49%	44.00%
January 2017	100%	59%	84%	82%	62%	44%	55%	17%	74%	64.11%
Average	75.10%	56.10%	51.00%	70.20%	36.80%	46.00%	43.20%	44.30%	66.70%	**54.38%**

Caring - Priority two:

Maintain a supportive environment for those living with dementia by implementing a dementia strategy and introducing dementia link nurses for all services.

Services have identified dementia champions and ensure that any patients with a diagnosis of dementia have a multi-disciplinary meeting to determine individual patient needs. An individualized care plan is prepared to ensure all aspects of care are identified.

St Mary's NHS Treatment Centre has enrolled a number of Dementia Friends, who have attended local training conducted by the Alzheimer's Society and they work in the clinical and support areas.

The clinical teams are committed and trained to identify and support the individual needs of each patient and will provide extra 1:1 support within a dementia friendly setting in the ward.

The PLACE Audit supports the environment regarding Dementia care achieving a site score of 89.09% compared to the national average of 75.28%.

A quality priority for the coming year relates to ensuring dignity champions are in place in all services, this compliments the dementia champion role to ensure that care is delivered, considering the dignity and individual needs at all times.

Responsive - Priority one:

Continue to respond consistently to patients' complaints and feedback.

'You said, we did' methodology has been in place throughout all services over the last year. The 'You Said, We Did' template is a laminated document which is completed in handwriting.

Departmental feedback is displayed within patient areas with staff developing associated action plans for services. These are monitored at a local level within the quality governance meetings and via performance meetings corporately.

Responsive - Priority two:

To deliver services free from discrimination and meet the needs of the Equality Act (2010).

We have made significant progress regarding Equality and Diversity and the implementation of the WRES over the course of the last 12 months.

Overseen by our Equality and Diversity Steering Group, chaired by a member of the Health Care Executive Team, we have initiated a divisional wide on-going educative programme to promote best practice in both employment and service provision as it relates to equality and diversity, predominantly in response to outcomes from the 2016 Care UK annual staff survey.

In addition, in accordance with EDS2, each unit within Secondary Care has a localised action plan in place which addresses specific local issues both in terms of the delivery of clinical services together with target setting relating to the WRES.

Quarterly reports on progress are provided by the Equality and Diversity Steering Group to the Health Care Governance Risk and Compliance Committee chaired by the Health Care Managing Director as well as to the Care UK Executive Board chaired by the Care UK Chief Executive.

Training compliance to date is noted below, which equates to an overal compliance of 93.6% for the year across secondary care.

Site Name	Course ID	Total Allocated	Total Completed	Part Completed	Not Yet Started	Percentage Compliance
Care UK Health - Barlborough Treatment Centre	Equality & Diversity eLearning	294	232	53	9	91.00%
Care UK Health - Devizes NHS Treatment Centre	Equality & Diversity eLearning	51	46	0	5	100.00%
Care UK Health - North East London NHS Treatment Centre	Equality & Diversity eLearning	239	213	23	3	94.56%
Care UK Health - Peninsula NHS Treatment Centre	Equality & Diversity eLearning	225	213	0	12	98.63%
Care UK Health - Shepton Mallet NHS Treatment Centre	Equality & Diversity eLearning	271	191	9	71	73.80%
Care UK Health - Southampton MIU	Equality & Diversity eLearning	33	30	0	3	100.00%
Care UK Heath - Emersons Green Treatment Centre	Equality & Diversity eLearning	402	325	6	71	85.37%
Care UK Health - Southampton NHS Treatment Centre	Equality & Diversity eLearning	289	254	7	28	95.02%
Care UK Health - St Marys NHS Treatment Centre	Equality & Diversity eLearning	183	155	0	28	98.31%
Care UK Health - Will Adams NHS Treatment Centre	Equality & Diversity eLearning	91	79	1	11	100.00%

Effective - Priority one:

The implementation of electronic discharge (EDS) via our patient administration system (PAS) for improved continuity of care and to reduce unplanned follow up in primary care.

All services have the capacity to produce an electronic discharge report although not in a standardized format currently.

In line with the National programme linked with software suppliers there is a move to standardize the templates provided within patient administration systems.

Phase 1 of the National Programme requires that headers are in place within the discharge report to a designated format.

This has been largely configured and completed in the test environment and a member of the internal applications team will be arranging to illustrate this to each site and obtain sign off before putting it into the live environment.

A quality priority for the coming year is the introduction of the standardised template with relevant fields populated electronically which builds on this priority and is line with National requirements.

Effective - Priority two:

To implement an antibiotic stewardship programme and strategy across secondary care.

Agreement has been sought to create a national statement of strategy across care UK Primary Care, Secondary Care and Health in Justice services.

This will allow clear roles, responsibilities and delivery priorities to be designed at a local level. An assurance framework with reporting capabilities is to be developed into the strategy to allow appropriate governance and assurance to be monitored centrally.

Treatment Centres have implemented local antibiotic stewardship multidisciplinary team meetings to support robust process within services.

This allows for a localized plan to be developed and implemented in line with other local Health Care agencies to provide a cohesive approach to antibiotic prescribing.

Well-led - Priority one:

Prepare secondary care diagnostic imaging services for Imaging Services Accreditation Scheme (ISAS) accreditation.

Secondary Care diagnostic imaging services have now completed a robust review of the entire scope of ISAS accreditation including a full review of the updated ISAS standard published in January 2017.

The services have engaged with the ISAS officer, met with organisations that have achieved ISAS accreditation and understand what is required to successfully attain ISAS accreditation.

Having robustly assessed these requirements, we have concluded that our organisational framework is sufficiently established to support a formal ISAS application.

Well-led - Priority two:

To develop and implement a training programme for clinical staff in middle management roles.

The Director of Nursing and Quality spearheaded the need for a leadership development programme for clinical nurses and allied healthcare professionals (AHPs) to equip them with the skills to manage effectively.

The Head of Education and Training established the Chrysalis Programme, which is run over 12-months. Its objective is to nurture both existing and future nurse and AHP leaders - providing structure to their development and focusing on safe and effective clinical practice for themselves, their team and the services they work and manage in.

The programme is a hybrid of eLearning, masterclass face to face sessions and practical workplace practice.

Chrysalis is innovative and bespoke, utilising the Care UK Management Essentials programme as its bedrock. Equipping its participants with a managerial and leadership skill set bespoke to the challenging needs of a healthcare setting.

The programme consists of three key themes:

1. Managing Myself
2. Managing My Team
3. Managing My Service

Each of these elements is focused on during a 12-month period including the following:

- 360 Insights evaluation and feedback
- eLearning modules from the Edward Jenner NHS Management and Leadership programme
- In-Practice and Reflective sessions
- Face to Face Masterclasses from the Care UK Management Essential Programme

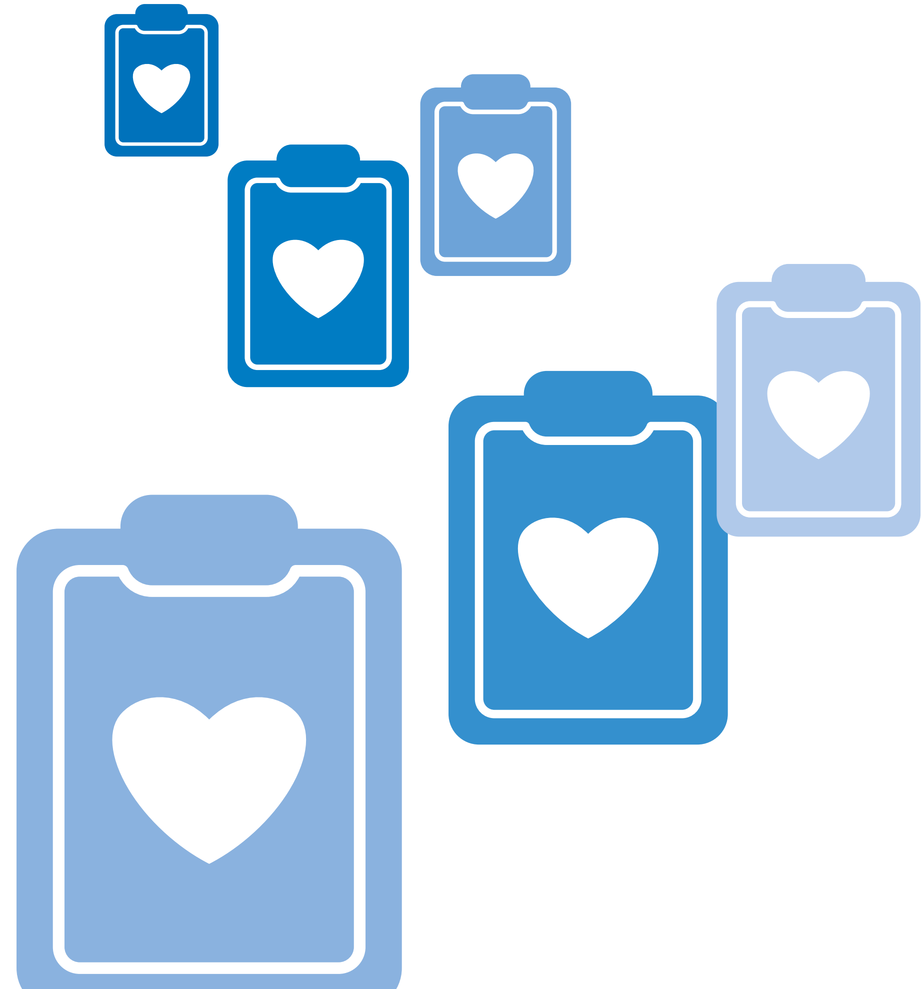
To date we have 45 employees enrolled on the programme. There are 4 active cohorts ranging from 10 - 13 participants. There is a fifth cohort panned for to run in July 2017.

The first three cohorts have all completed their 360 reviews, the insights programme and have completed the first two masterclasses. They are working through the eLearning modules with the first cohort due to complete the entire programme by the end of October 2017.

It has been agreed to review the programme after October 2017 so that it can be expanded for future cohorts to run through 2018 and onwards.

Part Three

Regulatory Statements for our services 2016-2017



Regulatory Statements for our services 2016-2017

In line with the National Health Service (Quality Account) Regulations 2011, Care UK is required to provide information on a range of quality activities.

From April 2016 - March 2017, Care UK provided or sub-contracted all of the services listed on Page two, at the locations specified.

Duty of Candour

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

Care UK have robust appropriate processes for communicating with a patient and/or family/carer following a reportable patient safety incident and these are followed in conjunction with Care UK Incident Reporting Policy and Procedure.

There is clear guidance for staff which outlines Care UK's policy on its duty of candour and the processes by which openness will be supported.

This support allows Care UK to meet its obligations to patients, relatives and the public by being open and honest about any mistakes that are made whilst Care UK employees care for and treat patients.

Safeguarding

The Department of Health requires all healthcare providers to safeguard all those using their services from abuse.

The Care Quality Commission (CQC) outcome statement similarly states that: *'People who use services should be protected from abuse, or the risk of abuse, and their human rights respected and upheld'*.

To ensure that we fulfil this guidance, all employees working in our NHS Treatment Centres complete annual mandatory Level 1 safeguarding training via online courses (eLearning).

All patient- facing staff also complete Level 2 safeguarding training designed to protect children and adults.

We have undertaken an annual review of Safeguarding within Secondary Care services. This will be shared with Commissioners, patient groups and local safeguarding boards.

In line with the Department of Health's guidance on Quality Accounts, the statement below summarises our approach to safeguarding within our Treatment Centres:

- Care UK meets the statutory requirement to conduct Disclosure and Barring Service (DBS) checks on all staff
- Safeguarding policies for children, vulnerable adults and allegations against staff are robust, up-to-date, and have been reviewed within the last year
- Safeguarding training, which encompasses the Mental Capacity Act, forms part of every staff member's induction and mandatory training schedule
- Named professionals are clear about their roles with regard to safeguarding and have sufficient time and support to fulfil them
- There is a named Safeguarding Lead for vulnerable people, including children, who has direct access to the Board, if required

Participation in clinical research

Care UK will support the National Institute for Health Research's (NIHR) multi-centre observational research study in 2017 on the 'return to work of patients following carpal tunnel release surgery'. Two hand surgeons from our Southampton NHS Treatment Centre will participate in the study. The research protocol and all study documents have been approved by the national NHS Research Ethics Committee. No other patients receiving NHS services provided or subcontracted by Care UK at any of our Treatment Centres from April 2016 to March 2017, were recruited to participate in research approved by a research ethics committee.

Our Treatment Centres participated in national audits and confidential enquiries appropriate to the services we deliver (see section to follow).

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Care Quality Commission (CQC) registration

Care UK is required to register with the CQC and must comply with the Health and Social Care Act 2008 (regulated activities) Regulations (2010) and the CQC (Registration) Regulations 2009 (Essential standards of quality and safety 2010).

All of our services are registered with the CQC and work to ensure they remain compliant with the essential standards of quality and safety.

The CQC inspected ten of our service locations between 16th March 2015 and 16th November 2016.

Four were found to be fully compliant with standards, whilst two services (Barlborough NHS Treatment Centre and Southampton NHS Treatment Centre) were judged 'outstanding' within the caring domain.

Peninsula NHS Treatment Centre was judged 'outstanding' overall. Three reports are still awaited from CQC.

Participation in Commissioning for Quality and Innovation (CQUIN)

In April 2009, the Department of Health launched the CQUIN framework to encourage healthcare providers to continuously demonstrate improvements and innovation in the quality of the care they provide. The framework supports the vision set out in 'High Quality Care for All' (Darzi, 2008) where quality is viewed an organisational principle.

CQUIN rewards excellence by linking a proportion of the provider's income to the achievement of local quality improvement goals. A proportion of our income in 2016/17 was conditional upon us achieving pre-agreed quality improvement and innovation goals as set out in the CQUIN payment framework. We are pleased to report that we have consistently achieved these goals, demonstrating our active engagement in quality improvement with our commissioners.

Details of the agreed CQUIN goals for each of our services for both 2016/7 and the coming year can be requested from the Hospital Directors at each Treatment Centre.

(NB: as CQUIN targets are locally agreed they may vary between Treatment Centres).

Participation in clinical audits and national confidential enquiries

The reports of the two national clinical audits (National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMS) were reviewed for April 2015 – March 2016 (see table below).

Patients' participation in national PROMS was lower than we would like, and Care UK will seek to improve participation rates by sharing and implementing processes that have been shown to produce a high response rate in comparable services.

Details of the national clinical audits and national confidential enquiries that Care UK participated in during April 2015 to March 2016 can be found in Appendix 2 . This also lists those we did not participate in, with a rationale i.e. we are not commissioned to provide the service being audited.

Category	Name of National Clinical Audit	% of cases submitted
Acute	National Joint Registry (NJR - 2016)	99%
Other	Elective surgery (National PROMs Programme - 2015/16)	74% - Varicose Veins 68% - Groin Hernia

Reporting against core indicators

The Department of Health requires independent healthcare providers such as Care UK to report against a core set of quality indicators, using information that is provided by the Health and Social Care Information Centre (HSCIC) to compare our results to others.

Patient Reported Outcome Measures (PROMs)

The NHS requires providers to ask patients having one of four specific procedures to complete questionnaires before and after their operation, to find out how much difference the operation has made to them. The four procedures are hip replacement, knee replacement, groin hernia surgery and varicose vein surgery.

The tables opposite show how well we have done by comparing our achievements to the national average and to the best and worst performers.

Indicator	Care UK Overall data		Health and Social Care Information Centre (HSCIC) data - April 2016- June 2016		
Patient reported Outcome measures (PROMS) participation rates	April 2015 - March 2016	April 2016 - June 2016	Highest Reported nationally (best performing)	Lowest Reported nationally (worst performing)	National Average
Hip replacement surgery	100.0%	92.44%	100%	0%	86%
Knee replacement surgery	100.0%	100.00%	100%	0%	94%
Groin hernia surgery	76.7%	68.00%	100%	0%	56%
Varicose vein surgery	82.2%	73.75%	1000%	0%	32%
HSCIC Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England – April 2015 to March 2016 (published Nov 2016) / HSCIC Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England – April 2016 to June 2016 (published Nov 2016)					

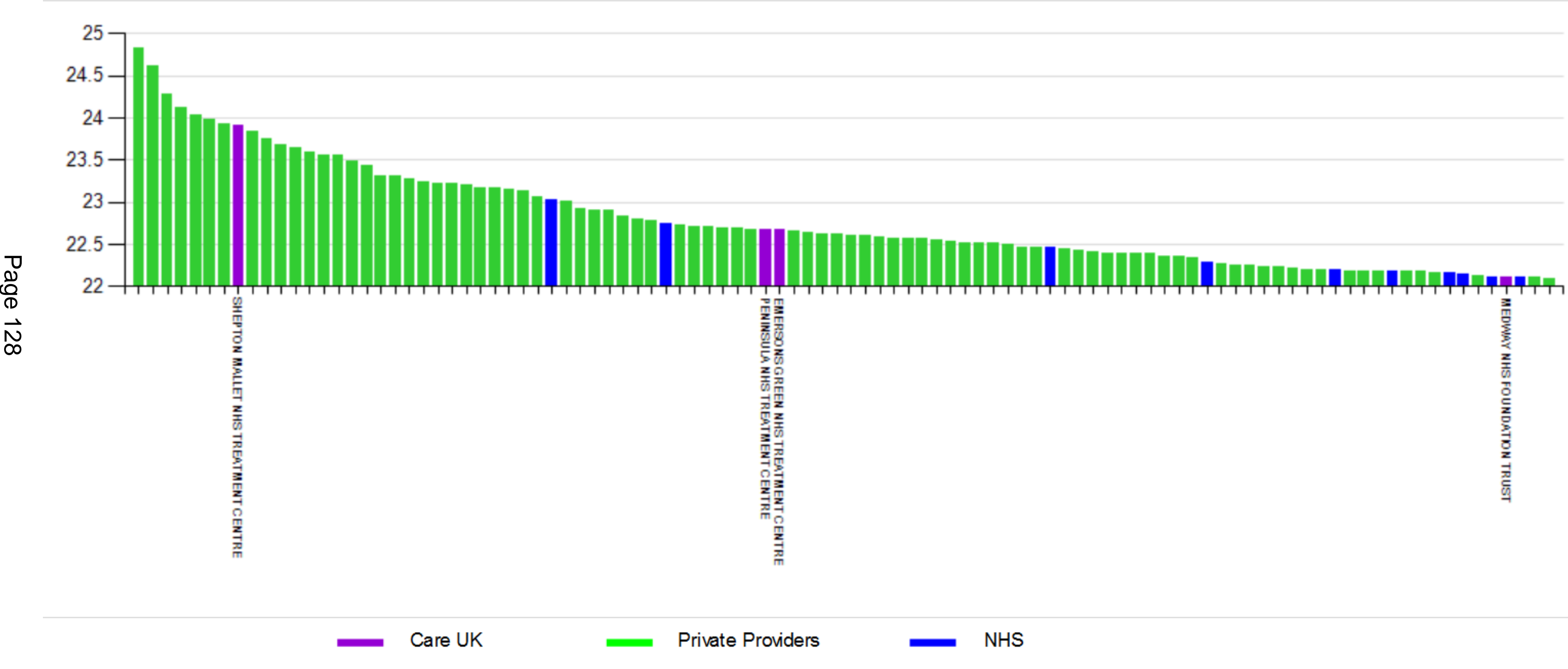
100% = rate adjusted down to 100% as volume of Q1s received exceeded number of episodes submitted to SUS

Indicator	Care UK Overall data		Health and Social Care Information Centre (HSCIC) data - April 2016- June 2016		
Patient reported Outcome measures (PROMS) adjusted health gain	April 2015 - March 2016	April 2016 - June 2016	Highest Reported nationally (best performing)	Lowest Reported nationally (worst performing)	National Average
Hip replacement surgery	22.22	Not available	31.00	14.00	21.00
Knee replacement surgery	16.45	Not available	42.00	1.00	17.89
Groin hernia surgery	0.78	0.21	0.66	-0.27	0.09
Varicose vein surgery	-6.89	-6.43	23.06	-62.26	-8.05
HSCIC Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England – April 2015 to March 2016 (published Nov 2016) / HSCIC Provisional Quarterly Patient Reported Outcome Measures (PROMs) in England – April 2016 to June 2016 (published Nov 2016)					

Care UK considers that these data are as described for the following reasons:

- It is taken from a national information provider.
- PROMS are an important quality indicator as they assess care quality from the patient's perspective. For this reason, Care UK is already taking the following action to improve our PROMs scores:
    - PROMs information is regularly reported to the Senior Leadership Team in a similar format to the table shown, so that areas for improvement can be swiftly identified
- Treatment Centres with PROMs scores that require improvement analyse their data with the assistance of Quality Health Ltd, who provide specialist knowledge of PROMs information. This analysis forms the basis for improvement action planning
    - The success of each improvement action plan is tracked by the Senior Leadership Team

Patient reported outcome measures (PROMS)



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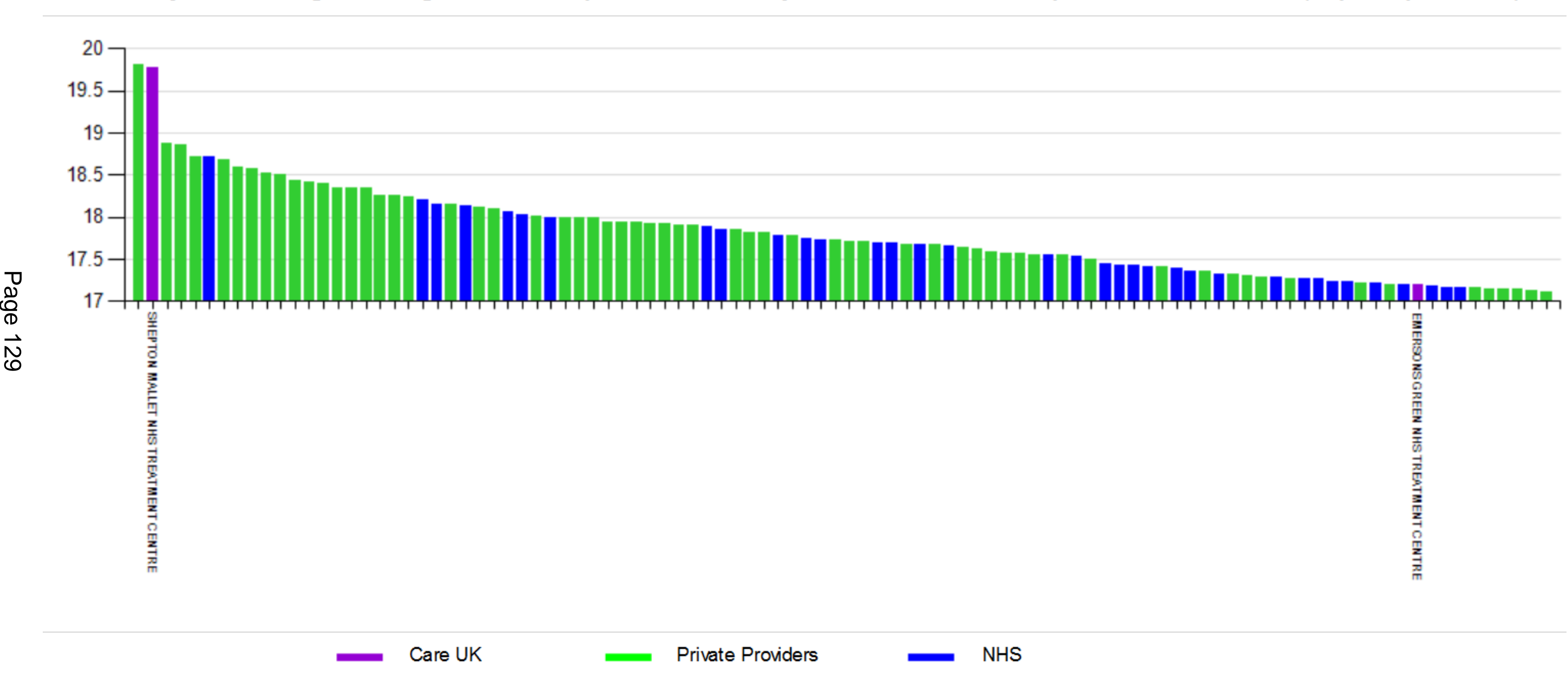
PROMS Adjusted average health gain - Knee Replacement Primary - Oxford Knee Score April 2015 - March 2016 (Top 100 providers)
20
19.5
19
18.5
18
17.5
17
SHEPTON MALLET NHS TREATMENT CENTRE
EMERSONS GREEN NHS TREATMENT CENTRE
Care UK
Private Providers
NHS

Emergency re-admission rate for patients aged 16 or over

This indicator looks at the number of patients who have been readmitted to our Treatment Centres within 30 days of surgery. Reasons for readmission can include infection, pain or other complications arising from their surgery.

Indicator	Care UK Overall data		Health and Social Care Information Centre (HSCIC) Data Independent Sector 2011-12	
Emergency readmission to hospital within 28 days of discharge - %patients aged 16 or over readmitted within	2016	Highest Reported nationally (best performing)	Lowest Reported nationally (worst performing)	National Average
All Treatment Centres	0.24%	14.53%	7.91%	11.78%
Data Source:	Local data	HSCIC/Indicator portal data set: '3b Emergency readmissions within 30 days of discharge from hospital'	42.00	1.00

Care UK considers that these data are as described for the following reasons:

- It is taken from local data that is submitted to the department of health.
- Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:
- Emergency readmission rates are tracked monthly for each Treatment Centre and reported to the Senior Leadership Team and Board
- Each month the Senior Leadership Team examines every instance of emergency readmission that occurred and discusses the causes and what can be done to avoid similar readmissions in the future.

Risk assessment of venous thromboembolism (VTE) for people admitted to hospital

People who undergo operations may have a risk of developing a potentially harmful blood clot or venous thromboembolism (VTE).

This indicator looks at how efficiently Care UK assesses their risk of developing a VTE.

Indicator	Care UK Overall data		Health and Social Care Information Centre (HSCIC) Data April-June 2016	
%admitted who were risk assesses for venous thromboembolism	April-June 2016	Highest Reported nationally (best performing)	Lowest Reported nationally (worst performing)	National Average
All Treatment Centres	99.55%	100.00%	64.96%	95.73%
Data Source:	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment - 201617/ NHS England website			

Care UK considers that these data are as described for the following reasons:

- It is taken from a national information provider.
- Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:-
- VTE risk assessment rates are tracked monthly for each Treatment Centre and reported to the Senior Leadership Team and Board.
- We set ourselves a target of 100% for this indicator and compare ourselves in this area against the independent sector (average 99.0%) and the NHS every three months.
- Reasons for not achieving 100% are examined each month by the Senior Leadership Team and explained to the Board with actions to remedy.

Infection with Clostridium difficile

Indicator	Care UK Overall data				Health and Social Care Information Centre Data
Rate of Clostridium difficile (number of infections/100,000 bed days)	Apr-Mar 2015-16	Aggregate 2008-16	Apr-Mar 2014-15	Apr-Mar 2014-16	
All Treatment Centres	0	0	15.1	14.9	
Data Source:	Local data	PHE Annual epidemiological comment, 2016. Ref: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535635/AEC_final.pdf			

Care UK considers that these data iare as described for the following reasons:

- It is extracted from published verified local data that is submitted to Public Health England.
- Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:
- Care UK has a Director of Infection Prevention and Control (DIPC) who provides Board oversight and leadership on all infection prevention and control issues
- This is further strengthened with a Deputy Director of Infection Prevention and Control who provides detailed guidance to our Treatment Centres, each of which have a trained local Infection Prevention and Control lead with identified time and resource to carry out their role
- Care UK policies are implemented to: ensure effective antibiotic stewardship; facilitate the adoption of local prescribing formularies; and monitor antibiotic usage and patient outcomes.

Patient safety incidents

Patient safety incidents	2015-2016 April 2015-March 2016	2016-2017 to date April 2016-January 2017
Rate of patient safety incidents that occurred across the trust (per 100 admissions)	2016-2017 to date	4.045
Number of such patient safety incidents reported that resulted in severe harm or death	2	4
Rate of patient safety incidents resulting in severe harm or death (per 100 admissions)	0.0036	0.0084

Care UK considers that these data are as described for the following reasons:

- It is extracted from published verified local data that is taken to a national body.
- Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:
  - Each Treatment Centre has a dedicated Health and Safety lead who has appropriate Health and Safety training and protected time to carry out their role
- An incident reporting system, DATIX, is used to report all incidents
- All incidents that are reported must be examined, and the initial lessons learned must be noted, within 3 days of the incident taking place. Compliance against this target is examined by the Senior Leadership Team and reported monthly to the Board
- Serious incidents are subject to root cause analysis, with results reported to the Board. Lessons learned are shared with all other relevant sites using a shared learning tool, which in 2016 was automated within Datix. The Head of Governance and Quality ensures that the lessons learned have been embedded in practice through compliance checks at a later date.
- Care UK also checks and compares its Accident Frequency Rate (AFR) each year and reports this to the Board.

Table of CQC Inspections

Balborough Treatment Centre – inspection date 16th March 2015

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring				★
Responsive			✓	
Well-led			✓	
Overall			✓	

The feedback received from CQC indicated that there were systems in place to identify and record patient safety incidents. Where serious incidents had occurred investigations were completed to identify learning and cascade this to staff. Not all incidents were reported to CQC as they should have been in 2014 but is now remedied.

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe		■		
Effective			■	
Caring				■
Responsive			■	
Well-led			■	
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe			■	
Effective			not rated	
Caring			■	
Responsive			■	
Well-led			■	
Overall			Good	

Southampton Treatment Centre – inspection date 18th May 2015

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring				★
Responsive			✓	
Well-led			✓	
Overall			✓	

"Care was provided that was outstandingly kind and compassionate within the surgical ward and department"

"There were clear open and transparent processes for reporting and learning from incidents."

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe			✓	
Effective			✓	
Caring				✓
Responsive			✓	
Well-led			✓	
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe			✓	
Effective			not rated	
Caring			✓	
Responsive			✓	
Well-led			✓	
Overall			Good	

St Mary's NHS Treatment Centre – inspection date 2nd October 2015

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led			✓	
Overall			✓	

Breakdown by service - Urgent and emergency services

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

Emersons Green NHS Treatment Centre – inspection date 30th March 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led			✓	
Overall			✓	

"There was good multidisciplinary team working across all departments to ensure effective patient care"

"All staff demonstrated genuine compassion for the people in their care, which was embedded into the culture of the departments"

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe			■	
Effective			■	
Caring			■	
Responsive			■	
Well-led			■	
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe			■	
Effective			not rated	
Caring			■	
Responsive			■	
Well-led			■	
Overall			Good	

Peninsula NHS Treatment Centre – inspection date 13th July 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring				☆
Responsive			✓	
Well-led				☆
Overall				✓

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe			■	
Effective			■	
Caring				■
Responsive			■	
Well-led				■
Overall				Outstanding

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe			■	
Effective			not rated	
Caring				■
Responsive			■	
Well-led				■
Overall				Outstanding

"Leaders empowered staff to promote caring and collaborative relationships with patients"

"The multidisciplinary team made exceptional effort to accommodate the cultural needs of patients, such as single sex room, all female staff teams for the duration of patients admission, specific dietary requirements"

Will Adams Treatment Centre – inspection date 9th August 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led			✓	
Overall			✓	

“Patients were positive about their experience and received care that protected their privacy and dignity”

“There were clear, open and transparent processes for reporting and learning from incidents”

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

Devizes NHS Treatment Centre – inspection date 13th September 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led			✓	
Overall			✓	

"There was a patient centred culture in all departments with staff showing care, kindness and compassion to all Patients"

"Patients complimented the treatment and care they received, commenting that staff were courteous and respectful"

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall			Good	

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

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Shepton Mallet NHS Treatment Centre – inspection date 11th Octover 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe				★
Effective				★
Caring				★
Responsive				★
Well-led				★
Overall				✓

"High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for patients."

"Multidisciplinary team working was excellent throughout the surgery service."

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall				Outstanding

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall				Outstanding

North East London NHS Treatment Centre – inspection date 21st September 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe		✓		
Effective			✓	
Caring			✓	
Responsive			✓	
Well-led		✓		
Overall		✓		

"Patients commented on how helpful and kind staff had been in providing support."

"The surgical service received consistent positive feedback from the Friends and Family test."

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall		Requires improvement		

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

Rochdale Ophthalmology CATS – inspection date 15th November 2016

Overall Rating	Inadequate	Requires improvement	Good	Outstanding
Services are...				
Safe			✓	
Effective				★
Caring				★
Responsive			✓	
Well-led			✓	
Overall				✓

"The service had a clear vision and strategy, which were understood by staff."

"All patients were treated by staff compassionately and their privacy and dignity was maintained"

Breakdown by service - Surgery

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective				
Caring				
Responsive				
Well-led				
Overall				Outstanding

Breakdown by service - Outpatients and diagnostic imaging

Rating	Inadequate	Requires improvement	Good	Outstanding
Service is...				
Safe				
Effective			not rated	
Caring				
Responsive				
Well-led				
Overall			Good	

National clinical audits

Name of National clinical audit	Care UK eligible to participate in	Care UK participation (Yes/No)	Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Adult Asthma	No	No	Care UK chose not to participate in these audits
Adult Cardiac Surgery	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Asthma (paediatric and adult) care in emergency departments	No	No	Care UK chose not to participate in these audits
Bowel Cancer (NBOCAP)	No	No	Care UK does not provide cancer services from Treatment Centres
Cardiac Rhythm Management (CRM)	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Case Mix Programme (CMP)	No	No	N/A
Child Health Clinical Outcome Review Programme	No	No	Care UK does not provide treatment of children from Treatment Centres
Chronic Kidney Disease in primary care	No	No	Care UK does not provide treatment of long term conditions
Congenital Heart Disease (CHD)	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
Diabetes (Paediatric) (NPDA)	No	No	Care UK does not provide treatment of long term conditions for children from Treatment Centres
Elective Surgery (National PROMs Programme)	Yes	Yes	None
Endocrine and Thyroid National Audit	No	No	Care UK chose not to participate in these audits
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	No	Care UK chose not to participate in this audit
Head and Neck Cancer Audit	No	No	Care UK does not provide cancer services from Treatment Centres

Name of National clinical audit	Care UK eligible to participate in	Care UK participation (Yes/No)	Comments
Inflammatory Bowel Disease (IBD) programme	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
Major Trauma Audit	No	No	Care UK does not provide major trauma within its Treatment Centres
Maternal, Newborn and Infant Clinical Outcome Review Programme	No	No	Care UK does not provide Maternity or Children's services from its Treatment Centres
Medical and Surgical Clinical Outcome Review Programme	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
Mental Health Clinical Outcome Review Programme	No	No	Care UK does not provide Children's services from its Treatment Centres
National Audit of Dementia	No	No	Care UK chose not to participate in these audits
National Audit of Pulmonary Hypertension	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
National Cardiac Arrest Audit (NCAA)	Yes	No	Care UK did consider participation in the Cardiac Arrest audit but numbers of this situation occurring within our facilities were too low for inclusion
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
National Comparative Audit of Blood Transfusion – Audit of Patient Blood Management in Scheduled Surgery	Yes	Yes	Care UK Treatment Centres have taken part in this audit
National Diabetes Audit – Adults	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
National Emergency Laparotomy Audit (NELA)	No	No	Care UK only provides elective surgery services from the Treatment Centres
National Heart Failure Audit	No	No	Care UK does not provide treatment of cardiovascular illness from Treatment Centres
National Joint Registry (NJR)	Yes	Yes	Care UK provides outcomes from its Treatment Centres for this audit
National Lung Cancer Audit (NLCA)	No	No	Care UK does not provide cancer services from Treatment Centres
National Neurosurgery Audit Programme	No	No	Care UK does not provide neurological services in Treatment Centres

Name of National clinical audit	Care UK eligible to participate in	Care UK participation (Yes/No)	Comments
National Ophthalmology Audit	No	No	Care UK chose not to participate in this audit
National Prostate Cancer Audit	No	No	Care UK does not provide cancer services from Treatment Centres
National Vascular Registry	No	No	Care UK does not provide treatment of cardiovascular illness from the Treatment Centres
Neonatal Intensive and Special Care (NNAP)	No	No	Care UK does not provide children's services from Treatment Centres
Nephrectomy audit	No	No	Care UK does not manage Long Term Conditions in Treatment Centres
Oesophago-gastric Cancer (NAOGC)	No	No	Care UK does not provide cancer services from Treatment Centres
Paediatric Intensive Care (PICANet)	No	No	Care UK does not provide children's services from Treatment Centres
Paediatric Pneumonia	No	No	Care UK does not provide children's services from Treatment Centres
Percutaneous Nephrolithotomy (PCNL)	No	No	Care UK chose not to participate in this audit
Prescribing Observatory for Mental Health (POMH-UK)	Yes	No	Care UK chose not to participate in this audit
Radical Prostatectomy Audit	No	No	Care UK chose not to participate in this audit
Renal Replacement Therapy (Renal Registry)			Care UK does not manage Long Term Conditions in Treatment Centres
Rheumatoid and Early Inflammatory Arthritis			Care UK does not manage Long Term Conditions in Treatment Centres
Sentinel Stroke National Audit programme (SSNAP)			Care UK only provides elective surgery services from the Treatment Centres therefore does not manage long term conditions or acute stroke
Severe Sepsis and Septic Shock – emergency departments			Care UK does not provide emergency services
Specialist rehabilitation for patients with complex needs			Care UK does not manage Long Term Conditions in Treatment Centres
Stress Urinary Incontinence Audit			Care UK does not manage Long Term Conditions in Treatment Centres
UK Cystic Fibrosis Registry			Care UK does not manage Long Term Conditions in Treatment Centres

Local audit schedule

Audit title	Purpose of audit	Frequency	ISTC	CATS
Documentation (Clinical)	Supports best practice in patient documentation and guidance from professional bodies	Quarterly	✓	✓
Patient falls	Patient safety and compliance assessment tool	Completed when any patient falls occur	✓	
Prevention of VTE (venous thromboembolism)	Assess compliance to NICE guidance and best practice clinical protocols for assessment and the provision of prophylaxis	Monthly	✓	
Peri-operative hypothermia audit	Assess compliance to NICE guidelines – CG65	Monthly	✓	
Pain audit	Assess effectiveness of pain management protocols	Quarterly	✓	
WHO surgical site safety checklist audit	Assess compliance to WHO surgical site safety checklist	Monthly	✓	
WHO observational audit	Assess compliance against WHO checklist (Sign in, Time In & Sign out)	Monthly	✓	
NEWS (National Early Warning Score) audit	Use of NEWS audit to identify early signs of the deterioration of a patient's condition	Monthly	✓	
Fluid balance audit	To assess fluid management in patients	Quarterly	✓	
Blood transfusion audit	Compliance with blood safety and national transfusion guidance	Bi-annually	✓	
Traceability audit - endoscopy	Compliance to JAG standards and re-accreditation	Monthly	✓	✓
Endoscopy environmental audit	Compliance to JAG standards and re-accreditation	Monthly	✓	✓
Medicines Management – Controlled drugs, Stock control, Responsibilities and prescribing and administration	To monitor all aspects of medicines management across our clinical services	Annually (Self-audit) & Annually (External audit)	✓	✓
Controlled Drugs Documentation audit	A dedicated audit for Pharmacists/Meds Management Leads focusing on the documentation element of controlled drugs usage	Quarterly	✓	✓
Anaesthetic Observation audit	Assessment of compliance and quality of Anaesthetic practice	Quarterly	✓	
Ward round (MDT) audit	Assessment of ward round practices and key team member involvement	Quarterly	✓	
Quality audit	To assess services against the CQC's Essential Standards	Bi-annually	✓	✓

Audit title	Purpose of audit	Frequency	ISTC	CATS
CAS alert & NICE guidance audit	To ensure that all alerts (CAS & MHRA) are reviewed, documented and circulated and all published NICE guidance is reviewed and implemented accordingly	Bi-annually	✓	✓
Agency/Locum/Temporary staff audit	To ensure that appropriate checks and local inductions are undertaken for all agency, locum and temporary members of staff	Bi-annually	✓	✓
Information Governance & Security audit	To monitor compliance against IG Toolkit requirements and ISO 27001 accreditation	Bi-annually	✓	✓
Emergency scenario audit	To ensure that all staff are prepared and are fully aware of their responsibilities in the case of an emergency incident	Quarterly	✓	✓

List of services and locations

Services	Facilities	Specialties
Barlborough NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Minor and major orthopaedic procedures, ophthalmology
Devizes NHS Treatment Centre	Day patients, Diagnostics,	General surgery, endoscopy, gastroenterology, gynaecology, urology, knee procedures, foot and ankle procedures, hand procedures, diagnostic imaging, ENT, ophthalmology, oral surgery
Emersons Green NHS Treatment Centre	Inpatients, Day patients, Diagnostics	General surgery, endoscopy, gastroenterology, gynaecology, urology, hip procedures, knee procedures, foot and ankle procedures, hand procedures, diagnostic imaging, ENT, ophthalmology, oral surgery
North East London NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, gastroenterology, ENT, ophthalmology, oral surgery
Peninsula NHS Treatment Centre	Inpatients, Day patients, Diagnostics	General surgery, hip procedures, knee procedures, shoulder and elbow procedures, foot and ankle procedures, hand procedures, ophthalmology, endoscopy
Shepton Mallet NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, gastroenterology, gynaecology, urology, diagnostic imaging, ENT, ophthalmology, pain management
Southampton NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, gastroenterology, gynaecology, urology, diagnostic imaging, ENT, ophthalmology, oral Surgery, pain management
St Mary's NHS Treatment Centre	Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, ophthalmology, diagnostic imaging
Will Adams NHS Treatment Centre	Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, urology, ophthalmology

Diagnostic services	Facilities	Specialties
Community Diagnostics	Outpatients, Diagnostics	Musculoskeletal services
Havant Diagnostics	Diagnostics	Diagnostic imaging
Additional services	**Facilities**	**Specialties**
Rochdale Ophthalmology Clinical Assessment and Treatment Service	Day patients	Ophthalmology
Royal South Hants Minor Injuries Unit	Walk-in service	Minor injuries
St Mary's Minor Injuries Unit	Walk-in service	Minor injuries and illnesses

Part Four

How we have maintained quality

How we have maintained quality

Throughout Care UK we have policies and procedures to guide employees in their everyday work caring and managing each patient's pathway.

We continually monitor our quality through audit (local/national); governance meetings (local/national); and at monthly business reviews.

Core performance indicators are developed from this to underpin all our senior leadership team's annual performance appraisals and objective setting.

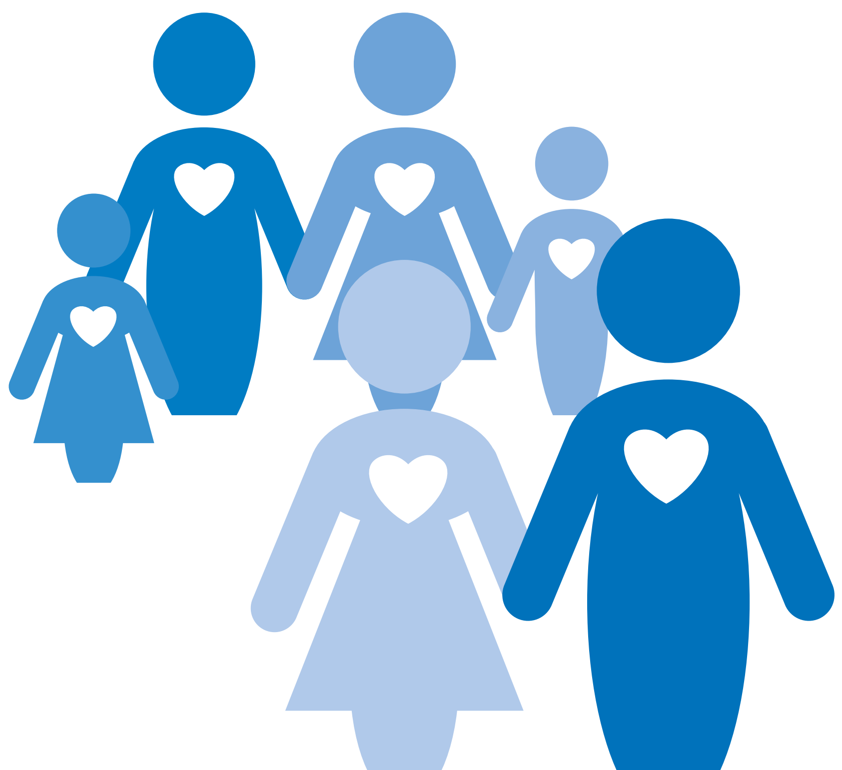
We share the lessons from where things have not gone well, both at a local level through monthly Quality Governance meetings, and at a national level through quarterly Quality and Governance Assurance Committee Meetings, chaired by the Director of Nursing and Quality. 'Shared learning' and 'shared good practice' is a fixed agenda item at our quarterly Professional Leads Meeting.

We focus on maintaining high quality patient care and endeavour to embed consistently safe, high quality standards, and an understanding of what 'good' looks like, across all our secondary care services.

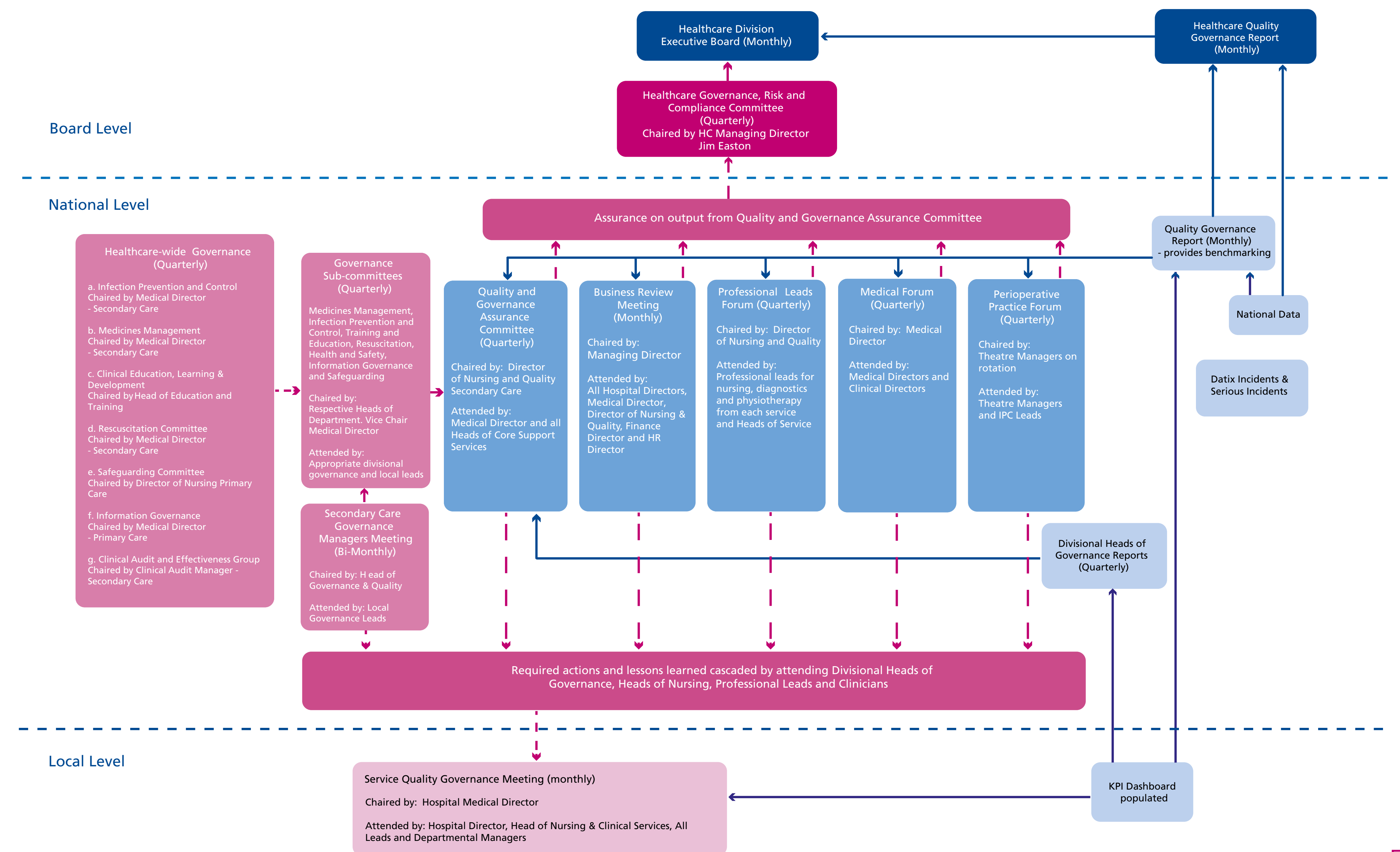
Exception reports are received and reviewed from all key service areas, with particular attention being paid to patients' safety.

We have adopted a number of approaches to ensure the services we provide are the best they can be, including accreditation with national bodies - achieving, for example, Joint Advisory Group (JAG) accreditation across all of our endoscopy services.

Our aim is to continuously improve the care that we offer and achieve excellent experiences for all patients choosing our services, as described throughout this Quality Account.



Below is a representation of the reporting and management structures within secondary care:



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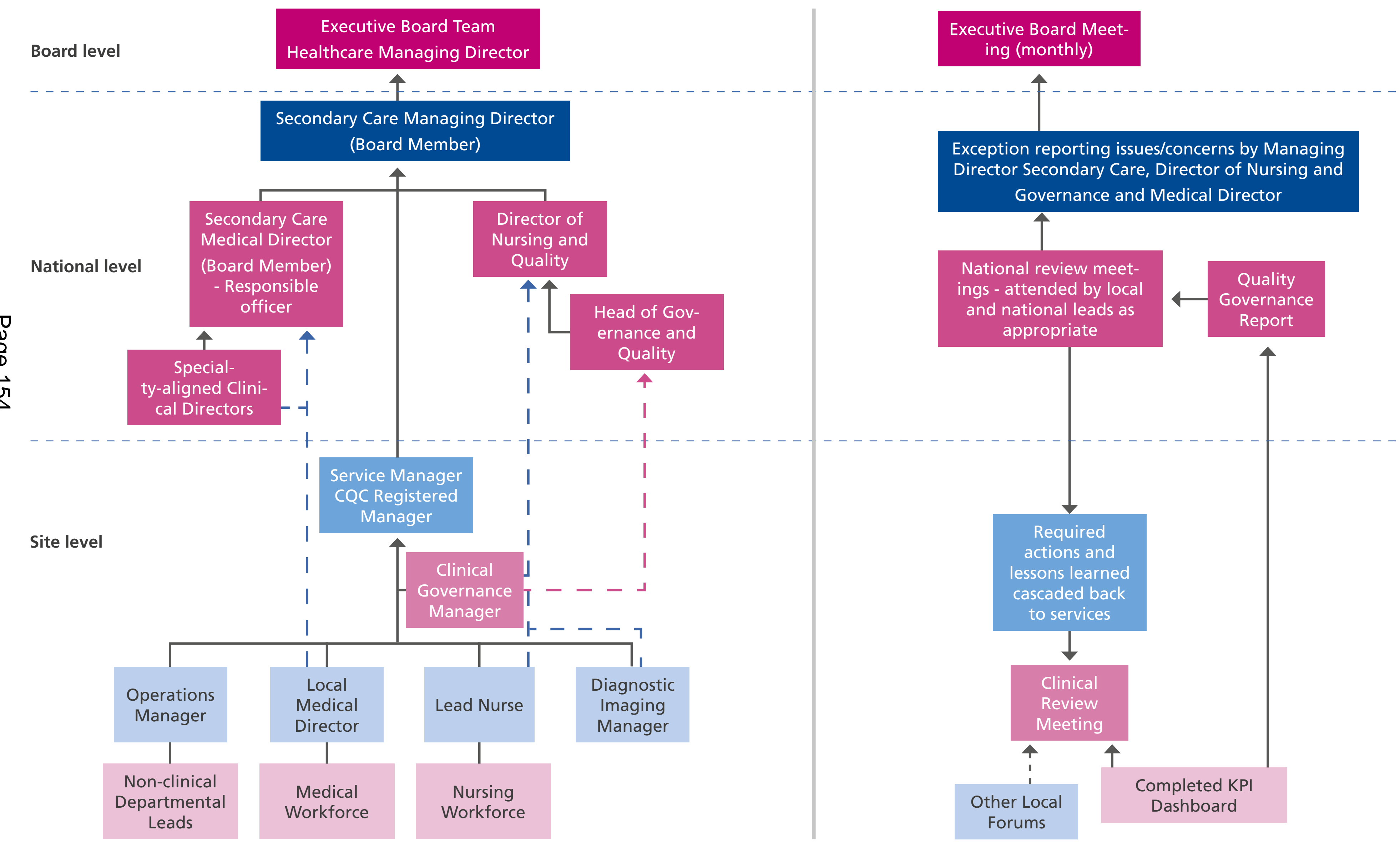
Below is a representation of the reporting and management structures within secondary care:



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Diagnostic services

Care UK provides a range of diagnostic imaging services within its NHS Treatment Centres and Clinical Assessment and Treatment Services (CATS), including: plain film X-ray; non- obstetric ultrasound (NOUS); magnetic resonance imaging (MRI); computerized tomography (CT); and dual-energy X-ray absorptiometry (DXA).

These services are delivered using state of the art imaging systems at both fixed and mobile locations.

Flexible opening hours, which include weekends and evenings, offer patients greater accessibility and convenience. Our team of dedicated imaging staff, comprising consultant radiologists, radiographers and sonographers, are all highly experienced healthcare professionals, registered with their respective professional bodies.

Referrals to our diagnostic imaging services come from a range of healthcare professionals; doctors, nurses and allied health professionals - and the results of completed imaging examinations are available to them within 48 hours of the patient's examination.

Care UK's robust quality governance framework for diagnostic imaging includes elements, such as: clinical audit; use of latest evidence based policies, protocols and NICE guidance; competency assessment of staff; and our Quality Assurance (QA) programme.

This framework ensures that services delivered by our operational teams are safe and clinically effective. Service- based teams are ably supported by an experienced divisional team which includes: a Clinical Director & Advisor for Radiology; a highly experienced Consultant Radiologist; and a Diagnostic Imaging Lead who oversee all diagnostic imaging services within Care UK's Health Care Division.

Our QA programme comprises an enhanced quality improvement and audit tool that we use to review and evaluate the quality of three key components of the clinical pathway for imaging examinations, namely: referral; imaging; and reporting.

We review a minimum of 5% of completed imaging cases, scoring each of the three key components on a scale from one to five (one being the lowest and five highest).

This provides valuable feedback for referrers, clinicians undertaking examinations and the reporting clinicians.

In summary, our QA programme helps us to:

- Ensure quality is continuously assessed at all key points of the imaging pathway (referrals/images/reports)
- Identify whether the correct management of the patient is achieved following diagnostic examination
- Identify any areas that might require improvement in the imaging pathway
- Offer assurances to our commissioners, patients and to our own organisation regarding the quality of the imaging services we provide and the reports that we send to our patients and referring clinicians.

During the reporting period (April 2016-March 2017) our QA programme has helped us review a significant number of cases as part of our quality improvement initiative. This has provided assurance about the quality of the services that we deliver to patients. It has also provided valuable feedback and opportunities for shared learning, both internally across Care UK and also externally with our key stakeholders.

For example, we have been able to give important feedback to our referring clinicians about the appropriateness

of imaging referrals, and whether the images they have requested are the 'gold standard' for answering the clinical question posed. It has also enabled us to review the quality of images produced by our radiographers and sonographers, and the content and accuracy of imaging reports provided by consultant radiologists and sonographers.

The QA programme allows us to monitor the trends and outcomes of imaging examinations, and to quickly identify any discrepancies or errors in reporting practice, ensuring that the clinical outcomes for patients are always the primary focus of this valuable quality improvement tool.

Outcomes from the QA programme continue to be excellent:

- 99% of referrals reviewed and accepted by Care UK were scored as appropriate against national imaging referral guidelines (iRefer) developed by the Royal College of Radiologists. There were only minor comments on how the quality of information provided by our referrers could be improved (about the importance of providing relevant patient history and previous imaging undertaken for the patient)
- 99% of cases reviewed during this period show the quality of images produced by our radiographers and sonographers to be excellent. This clearly demonstrates that our clinical teams are delivering high quality diagnostic images/examinations that enable accurate and prompt diagnosis to be achieved for our patients
- 99% of reports reviewed were also deemed to be accurate, clear and precise - offering a targeted response to the clinical question being asked by the referring clinician.

We are also developing an internal peer review system for our Sonographer workforce that will enable clinicians to 'quality assure' each other's clinical practice, observing colleagues when undertaking a range of ultrasound examinations, providing professional feedback to drive continuous quality improvement within our ultrasound services.

Where the QA programme reveals any discrepancies or errors from examinations undertaken within Care UK, a robust process including a full investigation, case review and the sharing of any lessons learned, is always undertaken.

Any significant errors are also formally reviewed as part of a focused Discrepancy Meeting, which includes the review of cases completed by both sonographers and consultant radiologists.

Our QA programme also allows us to track any trends in reporting errors and to identify where additional training or education may be indicated.

Our discrepancy/error rates for the reporting of imaging examinations remain at a very low rate. Although, this rate is hard to benchmark as QA programmes are not widely implemented across NHS Radiology Departments and thresholds for error are not clearly defined by the professional body (Royal College of Radiologists). We are wholly assured that the quality of our reporting is well above any suggested thresholds within the published evidence on this topic, and that we continue to provide a gold standard imaging service to our patients.

Patient led assessment of the care environment (PLACE)

Care UK are delighted that the care environments within all of our facilities scored above 85% for every PLACE category in 2016.

Cleanliness

The patient-led assessors gave us an overall score of 99% for the cleanliness of our secondary care sites.

We are immensely proud of this score, which was complemented by an overall score of 97% for the condition, appearance and maintenance of the buildings from which we provide care: these scores reflect our ambition to ever improve on the quality of our services demonstrating an improvement on 2015 scores.

In 2017 we expect to maintain these high quality ratings across all of our NHS Treatment Centres.

Dementia friendly

This was the second year that the suitability of environments for people with symptoms of dementia was assessed – in

accordance with criteria laid down by the Health and Social Care Information Centre (HSCIC). Whilst a positive 85% was scored across our secondary care premises overall last year, we have improved on this with a score of 87% in 2016. We are continuing the work to update environmental clues such as colour schemes, signage and flooring across our Treatment Centres.

Care UK PLACE Results 2016

Cleanliness

99.55%

Food

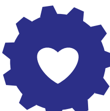
90.36%

Ward food

91.74%

Privacy, dignity and wellbeing

88.47%



Dementia

86.73%

Condition, appearance and maintenance

97.18%

Employee engagement

The annual Care UK staff survey, "Over to you!" mirrors the NHS Employee Survey in terms of questions relating to equality and diversity

Each year we carry out a staff survey, 'Over to You!' This survey not only informs us about what staff think, but also helps us measure the effectiveness of our employee engagement strategy.

Each unit, department, and team must formulate action plans based on survey results, and report on their progress. Each action plan has sections detailing: 'issues to celebrate'; 'areas where we need to make improvements'; and other factors that appear to merit further investigation.

The key measure generated by the survey is an engagement index, expressed as a percentage. Divisional targets are set year on year to increase our engagement index score – with outcomes stripped down as far as service line, unit, and teams within units, to support improvement action planning.

The survey is undertaken at the beginning of summer every year and in 2016 our engagement index improved for the third consecutive year to 66% (up from 63% in the prior year). Survey content is comparable to, and in certain sections mirrors, the NHS National Staff Survey content.

Related, and overwhelmingly, the survey indicated that our people know what is expected of them at work, feel proud of the work they do, view patient care as our top organizational priority, and know what to do if they wish to raise a formal concern at work regarding the provision of health care services.

Results compare well to the NHS staff survey outcomes and in particular with regard to employee health and well-being, providing the tools and materials required to do the job, and line management.

Whilst the outcomes to our equality and diversity questions (sourced directly from the Workforce Race Equality Standards) were broadly comparable to outcomes in the NHS survey, we have nevertheless initiated a divisional wide education campaign instigated by the Health Care Equality and Diversity Steering Group as a direct response to the survey.

This commenced in October last year and be rolled out on an on-going incremental basis to the end of September 2017 and is ensuring that equality and diversity has an organizational profile and is mainstreamed into our everyday working lives.

Infection, prevention and control

Care UK is committed to ever- improving standards of safe practice and environmental hygiene in order to prevent and control infection. This not only enhances service users' safety, it also means that they benefit from visibly clean, high quality service environments.

Organisational management

Following the recommendations of the Health and Social Care Act 2008 (2010; 2015), Care UK maintains a robust, hierarchical structure of infection prevention and control (IPC) guidance and supervision, provided by our IPC Committee, which is chaired by the Executive Director of IPC.

Our IPC strategy is delivered through a range of operational processes that consistently assess, measure and audit infection risks and use outcome information to plan and deliver actions designed to reduce avoidable infections, in line with the national agenda. Each service has a named IPC lead, and the Deputy Director of IPC brings this network of practitioners together on a quarterly basis for clinical supervision, shared learning and peer support.

Systems of assurance

Our internal IPC assurance systems include a monthly audit schedule specifically designed to monitor relevant areas of risk within each service stream. This year the audit schedule has been revised with the aim of aligning the audit scoring to better reflect risk. This means we are actively seeking to identify exceptions to our high standards of environment and practice and we target these to ensure improvements are planned for and actioned within a timely manner. Incidences of surgical site and healthcare associated infections are reported and collated monthly. This information and contributory factors are reviewed locally and are assessed by the Deputy Director. Lessons are shared via our governance framework, which incorporates quality governance, professional forums, the IPC committee and the Health Care Board.

Performance 2016 - 2017

Healthcare Associated Infections (HCAIs): Care UK had no reported cases of Clostridium difficile infection and no incidences of methicillin resistant or sensitive Staphylococcusaureus bacteraemia attributable to their care during 2016.

This is our sixth consecutive year of zero HCAIs.

Health care associated infections (HCAI) 2011-2015

MRSA bacteraemias

0 infections

MSSA bacteraemias

0 infections

E.coli bacteraemias

0 infections

Clostridium difficile incidence

0 infections

Surgical site Infection (SSI) rates (hip and knee replacement)

Surgical site infections:

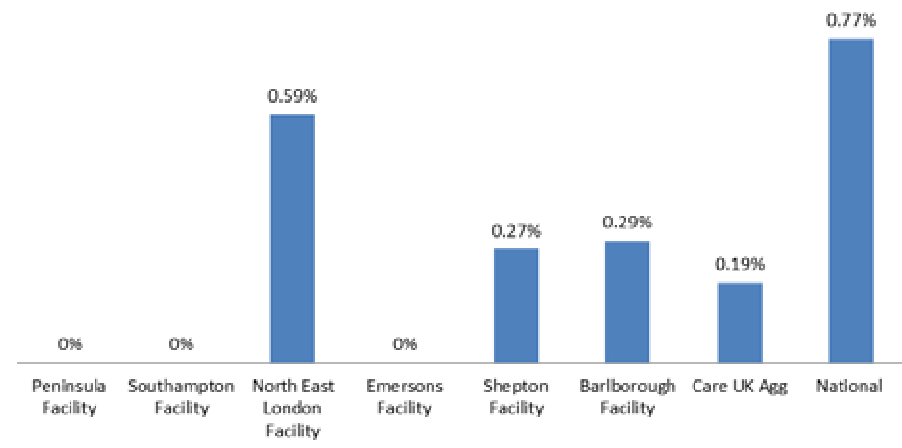
Care UK's secondary care services implement continuous surveillance of our hip and knee replacement outcomes via the Public Health England (PHE) National Surgical Site Infection Surveillance Scheme (NSSISS). We report every incidence.

Each Care UK secondary care hospital/ Treatment Centre undertaking hip and knee surgery contributes to the national database of post discharge outcomes under the Public Health England National Surgical Site Infection Surveillance Scheme (NSSISS).

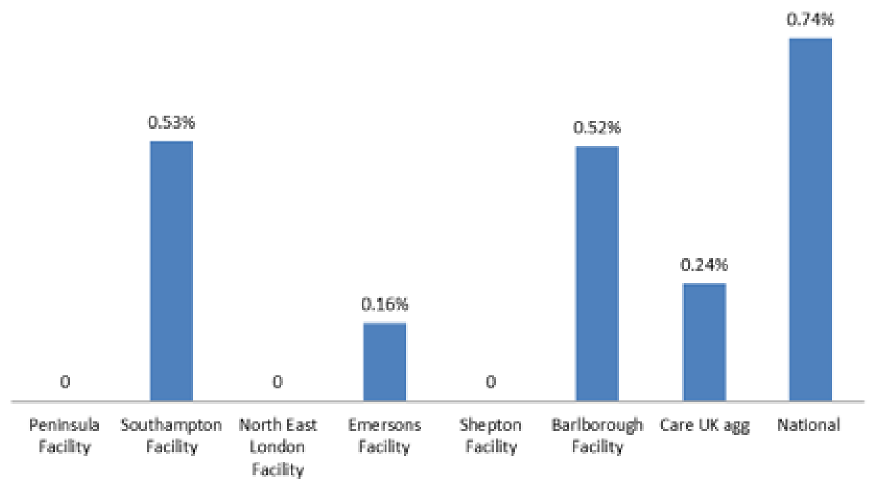
Care UK report incidences of surgical site infections on a monthly basis; this exceeds the national minimum requirement of quarterly reporting.

This enhanced visibility of the post discharge outcomes of our patients undergoing hip and knee replacement promotes transparency and confidence in the true values of our reported rates of infection.

Confirmed surgical site infections of knee replacements by Care UK treatment centre, Care UK aggregate compared to the national PHE 5 year incidence (Oct 2015 - Sept 2016)



Confirmed surgical site infections of hip replacements by Care UK treatment centre, Care UK aggregate compared to the national 5 year incidence (Oct 2015-Sept 2016)

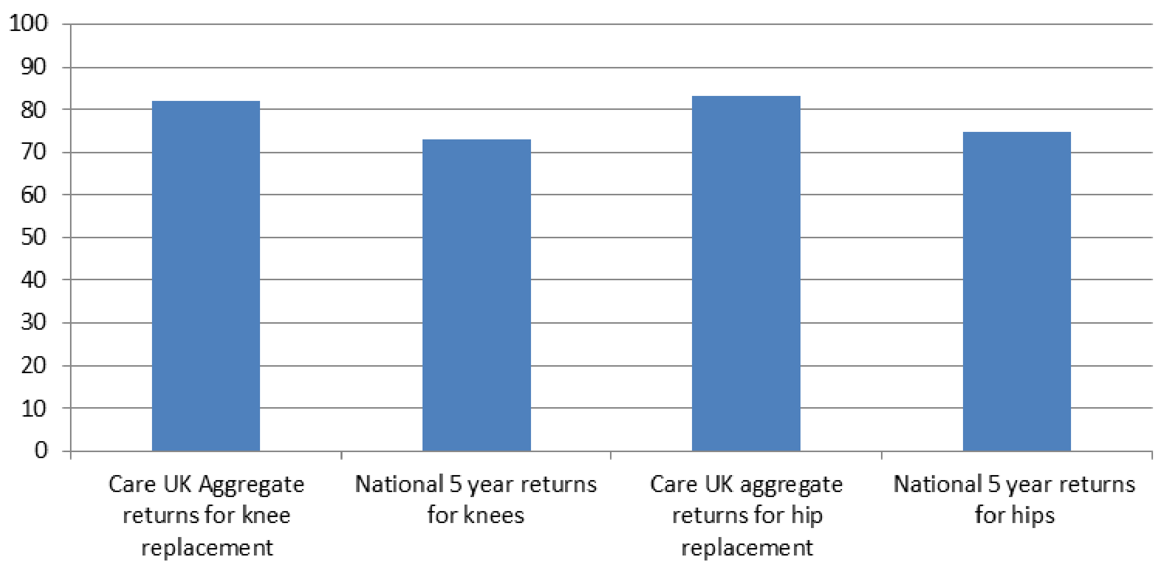


Surgical site infection rates (hips and knees replacements)

Further, Care UK actively seeks information about the experience of our patients following discharge after major joint surgery. We routinely collect data on more of our post operative joint patients than is the achievable for our NHS colleagues.

In line with national Public Health England guidance, Care UK monitors the return of patient completed questionnaires. Some of the treatment centres such as North East London bring their patients back to the clinic for the removal of clips and stitches; this provides the perfect opportunity to find out about the post operative experience of patients resulting in 100% return of the post discharge questionnaires.

Other treatment centres rely on patients posting the forms back after the 30th day since their surgery. If these forms indicate there has been a possible infection, Care UK infection prevention and control leads contact the patient and the GP to confirm whether an infection was present.



Ref: Public Health England Surveillance Service. 2017 Summary Report: Rates, Trends, Risk Factors and Additional Data.

Secondary care hand hygiene audit results by unit

Hand hygiene is a very important element of our comprehensive infection prevention and control (IPC) strategy, policies and procedures – all of which are designed

to minimise the risk of infection arising amongst our patients.

An annual training and audit schedule covers standard infection prevention and control precautions, including hand hygiene, use of personal protective equipment (PPE), decontamination and environmental cleanliness.

Our IPC leads and link practitioners conduct quarterly audits of the hand hygiene practice of staff within each service area. The hand hygiene audit tool and method of scoring has been redesigned this year to focus on each aspect of safe practice: this promotes excellence and reduces risk by focusing clinical staff on the detail of their practices to ensure consistent compliance. This results in lower month end audit scores but better action planning and directed training in response to the improved visibility of infection prevention and control practices.

Information governance data quality

We take our responsibilities very seriously to protect and maintain the confidentiality of patient information.

The Caldicott Guardian, who is responsible for the security of patient information, leads this work and is committed to the highest standards.

We have encouraged an open and transparent reporting culture and as a result have had a total of 131 internal information incidents within the year and we have had 3 SIRI Level 2 reportable incidents which the ICO has closed with no actions taken against us. We have continued to implement innovative and robust controls for managing the risks of breaches in all our operational areas as well enhanced our staff awareness through double checking of patients information with the patient before giving them the discharge letter and take home medicines, only printing patient information as you need it and redefined basic administration processes so there is a focus on completing one task before starting another one and reducing the risks of error.

We have a range of policies to guide employees and we train all staff at their induction and then on an annual basis in managing information and confidentiality. This is an externally assessed through our ISO 27001:2013 accreditation which we received our 3 year recertification in October 2016; a demonstration of our commitment to high standards in the management of information and security.

Any serious breaches are reported to the board, commissioners and information commissioner. Information governance is included in the annual audit schedule. Monitoring and managing data quality is key to providing a quality service. Our strategy is reviewed and refreshed each year to take into account new clinical and quality performance initiatives.

As in previous years we use the data quality dashboards published on a monthly basis by the NHS Digital to monitor the ongoing data quality of the full range of commissioning dataset items for admitted patients and outpatients. Our board receives a quarterly data quality statement detailing any issues and the actions taken to correct them.

137
Internal information incidents

3
SIRI Level 2 reportable incidents

Information governance toolkit attainment

We have achieved the quality standard of Level 3 100% on the IG toolkit, which is underpinned by our ISO 27001:2013-information security management system and accreditation.

Clinical coding

During 2016-17 we submitted records to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES). These are included in the latest published data:

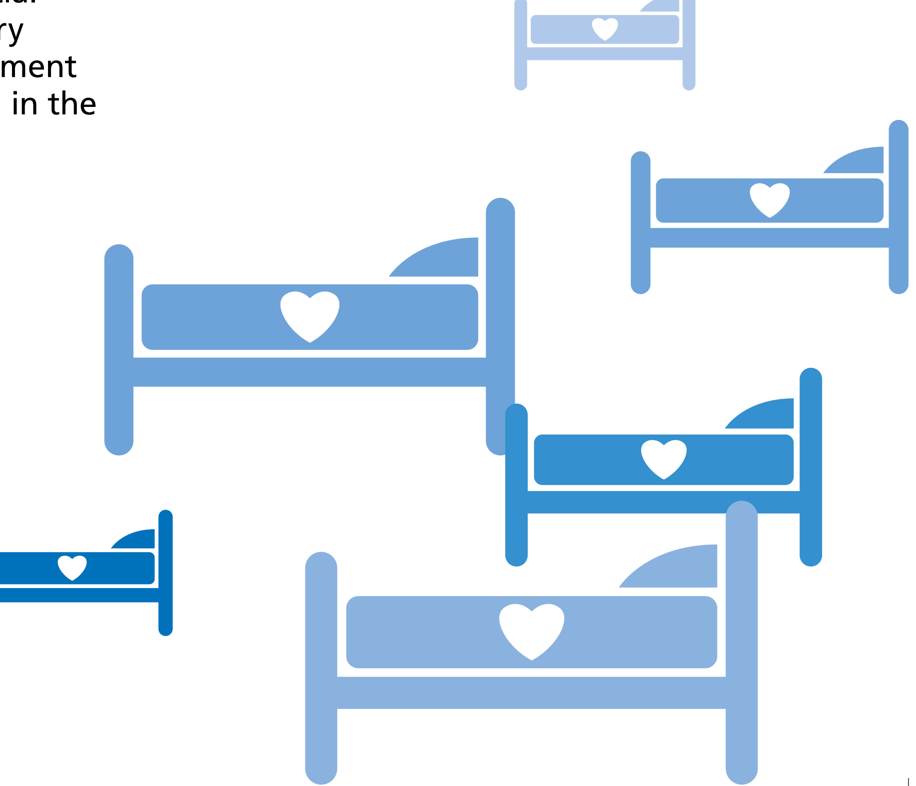
- Within Care UK there is a programme of clinical coding audits focused on data quality, in accordance with Information
- Governance Toolkit 13-505 and conducted in line with the Clinical Classification Service's clinical coding methodology: version 9. The 2016-2017 audit results demonstrated that all Care UK Treatment Centres were achieving the satisfactory percentage accuracy for either Level 2 or the higher Level 3, as recommended
- Care UK clinical coders receive ongoing training in line with the Information Governance Toolkit 14-510 attainment Level 2

Same sex accommodation

In line with Department of Health guidance on mixed sex accommodation, it is standard practice in Care UK facilities to provide separate accommodation for men and women throughout the process of admission, treatment and discharge. Treating men and women separately enables us to maintain the appropriate standards of privacy and dignity.

Care UK can confirm that there have been no breaches of the Department of Health guidance during the past year and this has been reported to the Health and Social Care Information Centre (HSCIC) every month. We are proud of this achievement and intend to maintain this standard in the future.

> "Treating men and women separately enables us to maintain the appropriate standards of privacy and dignity"



Local clinical audit

In total, 845 clinical audits of Care UK services were completed locally, between April 2016 and February 2017. Of these, 87% achieved 'compliance' status, 10% 'partial- compliance' and 3% 'non-compliance'.

Each audit forms part of Care UK's published Clinical Audit Schedule. This is reviewed and updated annually by our Clinical Audit and Effectiveness Group, which sets specific clinical audits for each service stream within our Health Care Division.

The group prioritises audits that are mandatory and ensures that all scheduled audits are meaningful and will provide a positive contribution to quality improvement and clinical excellence.

We use a range of audit tools, and provide resource and expertise, to facilitate high quality clinical audit practices. Those involved in local clinical audit practices are also encouraged to complete Care UK's CPD accredited clinical audit training session (mandatory for at least one member of staff per service), which has been highly successful in driving a culture of clinical audit by highlighting the positives that can be achieved in terms of quality improvement.

Core audits in the Clinical Audit Schedule (undertaken within all areas) include: medicines management; documentation; CAS alert and NICE guidance; information governance and security; quality audit and emergency scenarios.

These are supplemented by focused, service stream-specific audits. For our NHS Treatment Centres, these include audits of: venous thromboembolism (VTE) risk assessment; peri-operative hypothermia; implementation of National Early Warning Score (NEWS) assessments; WHO Surgical Safety Checklist usage; and observational audits - falls and fluid balance.

Service stream-specific audits within our diagnostic imaging services, include: reject analysis; clinical practice and documentation; and, dose reference level (Radiation dose audit).

Our musculoskeletal (MSK) services also conduct local clinically focused audits to evaluate clinical practice outcomes, including: acupuncture; joint injection and patient triage.

The results, compliance status and details of any actions arising from clinical audits are submitted monthly to the Health Care Division's Clinical Audit Manager.

Results are then logged with partial and non-compliant audits reported to Care UK's Health Care Board as part of the monthly reporting cycle and governance processes.

Services are responsible for conducting clinical audits and progressing any actions arising. All actions are assigned to specific individuals for completion within defined timescales. Re-audit is completed where indicated, in order to close the audit loop.

Our operational services are clearly focused on conducting high quality clinical audit and ensuring that outcomes support teams to either demonstrate their delivery of high quality, latest evidence-based clinical practice or highlight areas for quality improvement.

The following examples provide clear evidence of how clinical audit practice across Care UK has generated demonstrable improvements in the quality, safety and clinical effectiveness of our services - with shared learning mechanisms used to maximise the benefits across whole service streams.

Will Adams NHS Treatment Centre has improved their compliance against NICE guidelines CG65 (Peri-Operative Hypothermia) from 90% (partially compliant) in August 2016 to 100% (Compliance) by November 2016. This was achieved through the introduction of pre-heated blankets and a fluid warming cabinet.

The Peninsula NHS Treatment Centre has improved their compliance with WHO Observation Audit criteria from 86% (non-compliant) in June 2016 to 98% (compliant) in January 2017.

The improvements are the result of concerted efforts to ensure the highest standards of surgical safety in the centre.

Care UK's ward rounds are complex clinical activities that provide an opportunity for the multidisciplinary team to review a patient's condition together and develop a coordinated plan of care while engaging with the patient and/or carers.

They offer opportunities for sharing information and joint learning. Emersons Green NHS Treatment Centres went from 81% (non-compliant) to 97% when they re-audited. Working closely with clinicians to improve the way information was captured and by ensuring updates were documented electronically in real-time they managed to achieve a much improved score.

In summary, our Clinical Audit Schedule ensures that practices are consistently assessed and benchmarked across a range of guidelines and standards issued by NHS and professional bodies.

Shared learning forms an integral part of the clinical audit cycle and specifically underpins our approach to using clinical audit as an effective quality improvement tool.

In this context, clinical audit outcomes, the key lessons learned and the specific changes and improvements that have been made, are formally discussed and shared amongst colleagues both locally and across Care UK, to ensure we maintain high quality standards for all our patients.

National Joint Registry (NJR)

All of the NHS Treatment Centres operated by Care UK that undertake hip and knee replacement surgery have submitted data to the National Joint Registry since their opening.

The NJR has, since 2002, monitored joint replacement surgery in terms of both its clinical effectiveness and the effectiveness of the surgical implants used.

Nationally, more than 1.6 million procedures are reported annually (11th Annual NJR Report September 2014).

Care UK's current selection of hip and knee replacement implants takes into account: the top performing outcomes demonstrated by the NJR; Orthopaedic Data Evaluation Panel (ODEP) ratings; and, the most commonly utilised implants in England and Wales.

Implants have been selected for their: proven long term performance; low revision rates; the accessibility of manufacturers' support and inventory; ease of application - which is integral to the successful outcomes for the patient.

Our protocols for choosing the right implants take into account individual patient needs, activities, age and bone stock in order to provide them with the best possible outcome and a quick return to normal life and function.

These protocols are regularly reviewed to take account of the latest high impact scientific evidence and the NJR data on revision rates.

Enhanced Recovery Programme

Care UK was an early adopter of the Department of Health's Enhanced Recovery Programme for hip and knee replacement surgery. Patients' recovery is enhanced through careful pre-operative assessment, the use of modern techniques for anaesthesia and post-operative pain relief, and support for early mobilisation.

As a result, patients have shorter hospital stays and better outcomes. The current average lengths of stay at our NHS Treatment Centres are: 2.6 days for hip replacement and 2.3 days for knee replacement.

Hospital	No. of procedures 2016/2017	No. of consultants 2016/2017	NJR consent rate	Average patient age at operation 2016/2017	Outliers – mortality rate	Outliers – hip revision rate	Outliers –knee revision rate
Barlborough NHS Treatment Centre	1,870	9	99.69%	66			
Emersons Green NHS Treatment Centre	1,235	7	98.06%				
North East London NHS Treatment Centre	744	5	100%	67			Yes
Peninsula NHS Treatment Centre	731	8	100%				
Shepton Mallet NHS Treatment Centre	614	4	99.84%			Yes	
Southampton NHS Treatment Centre	427	4	96.06%	56			Yes

Please note:

Compliance, consent and linkability are:

- Red if lower than 80%
- Amber if equal to or greater than 80% and lower than 95%
- Green if 95% or more

Management of near miss and incident reports

It is a mandatory requirement for all providers of healthcare services to have a procedure for reporting incidents. Care UK's procedure is based on National Patient Safety Agency (NPSA) published work, and related policies are regularly revised to reflect latest best practice in this area.

We promote the open reporting of all incidents and accidents, including no harm/ prevented harm and near miss incidents.

If incidents do occur, we take immediate steps to minimise risk factors and prevent recurrence.

Our aim is to maintain a working culture that creates and maintains a safe, low risk environment for our patients and all those visiting or working within Care UK premises.

We also work with local commissioners, partners and external organisations to ensure any learning we derive from incidents is shared and overall risk is reduced. For example, all of our Treatment Centres have a nominated senior staff member who participates in the Local Information Network (LIN) to monitor and review any incidents involving controlled drugs.

Prevention of Never Events

Never events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'. Reviews of the circumstances surrounding never events typically expose process failures that could be addressed through modern Human Factor (HF) training. To this end, Care UK has engaged a specialist company of HF trainers to work alongside our own training department to help embed HF awareness throughout the organisation. Formal training is given to clinicians and support staff on an ongoing basis to further reduce the possibility of never events occurring in the future.

Care UK commissioned an external review carried out by a medico-legal training company, to assess the adequacy of our post hoc analysis of never events, should they occur, and our process for learning from events.

Following recommendations from this review our Incident Reporting and Investigation Policy were reviewed, along with our Root Cause Analysis tools and methodology.

There were 3 never events reported in 2016-17 across secondary care services. 2 incidents related to wrong tooth extractions, and there was a wrong-side femoral nerve block given.

Site	Category
Southampton NHS Treatment Centre	Wrong tooth extraction
Devizes Treatment Centre	Wrong tooth extraction
North East London NHS Treatment Centre	Wrong-side femoral nerve block

Root Cause Analysis

Once an incident has been investigated, we identify root causes, make recommendations and communicate those recommendations across the organisation to ensure any necessary changes are put into action. We then monitor the implementation of changes to practices, pathways and management, across all sites. Where indicated, we also review our policies and procedures to reflect these changes.

Risks identified through the reporting and investigation of incidents are also recorded in our Datix system alongside any action plans. These are frequently reviewed as part of our proactive approach to reducing the likelihood of future incidents occurring.

Patient deaths within 30 days

Patient deaths within 30 days of discharge were reported over this period although none were the result of treatment or incidents occurring while patients were under the care of Care UK.

Learning from Incidents

At a local level, shared learning from incidents and complaints is a standard agenda item at Quality Governance meetings - with additional, individual feedback being given to any staff members who were involved.

At a national level, we not only monitor the action plans resulting from incident investigations but ensure lessons learned are shared across all services. Our Professional Leads meetings, which are attended by all of our Heads of Nursing and Clinical Services, are a particularly useful forum for this.

In order to further improve the way we learn from serious incidents a new automated shared learning tool was developed in 2016, which facilitates the more effective sharing of lessons recorded in our incident reporting system, Datix, across services, and with staff that may not necessarily have direct access to the incident record.

Working in partnership with our commissioners and external stakeholders is another essential means of sharing our learning and promoting transparency in our services.

To promote this in Southampton, representatives from our Treatment Centre team attend Panel Review Meetings convened by commissioners.

These meetings enable teams of experts, including both senior managers and clinical staff, to get together to discuss and share learning derived from the root cause analysis of incidents.

Meetings are quarterly or as required. Inspectors from the Dental Deanery and NHS England have commented positively on the results of these meetings.

Table 1

This table provides the number of patient safety incidents as a percentage of all incidents per Treatment Centre.

	% of patient safety incidents as a percentage of patient attendances		
	All incidents including near misses	Severe Harm	Death
Barlborough NHS Treatment Centre	1.4770%	0.0000%	0.0000%
Devizes NHS Treatment Centre	1.0118%	0.0126%	0.0000%
Emersons Green NHS Treatment Centre	1.2029%	0.0000%	0.0000%
North East London NHS Treatment Centre	0.4659%	0.0000%	0.0000%
Peninsula NHS Treatment Centre	1.2589%	0.0000%	0.0000%
Shepton Mallet NHS Treatment Centre	0.6030%	0.0000%	0.0000%
Southampton NHS Treatment Centre	0.5599%	0.0023%	0.0000%
St Mary's NHS Treatment Centre	1.1611%	0.0055%	0.0055%
Will Adams NHS Treatment Centre	0.3217%	0.0000%	0.0000%

Table 2

This table provides actual numbers of incidents per Treatment Centre.

	Severe Harm	Death	No Harm	Total
Barlborough NHS Treatment Centre	0	0	261	337
Devizes NHS Treatment Centre	1	0	70	80
Emersons Green NHS Treatment Centre	0	0	252	279
North East London NHS Treatment Centre	0	0	101	128
Peninsula NHS Treatment Centre	0	0	71	111
Shepton Mallet NHS Treatment Centre	0	0	78	92
Southampton NHS Treatment Centre	1	0	169	243
St Mary's NHS Treatment Centre	1	1	180	212
Will Adams NHS Treatment Centre	0	0	31	43

care
NHS

Part Five

Feedback from Key Stakeholders

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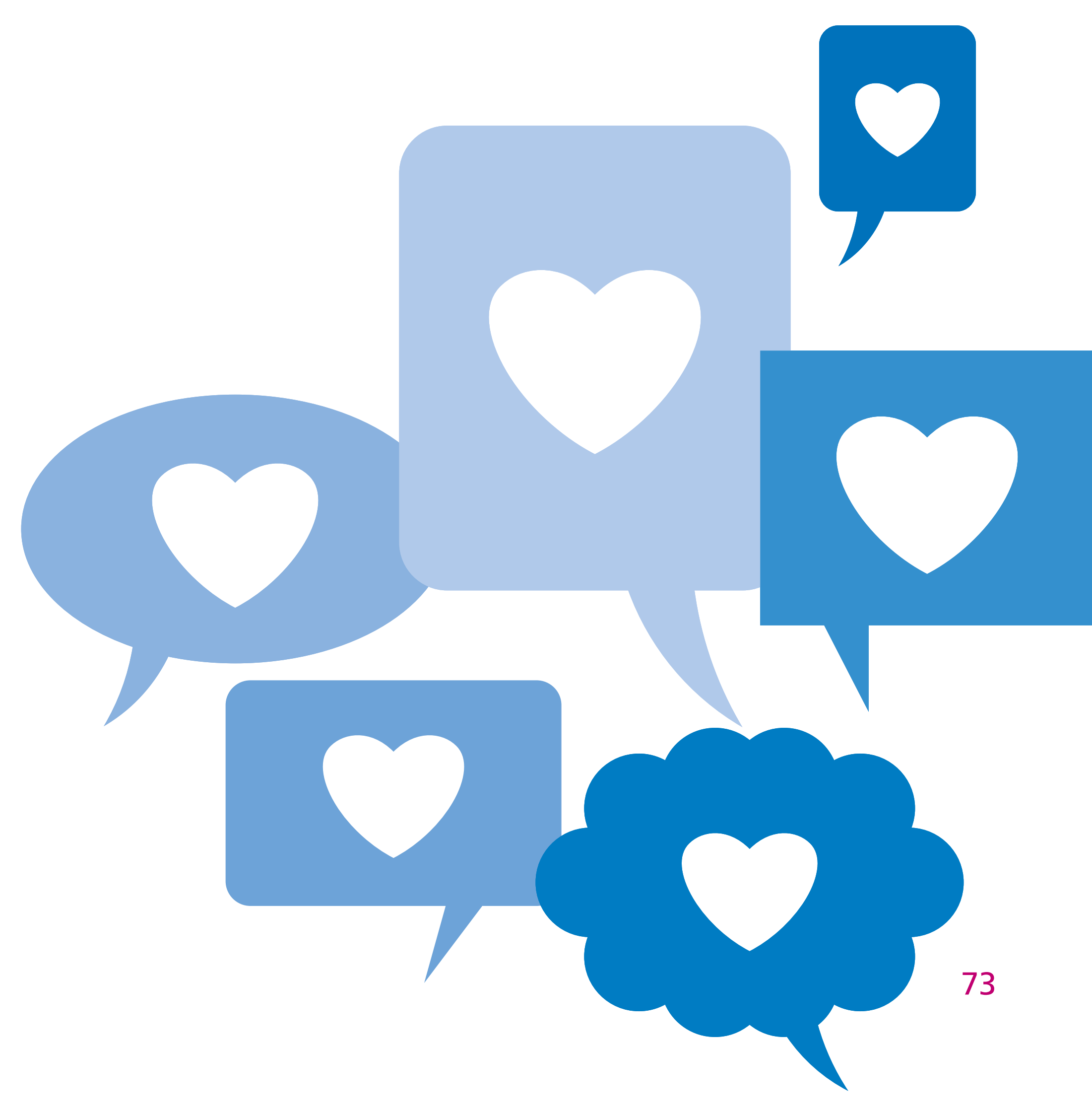
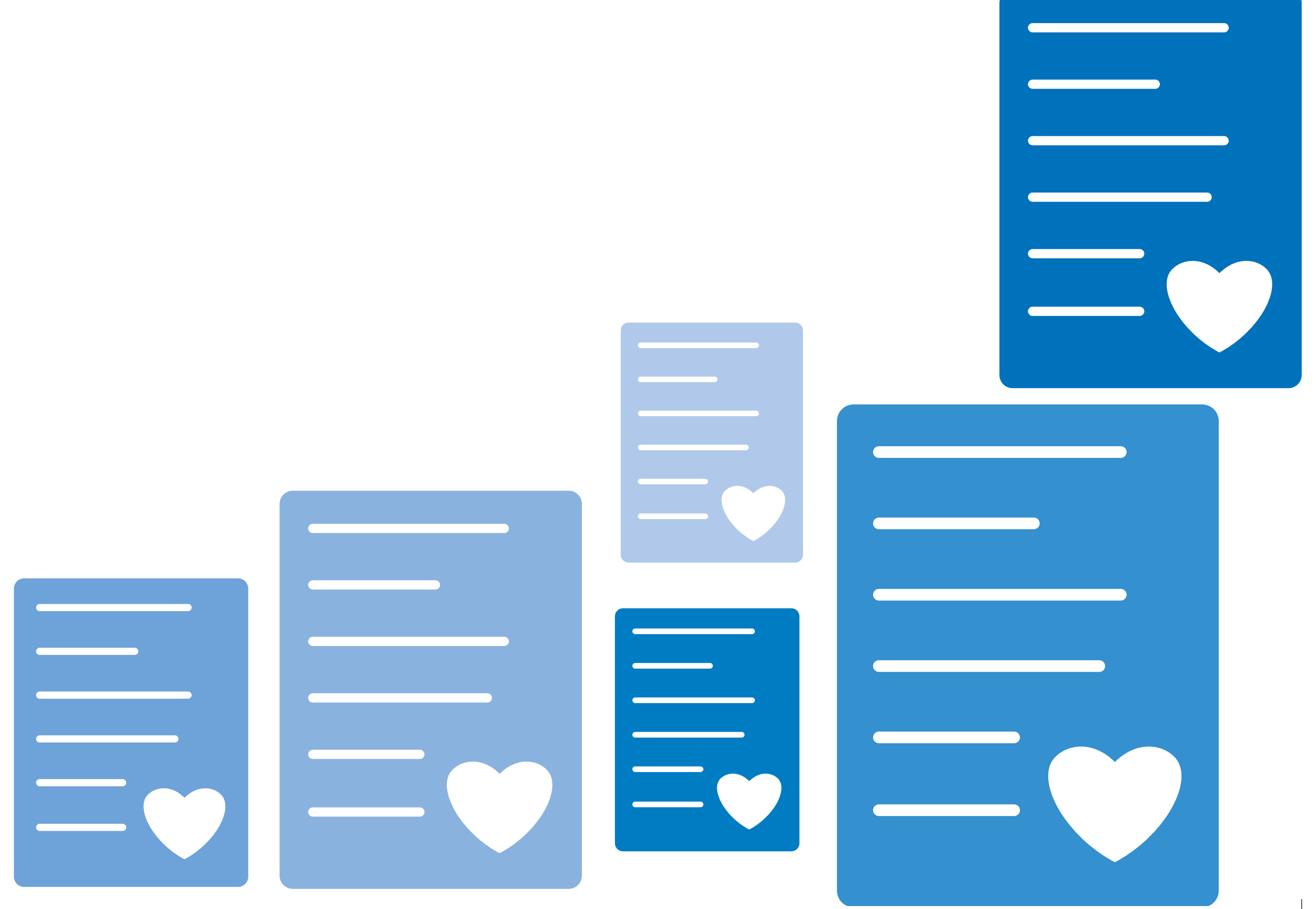


We would like to thank all of the staff, patients, commissioning groups, Capital Healthwatch and other key stakeholders for reviewing and commenting on this Quality Account. Each year we learn something new and want to improve on how we present this account year on year. The feedback below is verbatim unless stated otherwise.

Appendix

Service Reviews



Barlborough NHS Treatment Centre

Details of last year's local quality priorities

There are 2 local and 2 national CQUINs

- Local 1 – Human Factors, Never Events & Duty of Candour.

In order to raise awareness of the legal aspects of Never Events and Duty of Candour and also to ensure compliance locally, centrally and with regulatory bodies this CQUIN was chosen as this could be monitored by staff attendance at training and also details, actions and lessons learned could be captured through Datix.

  - The aim is have trained 90% of clinical staff by the end of the 3rd week April 2017
  - All new starters will receive this training during their induction

- Local 2 – Urinary Catheter Care

The aim of this CQUIN was to capture how many patients were catheterised at Barlborough and was there a clear clinical indication to justify catheterisation. It was also to improve urinary catheter care and support patients going home with a urinary catheter in situ. An audit tool was developed to capture all this information.

  - Monthly audits of 30 case notes to identify if there was a clear clinical indication for a catheter
  - Patients discharged home with a catheter to have a discharge letter requesting referral to Urology, District Nurse and a Patient information leaflet on flip flow catheters

- Guidelines developed to support clinical staff with insertion and management of urinary catheters
- Patient leaflet developed for management of flip flow catheters

	Q2	Q3	Q4
	Submit evidence of 60% Clinical staff have been trained on Never Events, Duty of Candour and Human Factors	Submit evidence of 80% Clinical staff have been trained on Never Events, Duty of Candour and Human Factors	Submit evidence of 90% Clinical staff have been trained on Never Events, Duty of Candour and Human Factors
Number of staff trained	116	125	
Overall percentage trained	89%	96	
Meets milestone requirement	yes	yes	

- National 1 – Reduction in Antibiotic Consumption

  In order to support the prevention of antimicrobial resistance crisis an audit tool was developed to support auditing of all patients at Barlborough who were prescribed antibiotics.

  - All patients who are prescribed antibiotics at Barlborough must be included in the audit
  - Monthly audit of all patients who received antibiotics to review if there was a clear clinical indication and a 72 hour review.
  - Quarterly reports to include trends from audits including lessons learned and actions taken.

- National 2 – Frailty identification and care planning

  This is relevant to us as a treatment centre focused on delivering high quality patient care as frailty is associated with:

  - Extended hospital length of hospital stays.
  - Increased falls risk
  - Increased risk of post operative confusion
  - Poor skin quality
  - Poor nutritional status
  - Increased rate of institutionalisation post discharge
    - Audit tool developed to capture all patients over the age of 75 years
    - All patients aged 75 and over to complete the frailty assessment and pathways completed for frailty of 12 or above

- Locally awareness has been raised with regards to frailty through training, national awareness days and the dementia friendly patient room on the in-patient ward.

VTE

Month	% recorded of total procedures
January	100
February	100
March	96
April	99.3
May	99.1
June	90
July	100
August	95
September	100
October	100
November	88
December	100

NJR

Fiscal Year	Fiscal Quarter	Fiscal Month	No. of Operations	No. of Hips	No of Knees	No. of Ankles	No. of Elbows	No. of Shoulders	Consent Yes	Consent No	Consent Don't Know	Consent Rate	NHS Number Supplied	NHS Number Traced	Tracing Rate	No. with Validate Override	Validate Override Rate
2016	Q3	Oct	182	84	98	0	0	0	182	0	0	100%	182	182	100%	0	0%
2016	Q3	Nov	213	85	125	0	0	3	213	0	0	100%	213	213	100%	2	1%
2016	Q3	Dec	107	47	60	0	0	0	107	0	0	100%	107	107	100%	0	0%
		Total	502	216	283	0	0	3	502	0	0	100%	502	502	100%	2	0%

Barlborough's priorities for 2017

Human Factors/Never Events Training for all staff at Barlborough

In the case of Never Events, despite there being defined processes and procedures to prevent them, on occasions they continue to occur, often with tragic consequences for patients, their families and the staff involved..

In April 2015 - January 2016 Barlborough NHS Treatment Centre had 3 never events and also had a further two Duty of Candour incidents.

Immediate learning from these incidents showed a failure to recognise what was classed as a never event and when duty of candour applied to incidents.

This CQUIN is to provide clarity for staff who may be involved in identifying, investigating or managing Never Events.

Frailty Identification & Care Planning

Barlborough are continuing with Frailty identification and Care Planning through 2017/2018.

By the end of the year we aim to have delivered Dementia Training to 95% of clinical staff.

The Dementia friendly room on the inpatient ward is now nearly completed and fit for purpose.

Improvement of health & wellbeing of Barlborough Staff

This is a new CQUIN at Barlborough which is divided into two sections. The first part is to raise awareness of and support the uptake of the flu vaccination for clinical employees.

The second part focuses on health & wellbeing of all employees, supporting them to make healthier lifestyle choices both at home and at work.

Reducing the impact of serious infections (antimicrobial resistance and sepsis)

This is a new CQUIN at Barlborough. The aim is to have trained 90% of clinical staff in the recognition and management of sepsis using appropriate screening tools and early warning indicators.

Patient Story

Bill presented at Barlborough NHS Treatment Centre with his wife after being referred for a total hip replacement. We were made aware that he was suffering with a diagnosis of Dementia.

Bill's wife was the main carer for her husband and it was obvious that whilst she was worried about his operation, she was completely exhausted and staff had concerns about her health and well-being also.

The patient's 'passport' was completed which enable all staff to be aware of how Bill may react to noise, smells, his interests, fears, likes and dislikes.

Bill and his wife were reassured that the staff would be more than capable in providing an environment that would be safe, stress free and comfortable. We do allocate a double room to patients with dementia so that a relative can stay should they so wish. On this occasion Bill's wife mentioned that she would appreciate time to rest at home and prepare for her husband's discharge.

The multi-disciplinary team meet every Monday and Bill's case was discussed. The date and time of admission was known, staffing needs were increased to provide 'one to one' care for Bill with healthcare assistants and trained staff as necessary.

A memory box was provided for Bill so that conversations could take place between him and the staff to help the care delivery. Bill came with photographs taken at his place of work (British Steel) and old football programs (Sheffield United supporter). Bill was such an interesting patient. We agreed that he could stay for five days if necessary, in order to allow his wife some respite.

Bill's wife visited daily and was thrilled to see that her husband was settled and enjoying his time with us. The staff provided a laundry service for Bill's clothes to enable his wife to rest at home.

At the end of Bill's stay we were able to organise Social Services so that his wife had the support needed.

We found it to be a wonderful experience for Bill, his wife and the staff. There was a great sense of achievement and we were able to contribute to a truly good outcome for both the Bill and his wife.

Changes – no changes needed to be made to the patient pathway, although we are always prepared and open to make changes. We continue to raise awareness by promoting Dementia Friends and delivering dementia training.

Devizes NHS Treatment Centre

Details of last years local quality priorities

Our aims for 2016 were to focus on the following key areas:

1. Monitoring of safer staffing to minimise the risk of adverse outcomes to our patients
2. Achieving Joint Advisory Group Accreditation in Endoscopy
3. Further development of multi disciplinary working within our teams to expand our involvement within achieving patient centred care.

Safer Staffing

In order to provide safe patient care it is essential that each department is adequately staffed at all times, to ensure we achieve this we have implemented Red Flag Report (this is our opportunity re review data and results within a multi disciplinary environment) to enable us to quickly identify if there is a concern regarding staffing.

The Red Flag Report looks at our achievement in the following areas:

- Responsive to care – response to call bells
- Fundamental care needs – responding to prompt pain relief and early mobilisation. .
- Vital sign monitoring – monitoring for early detection of a patient’s early deterioration.
- Medicines administration – review of any errors or omissions which have occurred.
- Staffing – reviewing the use of agency, staff skill mix or missed breaks and excessive sickness or overtime.

How we monitored progress

Our teams meet regularly to discuss safer staffing - we look at actual nursing staff in post as a proportion of our total staffing numbers. We also look at current staffing in relation to the number of planned patients to ensure we have the correct ratio of nurses to patients.

We undertake a monthly review of the locally agreed safety parameters across the hospital environment with an increased focus on our inpatient ward.

The focus is to identify any issues which have been flagged up in that month and may reflect on any clinical or adverse outcomes to patients and to discuss how they could have been prevented.

We compile a monthly Red Flag report which covers the following areas:

- Patient Safety parameters: staffing levels and the skill mix of the team; nursing observations; falls risks including pain management; pressure sores and access of ambulatory equipment.
- Any incident affecting:

  a) the patient i.e. falls, inadequate pain management, medication administration errors

  b) nursing levels on a shift (not staffed according to staffing module) and the levels of nursing at the time when an adverse event is documented.

At our monthly meetings the senior nurses discuss the report information and review any incident reports that month and identify any predisposing factors within their department areas and put in place actions to minimise the risk of future incidents occurring again.

Achieving Joint Advisory Group Accreditation in Endoscopy

We have been offering an Endoscopy service at the treatment centre for the past 6 years and have routinely submitted data to JAG regarding our outcomes

Our Endoscopy department have achieved high clinical outcomes and high patient satisfaction

How we monitored success?

We changed the layout of the building to include a new admission room. Once completed along with a new patient route throughout admission and procedure increased levels of privacy and dignity were achieved.

Our new facility has been inspected by the JAG assessors and has achieved full accreditation with no recommendations for further action – this is a very positive result.

We continue to monitor patient feedback to ensure the quality of our service is maintained at its highest level.

Multi Disciplinary Working

In order to ensure our patient journey from referral to discharge is as smooth and straight forward as possible we have entrenched a culture of multi-disciplinary working across the treatment centre.

Our culture ensures that any decisions which affect the patient journey and our internal processes are taken following full consultation with teams throughout the organisation – from our administration departments to our Consultants.

Our aim in fully embedding the multi-disciplinary culture was to ensure each department was considered in any potential changes or new initiatives, this allows us to keep the full patient experience in mind when improving our services.

We also wanted to ensure we could pro-actively plan for patients with increased needs, our Multi-Disciplinary team meetings allow us to plan a patient's journey before they arrive for their appointment.

How we monitored progress

The results of our Multi-Disciplinary team meetings are reviewed monthly and are shared at our Clinical Governance Meetings to ensure any learning's can be disseminated to the whole team.

Devizes Treatment Centre	Local results	National results
Proms Data Improved Outcomes Groin Hernia Varicose Veins	April 2014 to March 2015 finalised Data 53.8% 58.8%	50.7% 39.2%
VTE Compliance - audit looks at the percentage of patients screened for VTE risk	100%	No national results or benchmarking available.
Complaints	October 2015 to September 2016 5 – this equates to 0.03% of patient episodes	
Incidents	1 Dental procedure on a wrong tooth which was rectified the following day.	99.3

Devizes' priorities for 2017

Our aims for 2017 are to focus on the following key areas; these correspond with some of the quality targets set for us by commissioners:

1. Working to improve the health and wellbeing of our employee through a greater understanding of their perceptions and needs within their roles.
   - We aim to undertake two employee surveys over a two year period; the first will gauge and benchmark our current position on how staff view these areas of musculoskeletal health and stress in the workplace. This will enable us to take any relevant action to help improve this position.
   - We will then undertake a further survey and hope to see an improvement of at least 5% on the previous results.
   - We hope to also see a reduction of employee absence within the specific areas of musculoskeletal health and stress in the workplace.
2. Raising the profile of our initiatives around individualised patient centered care with a focus on patients with varying mental health requirements (this initiative corresponds with work across the NHS on parity of esteem).
   - Our aim is to provide an additional employee training programme focusing on the varying needs of patients' mental health issues.
   - The training programme will be rolled out to all staff across the centre over the course of the year – our aim is to achieve an attendance rate of 95%.
3. Working to protect our patients and visitors through minimising the risk of contracting influenza whilst visiting our centre – we aim to do this through increasing our staff uptake of the influenza vaccine.
   - Our aim is to increase vaccination to at least 75% of our staff in the lead up to the flu season. We will do this through education of staff around the importance of vaccination and ensuring ease of access to vaccination clinics throughout the working day.
   - We will hope to see a continuing decrease in our absence level throughout the winter period in comparison with previous years.
   - All patients to respond to requests to use the hand sanitisers on admission and throughout their visit.
4. Improve ease of access for both patients and referrers to our service through ensuring all Out-patient clinic appointments are available to book electronically on the Electronic Referral System.
   - All out-patient clinics will be published on the electronic system and waiting times will be kept as low as possible to ensure maximum choice for patients is available.

- This will apply to all of our specialties with the exception of oral surgery as the electronic system is currently not in use within dental practices.
- A greater number of GP's will include Devizes on their top 5 provider list.

Patient Story

Patients attending for diagnostic procedures within our Endoscopy Department often feel nervous and anxious. This anxiety is unpleasant for the patient and can also have a negative impact on the clinical procedure.

Our team work hard to alleviate this anxiety and try to take each patient's individual needs into account.

During a pre-assessment phone call ahead of an endoscopy procedure Michael mentioned his high levels of anxiety regarding his appointment.

It was identified that Michael enjoyed music and found it to be relaxing.

The team therefore agreed to play his favourite music throughout the duration of the procedure.

Michael was delighted with how smoothly the procedure went and how willing to accommodate his needs the team were.

Emersons Green NHS Treatment Centre

Details of last years local quality priorities

Our aims for 2016 were to focus on the following key areas:

1. Monitoring of safer staffing to minimise the risk of adverse outcomes to our patients
2. Enhancing our approach to maximise Privacy and Dignity of our patient's experience.
3. Further development of multi disciplinary working within our teams to expand our involvement within achieving patient centred care.

Safer Staffing

In order to provide safe patient care it is essential that each department is adequately staffed at all times, to ensure we achieve this we have implemented Red Flag Report (this is our opportunity re review data and results within a multi disciplinary environment) to enable us to quickly identify if there is a concern regarding staffing.

The Red Flag Report looks at our achievement in the following areas:

- Responsive to care – response to call bells
- Fundamental care needs – responding to prompt pain relief and early mobilisation. .
- Vital sign monitoring – monitoring for early detection of a patient's early deterioration.
- Medicines administration – review of any errors or omissions which have occurred.
- Staffing – reviewing the use of agency, staff skill mix or missed breaks and excessive sickness or overtime.

How we monitored progress

Our teams meet regularly to discuss safer staffing - we look at actual nursing staff in post as a proportion of our total staffing numbers. We also look at current staffing in relation to the number of planned patients to ensure we have the correct ratio of nurses to patients.

We undertake a monthly review of the locally agreed safety parameters across the hospital environment with an increased focus on our inpatient ward.

The focus is to identify any issues which have been flagged up in that month and may reflect on any clinical or adverse outcomes to patients and to discuss how they could have been prevented.

We compile a monthly Red Flag report which covers the following areas:

- Patient Safety parameters: staffing levels and the skill mix of the team; nursing observations; falls risks including pain management; pressure sores and access of ambulatory equipment.
- Any incident affecting:

  a) the patient i.e. falls, inadequate pain management, medication administration errors

  b) nursing levels on a shift (not staffed according to staffing module) and the levels of nursing at the time when an adverse event is documented.

At our monthly meetings the senior nurses discuss the report information and review any incident reports that month and identify any predisposing factors within their department areas and put in place actions to minimise the risk of future incidents occurring again.

Privacy and Dignity

Our teams work hard to ensure the privacy and dignity of our patients is maintained throughout their treatment with us.

In order to ensure the high profile of Privacy and Dignity across our treatment centre we have implemented a new Dignity Champion role. The focus of the role for a staff member was to review all of our processes and pathways to ensure privacy and dignity was not compromised at any point of care.

Privacy and dignity forms part of the government's strategy, Essence of Care. This strategy was implemented in 2009 as a way to standardise fundamental aspects of nursing care across all providers of health care.

How we monitored success?

We developed a training programme based on The Skills for Care Dignity Standards and Standard seven of the Care Certificate. Staff learning was assessed at the end of the short course.

Dignity Leads observe their departments and report on a quarterly basis regarding any findings or learnings. We use the Essence of Care tool for Privacy and Dignity to monitor current practice and then repeat the same data collection exercise (qualitative information) to review where and what improvements have been made within both patient and staff experience/ knowledge and understanding.

Multi Disciplinary Working

In order to ensure our patient journey from referral to discharge is as smooth and straight forward as possible we have entrenched a culture of multi-disciplinary working across the treatment centre.

Our culture ensures that any decisions which affect the patient journey and our internal processes are taken following full consultation with teams throughout the organisation – from our administration departments to our Consultants.

Our aim in fully embedding the multi-disciplinary culture was to ensure each department was considered in any potential changes or new initiatives, this allows us to keep the full patient experience in mind when improving our services.

We also wanted to ensure we could pro-actively plan for patients with increased needs, our Multi-Disciplinary team meetings allow us to plan a patient's journey before they arrive for their appointment.

How we monitored progress

The results of our Multi-Disciplinary team meetings are reviewed monthly and shared at our Clinical Governance Meetings to ensure any learning's can be disseminated to the whole team.

Emersons Green Treatment Centre	Local results	National results
National Joint Registry (NJR) - procedures recorded for this hospital are: Hips 90 day mortality Hip Revision Rate	Data for 1 April 2003 - 31 July 2016 0.22 0.66	1.0 1.0
National Joint Registry (NJR) - procedures recorded for this hospital are: Knee 90 day mortality Knee Revision Rate	Data for 1 April 2003 - 31 July 2016 0.67 1.0	1.0 1.0
Patient Reported Outcome Measures (PROMS) Groin Hernia Hip Primary Hip Revision Knee Primary Varicose Veins Primary	April 2014 to March 2015, finalised data, April 2015 Improved Outcomes 38.6% 98.3% 100% 97.4% 82.5%	April 2014 to March 2015, finalised data, April 2015 Improved Outcomes 38.1% 97.3% 85.7% 93.8% 82.5%
VTE Compliance - Monitors the number of patients screened for VTE	100%	No national figures available
Complaints	October 2015 to September 2016: 20 – equivalent to 0.04% patient episodes	
Serious Incidents	1 Late diagnosis of an infection which required further treatment at another hospital 1 foot drop 1 delayed diagnosis (gynae)	

Emersons Green's priorities for 2017

Our aims for 2017 are to focus on the following key areas; these correspond with some of the quality targets set for us by commissioners:

1. Working to improve the health and wellbeing of our employee through a greater understanding of their perceptions and needs within their roles.
    - We aim to undertake two employee surveys over a two year period; the first will gauge and benchmark our current position on how staff view these areas of musculoskeletal health and stress in the workplace. This will enable us to take any relevant action to help improve this position.
    - We will then undertake a further survey and hope to see an improvement of at least 5% on the previous results.
    - We hope to also see a reduction of employee absence within the specific areas of musculoskeletal health and stress in the workplace.
2. Raising the profile of our initiatives around individualised patient centered care with a focus on patients with varying mental health requirements (this initiative corresponds with work across the NHS on parity of esteem).
    - Our aim is to provide an additional

employee training programme focusing on the varying needs of patients' mental health issues.

- The training programme will be rolled out to all employees across the centre over the course of the year – our aim is to achieve an attendance rate of 95%.

3. Working to protect our patients and visitors through minimising the risk of contracting influenza whilst visiting our centre – we aim to do this through increasing our employee uptake of the influenza vaccine and increase patient awareness in how they can assist in preventing the spread of infection.

- Our aim is to increase vaccination to at least 75% of our staff in the lead up to the flu season. We will do this through education of staff around the importance of vaccination and ensuring ease of access to vaccination clinics throughout the working day.
- We will hope to see a continuing decrease in our absence level throughout the winter period in comparison with previous years.
- All patients to respond to requests to use the hand sanitisers on admission and throughout their visit.

4. Improve ease of access for both patients and referrers to our service through ensuring all Out-patient clinic appointments are available to book electronically on the Electronic Referral System.

- That all out-patient clinics will be published on the electronic system and waiting times will be kept as low as possible to ensure maximum choice for patients is available.
- This will apply to all of our specialties with the exception of oral surgery as the electronic system is currently not in use within dental practices.
- A greater number of GP's will include Emersons on their top 5 provider list.

Patient Story

We received a referral for an endoscopy procedure. During the triaging of the referral it was identified that Olga had learning difficulties and was known to demonstrate challenging behaviour.

A multi-disciplinary team meeting was convened to discuss the referral and implement an individualised care plan for Olga to ensure a good patient experience and a good clinic outcome.

The following measures were implemented:

- Olga and carer were invited to visit the department prior to the day of the procedure to meet the team and view the environment to relieve anxieties that may have presented.
- We ensured that all members of the team were aware of the importance of the use of accessible language throughout the visit and on the day of the procedure.
- We discussed with the Olga and her carer ways to manage anxiety. Music was identified as a key factor in this so it was arranged that the Olga's favourite music would be played throughout the procedure.
- On the day of the procedure the Olga's carer remained present throughout the sedation process and was again present in the recovery area to provide emotional support and familiarity.
- Olga's appointment was scheduled at a specific time of day appropriate for her to ensure that he felt calm and relaxed throughout the total experience.

The procedure went very well and both Olga and her family were delighted with the outcome and the efforts that had been made to ensure the best possible experience.

North East London NHS Treatment Centre

Details of last years local quality priorities

What are we were trying to improve

We have been trying to improve an ongoing local measure which gives us an indication of our success:

Friends and Family Test score in all departments.

There was a lack of consistency with our Friends and Family scores and response rates and we set out to improve the consistency of our data collected and through a process of ongoing improvement raise the standard of our data collected.

Why we are trying to improve

This measure is reportable to the HSCIC and gives us an indication of our success; The Friends and Family Test score is a measure for us that is indicative of our employees performance.

How we monitored progress

We collated data at the end of every month and presented this at our Quality and Governance meeting and feedback to all employees.

Friends and Family Test Score Outcomes

		April 16	May16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17
Inpatient Friends and Family Test - Would recommend %	ISTC - 99% NHS - 94%	96%	100%	100%	100%	100%	98%	100%	97%	100%	100%
Inpatient Friends and Family Test - Response rate %	>50%	68%	59%	60%	33%	88%	80%	91%	45%	100%	100%
Daycase Friends and Family Test - Would recommend %	ISTC - 99% NHS - 94%	99%	97%	98%	97%	96%	97%	98%	100%	99%	99%
Daycase Friends and Family Test - Response rate %	>50%	89%	90%	98%	93%	97%	100%	89%	87%	96%	99%

NEL Treatment Centre	Local results	National results
NJR	The consent rate for North East London Treatment Centre in 2016 was 100%	Nationally the consent rates for NHS providers is 92% And independent providers is 95%
PROMS	100% of hip replacement patients stated that their condition had improved	Nationally 97.8% of hip replacement patients stated that their condition had improved
VTE	Quarter 2 2016-17 July-Sept 2016 99.81%	Quarter 2 2016-17 July-Sept 2016 95.51%
Complaints	A reduction of 6% in the number of complaints (2015 54 complaints and 2016 51 complaints)	Nationally there a fall of 3.8% in the number of written complaints
Incidents related to patient harm	NHS safety thermometer 100%	National average 94%

Details of next year's priorities

- There are a high number of both non clinical and clinical cancellations, and Did Not Attend (DNA) appointments. This issue leads to poor patient experience, lost slots and the fact that these patients then have to be booked into another list at a later date.
    - Cancellations and DNAs will reduce month on month

Patient Story

Received from Joan on 25th December 2015

"I have had pain in my hip for about 16 years now and had previously been to my GP about it around 2008-2009. At that time I was told to wait until I was older to have anything done to it.

Recently I did some research on the Internet and spoke to family members and friends about where would be the best place to have my hip looked into.

After doing some research on the Internet I decided I would like Mr Fabula at the North East London NHS Treatment Centre (NELTC) to assess me for a hip replacement.

I booked in to see my GP on 15th July 2015. I asked for a 'choose and book referral' to Mr Fabula at NELTC.

My doctor referred me and in early August I received a phone call from NELTC. They booked me in for a pre-assessment appointment, which can take up to 3 hours, at 11:20 am on 3rd September 2015.

I also received written confirmation of this appointment. On 3rd September 2015 upon arrival at NELTC there were no delays.

The pre-assessment includes height measurement, weight measurement, blood samples, ECG, X-ray, filling out forms regarding medical history, an appointment with the anaesthetist (with whom I agreed to have an epidural for the procedure) and an appointment with the consultant Mr Fabula.

The pre-assessment ran like clockwork, moving from room to room to see nurses, anaesthetist, consultant with only a few minutes wait between each assessment.

In view of the x-ray and clinical findings Mr Fabula offered me a total right hip replacement. NELTC wished to carry out my hip replacement within six weeks however due to work commitments I asked for this to be delayed.

My orthopaedic procedure was booked in for 12 noon on 23rd November 2015.

Monday 23rd November soon came and at 12 noon I was at NELTC. By 1:00 pm I was having my epidural and I was taken into theatre.

I remember looking at the clock in the recovery room and it was 3:10 pm. My procedure was done. By 4:00 pm I was back in my bed on the ward eating toast with family members around me.

Next I was asked what I would like of the menu for dinner; dinner was served about 6:30 pm.

The next important thing was to get my waterworks to kick back in.

This happened slowly at first around about 10 or 11 pm but got better as the night went on.

At all times the team at NELTC were attentive and made sure I was comfortable."

Peninsula NHS Treatment Centre

Details of last years local quality priorities

What are we trying to improve?

Response to calls to the patient 24hr Clinical helpline.

Why we are trying to improve?

A number of patients had indicated that calls made to the helpline had not been answered and the patient had to seek assurances elsewhere.

How we monitored progress

Initially we audited the helpline call monthly and monitored the calls made. We found that a number of calls were not answered as messages had been left on the answer phone and not actioned. Also calls to the admin team for appointments and booking were coming through the clinical helpline. In addition a number of calls were received from patients with general enquiries about the centre and pre-operative questions.

We employed a Senior support nurse to answer the calls during the core hours of the day.8-5, and gave training to the ward Registered Nurses to answer calls out of hours and direct to the most appropriate person for action. The Senior support nurse audited all calls and discussed themes at monthly Quality governance meetings. We also changed the information given to patients in Out Patient Department (OPD) and on discharge so that calls for administration or pre-operative issues were referred directly to the admin, OPD team and not via the clinical helpline.

We found that the number of patients reporting that calls had not been answered dropped significantly and the total number of calls to the helpline reduced. Continued monitoring showed that the number of admin and pre-op calls stopped.

We were also able to address the most common themes e.g. anti-embolic stocking usage and put systems in place to answer the questions asked in more detail to the patients at discharge.

Local outcomes

Jan 16-Jan17	Local results
NJR	98.5%
VTE	99.06%
Complaints	9
Incidents related to patient harm	5

Details of next year's priorities

What are we trying to improve?

- Embed the new build including the Endoscopy suite working towards and achieving JAG accreditation.
- Ensuring patients identified with a potential cancer diagnosis at Endoscopy are referred to cancer 2 week pathway.
- Reduction in antibiotic prescribing for patients identified with suspected Urinary tract infection (UTI).
- Improved discharge planning. >60% of patients are currently discharged in the afternoon and this has an impact of bed capacity.
- Day one mobilization of >75% of patients to ensure timely discharge.

What will success look like?

- A fully functioning, compliant Endoscopy suite and pathway that is JAG accredited
- Patients referred on the day of procedure and seen within 2 weeks by an appropriate Consultant.
- Patients with confirmed UTI treated with antibiotics.
- Patients discharged in a timely fashion with >75% of patients discharged home before 12 noon. Dedicated discharge nurse co-coordinator.
- >75% of patients for hip and knee arthroplasty are mobilised on day 0.

How will we monitor progress?

- The Theatre Manager and Endoscopy lead nurse to oversee the process and ensure milestones are achieved as per requirements of JAG.
- Spreadsheet kept of all patients referred to cancer 2 week pathway to ensure care is received in a timely fashion.
- Reporting of all suspected infections, overseen by the Infection Prevention and Control lead and patients with confirmed infection only treated with appropriate antibiotics. Review at Antibiotics stewardship meetings quarterly.
- Ward Manager to oversee discharge times and collated data in a locally agreed format.
- Physiotherapy lead to oversee day 0 mobilisation and collate data in a locally agreed format. To feedback achievements and actions at QG meetings.

Patient Story

Adam was a gentleman who was to be admitted for joint replacement during May.

He was known to have some degree of learning difficulties and lived with his carers Mr and Mrs B. They had employed him to help out at their guest house, subsequently he was invited to live with them and from this time he called Mrs B "mum". Previous to this Adam was living in an institute for the mentally infirm and he did not have any parents as they had given him up at birth.

Prior to his admission Adam's needs were discussed with the triage nurse and Mr and Mrs B so that his stay within the unit would be as smooth as possible. A side room was arranged for him and an extra bed was made available for his "Mum" to stay with him, if he became anxious.

Both Mr and Mrs B also had rooms booked in a nearby hotel. They were both keen to be very involved in Adams care so were allowed to have free access to the ward as and when they needed and were issued a patient passport.

Adam had never had any major surgery; his carers wanted this to be a positive experience for him so that if he needed any further hospital admissions he would not be afraid.

Adam was admitted for a total knee replacement procedure; Mrs B stayed with him throughout his admission and explained everything to him in simple terms so that he was able to understand exactly what would be happening to him.

She was there on the ward when he returned from theatre and was available to go into recovery had she been needed. Both her and Mr B were able to stay with Adam later than most visitors and were grateful that we had accommodated both Adams needs and theirs. As he settled well into the ward environment they did not stay the night with him, but were "on call" at the local hotel.

Adam had an unremarkable recovery; mobilised well and reached all physiotherapy goals. His pain was well controlled, his vital signs were stable and he was able to easily do everything asked of him. He needed additional time but the ward team ensure he had everything he needed.

His carers were involved in all aspects of his care and were shown how to look out for any skin issues, infection, Deep Vein Thrombosis (DVT). They were able to encourage Adam with his physiotherapy and were also taught how to continue administering his medication post discharge.

As the family were re-locating away from the area the family had organised a 2 week stay for Adam in St Austell community hospital whilst they moved.

Mr and Mrs B were very impressed with the way the Peninsula made everything easy for them and Adam during his stay, especially the fact that plans were made for them to be with him 24 hours a day if there was a need.

They found the centre to be a very caring and welcoming environment with all of his needs taken care of, making the whole experience for them and Adam, a positive and happy one.

Shepton Mallet NHS Treatment Centre

These quality objectives have been discussed and agreed with the CCG – they are combined set reflecting local Somerset-wide and Care UK priorities. Three have been locally developed to reflect actions following variant clinical outcomes.

Details of last year's local quality priorities

- Antimicrobial stewardship programme
- Introduction of pre-operative multi-disciplinary meetings for patients with a prolonged pathway or chronic conditions which require management prior to admission
- Acute Kidney Injury (AKI) risk assessment tool
- Introduction of risk assessment to reduce routine catheterization of patients - receiving spinal anaesthesia
- Implementation for the Local Safety Standards for Invasive Procedures (LocSSIPs)
- ISO accreditation for Quality ISO 9001 – achieved with no non-conformities
- JAG re-accreditation for 5 years - achieved
- Renewal BSI Quality Management System 13485:2003 and EN ISO 13485:2012 accreditation for decontamination

What are we were trying to improve (last year):

- Reduction in the usage of antibiotics to reduce the antibiotic resistance – antibiotic audit introduced. All reviewed at Antibiotic Stewardship meetings
- The cancellation of patients on the day of surgery through pre operative management/the transfer of care sooner to reduce the patients referral to treatment time – MDT's introduced
- To identify patients pre operatively who would be at greater risk of AKI post operatively – AKI risk assessment created by consultant anaesthetist
- To reduce the impact of unnecessary invasive procedures on suitable patients, Urinary Tract Infections (UTIs)

Local outcomes

Jan 16-Jan17	Local results
PROMS (See below)	99.8% THR/TKR
Complaints	15 formal
Compliments	248 formal
Incidents related to patient harm-(202 incidents reported all categories)	1 patient incident which caused actual harm – a skin tear following a fall.

Details of next year's priorities (on site)

- Clinical frailty – continuation Rockwood score deviation from Care UK corporate policy and in line with Commissioner requirements
- Dementia strategy – more work on environment, additional training
- Medication intervention reporting
- Participation in VTE committee
- Commencement of anaesthetist led pre-assessment clinics for complex patients with multiple comorbidities and patients who are taking anti-coagulants/anti-platelet medication.

What are we trying to improve?

- Individual care planning for all patients attending Shepton Mallet Treatment Centre – particularly patients over 75 who are risk assessed at their first Out Patients appointment for clinical fraility and dementia.
- Relationship with GPs – introducing signposting to community services third sector via increasing knowledge through members of the Community Participation Group in line with Five Year Forward View national objectives and the post of Health Care Co-ordinator – a joint venture with Health Connections.

Patient Story

When marathon running and cycling policeman, Daniel Bishop, 41, from Taunton experienced pain while out running, he thought it was simply groin strain.

However, the pain became progressively worse to the point where he was unable to walk let alone run any distance, carry out his operational duties as a police officer or even sleep at night. He went to his GP who referred him for an x-ray at Musgrove Park Hospital.

"I first saw my doctor at the beginning of August and I had the x-ray the following day. The very next day after that I began physiotherapy, said Daniel. "It was the physiotherapist referred me to an Orthopaedic Assessment Centre in Taunton who in turn referred me on to see an Orthopedic Consultant at Shepton Mallet NHS Treatment Centre where it was decided that I would need a hip replacement – unusual for someone of my age but there was no other option."

Daniel had his surgery at Shepton Mallet NHS Treatment Centre on 19th December.

"It was the first time in my life that I had stayed in hospital and my first operation," said Daniel. "I was understandably anxious, but from the moment I got to Shepton Mallet NHS Treatment Centre I felt so relaxed, the staff were fantastic."

At his first outpatient appointment Daniel discussed his treatment with his consultant. "I was able to speak about my life and my work and take into account my occupation when deciding what was best for me."

As a consequence Daniel received a ceramic hip and plastic socket, which is a combination better suited to deal with impact and which will allow Daniel to return to work once his convalescence is over.

Daniel is delighted with the results of his operation and the care he received from Shepton Mallet NHS Treatment Centre said: "I have gone from experiencing acute and chronic pain which leads to feeling permanently exhausted, to no pain and feeling confident about getting active again. As someone who ran and cycled it has been immensely frustrating not to be have been able to do those things. I know that my marathon running days are over but I am really looking forward to getting back on my bike and to taking our two dogs for long walks again."

He added: "I've been telling everyone about how great the treatment was from Shepton Mallet NHS Treatment Centre. The staff are fantastic, as is the catering. You're given plenty of time by everyone which made it feel more like I was staying at a friend's house than being in hospital. I felt completely at ease during my stay and never felt worried or has reason to feel embarrassed in any way. I loved the fact that what I do for a living was taken into account when my treatment was planned. It was good too to be able to get the operation relatively quickly, for it means I can be back at work sooner rather than later. I feel very fortunate to have had my surgery at Shepton Mallet NHS Treatment Centre."

Southampton NHS Treatment Centre

Details of last years local quality priorities

What are we were trying to improve?

- Safety procedures for oral surgery pathway
- Groin hernia PROMs
- AKI (acute kidney injury) provision of care and prevention
- Implementation of multifactorial assessment to identify patient's individual risk factors for falls
- Sepsis Pathway

How we monitored progress

- Local procedural teams engaged to develop Standard Operating Procedures (SOP) for Oral Surgery pathways: action plan log, ongoing implementation of monitoring framework embedded in to standard monitoring, going forward.
- In line with PROMs database publications.
- Acute kidney injury (AKI) – training of staff, and audited AKIs reported
- Falls – education, audit and monitoring risk assessments
- Auditing sepsis against NEWS scoring system, and implementation of sepsis tool

Local outcomes

	Local results
AKI	Improved recognition and early management. Over 95% of appropriate staff trained on AKI.
Falls	Implementation of risk assessment tool for at risk patients. No high harm falls.
Sepsis	Implementation of sepsis tool, audit tool in place, high attendance on training sessions and awareness displays in place.
Complaints	Complaints well managed, average 3.5 per month (0.28% of activity in 2016), these are themed and analysed. Trend downwards.
Incidents related to patient harm	Never events – actions, HF and monitoring framework.

Details of next year's priorities

What are we trying to improve?

- Reporting of near miss and no harm events with corresponding reflection and learning
- Full LocSSIPs implementation and monitoring in line with NatSSIPs framework
- Influenza uptake
- Suggested – 'My name is..' audit
- Handover processes, including a daily safety briefing

Patient Story

Tonsilectomy carried out 2 December 2016

Patient was anxious upon arrival for her operation due to a previous bad experience at another facility. Patient states the care and compassion shown to her was over and above her expectations.

The post-operative care was also outstanding. Patient also noticed how united the staff were, working together as a team, in good humour.

They all helped each other with lots of praise and thanks being exchanged between each other which also enhanced the patient's experience.

The actions of the staff helped reinforce to the patient that the values she thought had been lost within the NHS do still exist.

St Mary's NHS Treatment Centre

Details of last years local quality priorities

Over the past year there have been many new initiatives that have helped to improve the quality of care we provide to our patients and improve the patient experience as listed below.

We remain focused that our patients should be and are, at the heart of everything we do.

Pre-op calls by Health Care Assistant's (HCA)

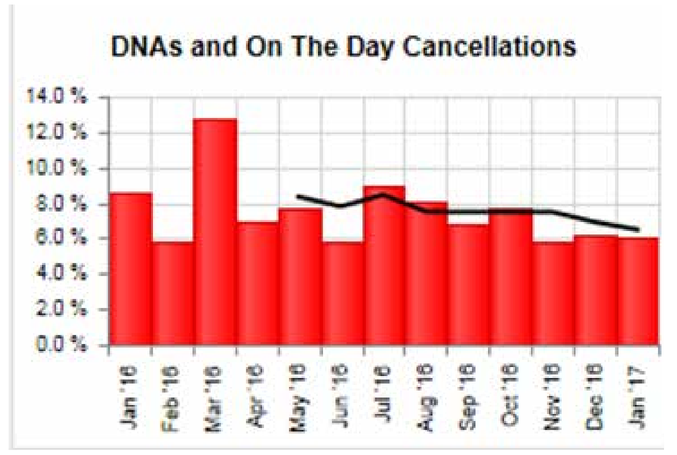
This was previously undertaken by administration staff and the change has resulted in a reduction of DNAs, cancellations and improvement of patient experience

Working on the premise that patients would prefer, prior to their clinical procedure, to talk to a clinician about what to expect via the pre-op call process, the centre introduced Health Care Assistants within this role.

This has helped to support patient care with HCA's being more experienced to identify and flag clinical concerns on behalf of the patient and works to reduce clinical cancellations and DNAs.

The reduction of clinical cancellations and DNAs ensures that the patient receives treatment at the earliest opportunity and allows us to run efficient lists to support the care of the local community with good wait times.

Below shows the DNA and On The Day cancellation data extracted from the internal Pisces effectiveness tool.

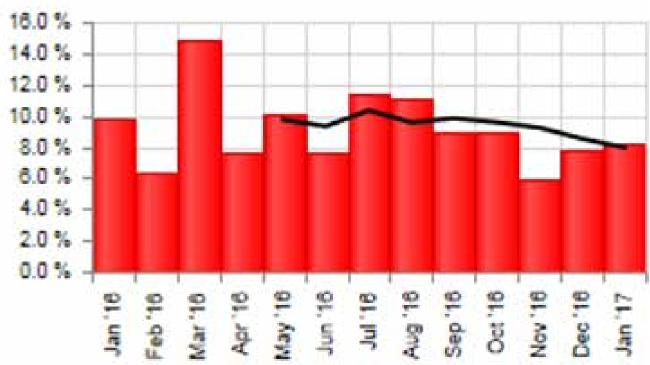


Endoscopy Anxiety Score

The Endoscopy anxiety score was introduced to combat the higher levels of cancellations and DNAs for this specialty. Patients scoring high on the score when they undergo their pre-operative phone call are passed to the Endoscopy Lead Nurse, who is able to contact the patient again and discuss their concerns in order to provide the reassurance needed.

It cannot be underestimated the importance of being able to speak to a staff member who really understands and knows the clinical process. This, we consider, has really helped to reduce the anxiety levels of patients who undergo this evasive and sometimes intimate procedure.

It is important that patients have this diagnostic procedure at the earliest opportunity to decide on the pathway of care needed. Whilst we are not a cancer pathway, this is identified for some patient on a frequent occurrence. The reduction of DNA's supports timely patient care which is something we are passionate about.



Patient Forum and Joint Patient Forum

The Patient Forum was reintroduced at the centre to further engage with the general public and meets quarterly to discuss the service and oversee the patient experience by reviewing complaints and compliments. This year we have been able to 'join forces' with the Southampton Patient Forum to exchange ideas and understand the local differences of the area in which they serve. This exchange of information has been invaluable and we have changed how our Patient Forum undertakes its role in a more focussed way.

A recent visit to the Joint Forum in September 2016 by the Head of Governance and Quality in Secondary Care really cemented the importance of their role in advocating for patients. Members of the forum have supported the Centre at the Open Day in February 2016 and marketing events that 'fly the flag' for the local services we provide. Future priorities include members becoming more involved in the Patient Satisfaction Survey, and this forum is planned to continue through the coming year.

Optometrist training and Optometrist Forum

The first Optometrist Forum was held in January 2016 and has gone from strength to strength. This improved collaboration with our important community referrers, supported by our two Consultant Ophthalmologists and Ophthalmology Team and incorporates Clinical presentations on a range of ophthalmic disorders. It has united and supported these often isolated clinicians. This has been further enhanced by the organising of clinical visits / observational sessions by local Optometrists into the Centre, which supports their Continuing Professional Development.

The aim here is to share our learnings, provide education and provide confidence to the referrer to enable them to refer to the service ensuring the growth of our ophthalmic service. Feedback is very positive and these forums are well attended with an increase of referrers attending. These are held in the evening to maximise the opportunity for the referrer to attend.

Introduction of Clinical Educator Role

The introduction of the Clinical Educator that covers both sites delivering bespoke training to the needs of the service has without a doubt improved focus on the continuing support and education of our clinical staff members. This has supported and improved morale, motivated individual clinicians and is supported by Clinical Leads and an essential part of Continuing Professional Development. Without a doubt this improves the quality of care the clinicians provides to their patients.

Local outcomes

	Local results	National results
NJR	N/A	N/A
PROMS	96% (3 QTRS)	74.5%
VTE	100%	96%
Complaints	2016 - 97 complaints 0.09% of Activity	
Incidents related to patient harm	16 (incl. 1 SIRI) 0.01% of Activity	

Details of next year's priorities

X-ray Equipment

To replace with up to date technology the X-ray equipment used at St Mary's and Havant Diagnostic Centre to ensure safe, effective and reliable service, ensuring the highest quality of images are provided to aid patient diagnosis .

This will be project managed by the supplier of choice with Care UK ensuring a team of expertise also support this project to provide a seamless transistion. The image quality and subsequent diagnosis will be testament to the investment made here.

Navigation systems in Minor Injuries Unit (MIU)

This system has been introduced to ensure the safe and effective assessment of patients by a Nurse Practitioner in the Minor Injuries/Illness Unit at St Mary's NHS Treatment Centre and involves nurse intervention prior to checking in with the reception staff.

This will ensure patients are correctly assessed within the KPI timeframe and appropriately directed to the appropriate clinician from the first initial contact of the patient attending the department. This will provide the safest assessment process to date at St. Mary's Treatment centre.

Introduction and continuation of transferred activity or additional specialties being provided at the centre

Our focus will remain on providing high quality care to the local community. We currently have the opportunity to provide transferred activity in orthopedics, endoscopy, colorectal, general surgery and urology. By the 1st April it is proposed that all urology referrals will be received at the centre for us to triage in the first instance.

KPI performance, referral patterns, internal and external audits, trained staff, will validate the high quality of care being provide and will provide opportunity to address any issues that present.

Documentation live audit and review of transfer of care documentation in MIU

This review will look at the quality of documentation within the Minor Injuries Unit at St Mary's NHS Treatment Centre, looking at LIVE data and assessing the quality of that information and whether it is safe and effective for purpose.

This is due to start mid February 2017. All transfer of care documentation will also be reviewed, to ensure the quality of that information and appropriateness of transfer and if necessary produce action plans to assist the continual improvement process through training and support.

Patient Story

Graham was due to come in for an Endoscopy procedure, he had some mental health issues and some severe anxieties.

Graham felt unable to attend and undergo the procedure and phoned the centre to cancel the appointment.

It was due to the compassionate and sensitive approach by the whole team from the schedulers, administration colleagues and clinical staff that extra care and support was put in place.

Graham was able to attend the Centre before the procedure date, in order to meet some of the team and be showed around the building. From that time on the team took full respo

nsibility to make sure he felt able to attend. The team met him on arrival for the procedure and supported him directly on to the Wards. Graham was positioned first on the Theatre list and he was able to have his procedure successfully.

The personal touch by one our Patient Administrator Supervisor alerted her to ask the right questions and discuss with Graham and the team to ensure the care package provided for him was appropriate, empathetic and understanding.

Communication being the key- the guiding principle being if the centre are aware of potential difficulties, subtle temporary changes can be made to help patients who may need extra support.

Will Adams NHS Treatment Centre

Details of last year's local quality priorities

What are we were trying to improve

The CQUIN which we were allocated for 2016/17 was improving the health and wellbeing of staff by uptake of the flu injection. Our aim was to protect our service users from the flu and our colleagues.

How we monitored progress

Clinics were set up on 2 convenient days for staff to receive their vaccination and staff booked themselves an appointment. Extra days were added for staff who were unable to attend the first dates. Promotional material was used throughout the centre to encourage staff to have the injection. Verbal encouragement was also given and members of staff were given the opportunity to discuss any concerns.

Reminders were given at Unit Meetings, Head of Department meetings and Ward and Theatre Meetings. The Infection Control Lead discussed the benefits of having the injection at the mentioned meetings. The data was submitted to Care UK and the CCG.

Local outcomes

	Local results
VTE	Apr 99.4% May 98.7% June 99.6% July 99.1% Aug 99% Sept 98.3% Oct 99.5% Nov 99.8% Dec 99.6%
Complaints	6 complaints were received in 2016. All were responded to within 3 & 20 days they were all first stage. We are waiting for the results of the recent (Jan 2017) CCG audit however we were informed at the time that there were no concerns.
Incidents related to patient harm	There were 2 incidents which involved a leur lock syringe and needle which became separated causing injury to the patients eye. There was one incident where an expired lens was inserted into the patients eye.

Details of next year's priorities

Discussions are underway with the CCG to identify key priorities for the coming year.

Patient Story

When Mrs Joyce Sutherland received an unexpected double diagnosis of Wet Age-related Macular Degeneration (Wet AMD) and cataracts from her trusted family optician at Burnett, Hodd & Jenkins, in Sidcup, she listened to his advice and opted to use the Will Adams NHS Treatment Centre in Gillingham, Kent, despite the 50-mile round trip.

"He explained that the Consultant Ophthalmic Surgeon at the centre, Mrs Mahboub Hawkes, had an excellent reputation in the treatment of both conditions - and the centre also had very short waiting times," she explained.

Wet AMD can develop very suddenly and it can only be treated if caught quickly. A fast referral to a hospital specialist is essential.

Mrs Sutherland said: "The team at Will Adams NHS Treatment Centre were incredible, especially the nurses who were very caring and professional. They treated the Wet AMD first, putting me at ease during the series of injections into my right eye. I was very impressed by the cleanliness of the centre too and the free and plentiful parking meant the trip from Welling was not really an issue."

Once the team had treated the AMD, Mrs Hawkes scheduled the first cataract removal. She suggested operating on the right eye first: Mrs Sutherland had some sight in her left eye and so she would have some vision while the right eye healed.

The operation was a success and Mrs Hawkes scheduled the second operation. Mrs Sutherland said: "She was wonderful: she gathered from our conversations during my treatment that we had booked a holiday to Australia to see our son and she wanted to help me make the most of it. And she did: my vision cleared almost immediately. I was amazed."

Two months after her operation, Mrs Sutherland and her husband shared the 800 miles of driving as they travelled around Darwin and the Northern Territories, where her son works as an engineer.

She said: "It was incredible. Before the treatment, I could no longer drive and I had to stop teaching my regular arts and crafts group at Hall Place, in Crayford. Now I am back doing everything I love to do and it is all thanks to the team.

"To anyone who is placed in a similar situation, I can only urge them to go to their optician as quickly as possible. To lose one's sight is so debilitating and frightening. There is hope and great professionals who can help."

Mrs Hawkes said: "We were very happy to help Mrs Sutherland, who gives so much to her community with her work with older people.

"Wet AMD is a particularly troubling condition because, if it is not quickly spotted and treated, patients can be left with severe visual impairment. I am delighted Mrs Sutherland's optician so quickly diagnosed her condition and referred her to us - that played a significant part in our ability to stop the degeneration and get Mrs Sutherland back behind the wheel."

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0333 999 2570
careukhealthcare.com

All information correct at time of publication (May 2017)

HC3307 March. 17 (4726)

QUALITY REPORT & QUALITY ACCOUNT 2016/17 - DRAFT

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To be included when approved

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

Every Quality Report must contain priorities for improvement, to be achieved in the following year, in the three dimensions of quality identified by Lord Darzi:

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

These priorities are selected on the basis of feedback from our patients, stakeholders and staff, and are approved by the Trust Board.

The 2015/16 Quality Report identified the priorities to be achieved in 2016/17. A summary of the performance against each of these priorities is described below with more detail being provided in Part 3.

Priority 1: Improving Patient Safety

Priority 1.1 To develop a framework to share learning from serious incidents leading to a reduction in recurrent themes

During 2016/17 we have successfully developed and launched our Organisational Learning strategy and learning activities are now integrated in all of the clinical divisions.

Monitoring the success of the learning activities is complex but has been achieved through the bi-annual thematic review of serious incident reports. We have over the year seen a reduction in certain themes although it is felt that only twelve months is not statistically robust and improvements should be judged over a minimum of eighteen months. We believe that the target has been partially met and work will continue into the coming year.

Priority 1.2 Inpatients in community hospitals will have a venous thromboembolism (VTE) assessment on admission

We are pleased that a repeat clinical audit in November 2016 which measured current practice against the standards in NICE clinical guidance 92 'Venous thromboembolism: Reducing the risk' showed significant improvement. This audit found 92% of patients audited had a VTE risk assessment form completed on admission and 8% had the form completed at a later date. This met our target of 90% of patients having the assessment on admission and compares favourably to the previous audit results.

Priority 1.3 To reduce the number of pressure ulcers

This year there were 87 grade 3 and 4 pressure ulcers reported onto StEIS, the national reporting system for serious incidents. This did not show a reduction compared to previous years however this is not directly comparable, due to changes in the definition but we are able to evidence robust monitoring, investigating and learning processes.

Priority 1.4 Implement robust governance processes to effectively identify, manage and reduce ligature risks in all out impatient units

All inpatient sites were assessed for ligature risks between April – October 2016 with community sites assessed by February 2017. Action plans and programmes of building work were developed where necessary. All of these were closely monitored by the Ligature Management Group. The project manager supported the clinical areas to develop mitigation plans for those risks that remained.

Priority 2: Improving Clinical Outcomes

Priority 2.1 To embed care planning frameworks in our clinical services

Clinical audit results demonstrate that whilst there has been an overall increase in the numbers of patients with care plans in place, the number of patients involved in designing these has fallen in some areas. We are making good progress towards meeting this target in many areas but inconsistencies across the Trust require that we continue this improvement work into the coming year.

Priority 2.2 The physical health needs of inpatients in Learning Disability and Mental Health services are appropriately assessed, monitored and treated with action taken if there is any deterioration in physical health

This is a priority which was extremely important to the Trust and involved retraining and assessing the competency of every clinical staff member. We are very pleased to say that in January 2017, 87% of staff in adult mental health and older peoples mental health had been assessed and verified as competent to assess physical health of patients. Adult Mental Health and Specialised Services audit demonstrated that 94% of patients had a full physical health review within 7 days of admission or a reason recorded why it was not appropriate. Learning Disability services demonstrated that 72% of patients had a full physical health assessment carried out on admission. In the five cases where this was not completed but two of those cases (40%) recorded why this was not possible and the plan in place to monitor physical health.

Priority 2.3 Risk assessments and appropriate risk management plans are in place for all community and inpatients Mental Health, Specialised, Older Person's Mental Health and Learning Disability services

We are making good progress towards meeting this target in many areas but recognise this is not consistent across the Trust and that there is more still to do.

Risk assessments completed in RiO are reported via Tableau and the chart below demonstrates that levels of compliance with risk assessment completion are over 95% in all divisions, except for Adult Mental Health services. This is an improving picture from the baseline audit conducted in June 2016 when the majority of teams had compliance figures of less than 90%.

Priority 3: Improving Patient Experience

Priority 3.1 Our complaints process provides satisfaction to the complainant

We have partially achieved this indicator, meeting the target of having 90% of the standards in the 'Assurance of Good Complaints Handling' in place, but did not meet the 90% final response target.

As part of the process when someone makes a complaint, the customer experience advisor discusses with the complainant a timeframe for the complaint to be investigated and a response letter to be sent. We are disappointed that improvements made in 2015/16 were not sustained with overall 79% sent within agreed timeframes.

Priority 3.2 To involve patient and carers in the development of services

In May/June 2016 70 clinical teams completed self-assessments which mapped how they were involving patients, carers and families in services being provided. The self-assessments identified both elements of good practice and areas where increased engagement was required.

'A best practice guide to working with the people who use our services' was developed following the above self-assessment. The guide showcased examples of best practice within the Trust which staff could use as a resource to develop further the way they work with patients. It also described the different levels of engaging and involving others with a description of what 'good looked like'.

Priority 3.3 To have a strategy to reduce restrictive practice in adult mental health services

Our aim was to develop and implement a reducing restrictive practice strategy in our Adult Mental Health Services. This has been completed in part with the Safer Forum focusing on three main areas of work;

- development of a comprehensive suite of policies and documents for the wider mental health division incorporating adult mental health, specialised services and learning disabilities
- review of restraint training provided by the Trust
- liaison / relationship with the police.

There is ongoing work to implement the strategy aligned with learning from other organisations.

Priorities for improvement in 2017/18

In November 2016 a working group of Clinical Directors and Associate Directors of Nursing from all Divisions met to generate the quality account priorities for the year 2017/18. Representatives at the meeting also included information which they had gained from stakeholders, staff and patients to feed into the conversations. Also taken into consideration were the views and findings reported to us by the Care Quality Commission and Healthwatch.

It was important to the group that the priorities represented the following:

- Quality improvement work already in progress through within the Trust the Serious Incident and Mortality, Care Quality Commission and the Family Involvement action plans.
- The engagement of patient and service users in their own health management.
- The new models of care being developed through the multispecialty community provider (MCP) models.
- Reflected the views of our commissioners and linked with the annual quality contracts.

The specific detail of each priority was ascertained using a GAP analysis technique.

Priority 1: Domain - Improving Patient Safety

Improving Risk Assessments and Crisis Planning

Priority 1.1
Improvements are required to provide assurance that every patient has had their individual level of risk assessed at every stage of their journey and / or on changes to their clinical condition.

Priority 1.2
The improvement activity of 'no decision in isolation' must become a key safety feature of every multi-disciplinary meeting for the most unwell people such as inpatients, those open to Adult Mental Health teams or on shared care.

Priority 1.3

Improvements are required to ensure that patients are discharged from services with a crisis contingency plan which is individualised to their needs and shared, where applicable, with their carer or family member, general practitioner (GP) or other relevant health or social care organisations.

Why have we chosen these priorities?

Using a GAP analysis methodology these priorities have been chosen for the following reasons:

- Quality risk assessments and crisis contingency planning are a preventative safety feature of the care delivered to any patient; patients and their families must feel involved in care, and creating risk and treatment plans through joint working (co-production) is of paramount importance for true engagement and partnership working. Our engagement activities tell us that this has not always been the case and patients and their families have not always felt involved.
- A review undertaken into the factors that contributed to serious incidents highlighted poor risk assessments and crisis planning. This featured in 75% of the investigation reports. Assessing and planning care and treatment directly with patients should reduce related patient safety incidents.
- The Mazars report, *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015*, published in December 2015 recommended a principle of learning and improving from our reviews of multiple rather than isolated incidents through thematic reviews. Risk assessments and care planning have been identified as a theme in incidents therefore it is important to be recognised as a specific Trust-wide priority for improvement.
- Our commissioners are aware of some instances of poor risk assessment and crisis planning which has become apparent from their observation of our serious incidents and complaints; we have been tasked to improve in this area as a quality contract requirement.

Ambition

Every patient must have an updated and individualised risk assessment which is clearly accessible within the clinical records.

Risk assessment must be created using a holistic approach, including both physical and mental health needs and accompanied by specific care plans.

Risk assessment must evidence input from all clinical specialities involved in the individuals' care.

Risk assessments must be discussed and approved at multi-disciplinary meetings to ensure 'no decision in isolation'. The purpose of this review is to ensure that there is an activite management plan in place for each individual.

The discharge risk assessment and crisis contingency plan must be created involving the patient and carers, and a copy shared with the GP.

How we will measure and monitor progress

Progress will be measured on a monthly basis against agreed performance targets. These will include the percentage of staff being trained in how to complete a risk

assessment and crisis contingency plan. Results will be discussed at the Quality Improvement Delivery Meeting on a monthly basis and be formally monitored on a quarterly basis internally through the Quality and Safety Committee and externally at the Clinical Quality Review Meeting chaired by our Commissioners.

Priority 2: Domain - Improving Patient Experience

Self-Management Agenda

All patients and service users are actively encouraged to participate in their own care playing an active part in creating and agreeing the contents of their management plans for both mental and physical health needs.

The associated priorities are:

Priority 2.1
Every patient and service user, and their families and carers (when appropriate) must be offered the opportunity to be involved in the creation of their risk assessment, care plans and crisis contingency plans in a format that they understand.

Priority 2.2
All patients and service users are actively encouraged to manage their own health needs and are supported to do so. Where appropriate, families are involved in information gathering about patients and service users, helping to inform assessment and development of care plans and support ongoing care.

Priority 2.3
All patients and service users should play an active part in creating and approving all patient literature that is in a format that they understand.

Why have we chosen these priorities?

This priority links directly to the work supported by NHS England who state:

"People have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management is a term used to include all the actions taken by people to recognise, treat and manage their own health. They may do this independently or in partnership with the healthcare system.

We need to fully understand how self-management can improve people's health and what support people need for good self-care. NHS England has a number of projects underway to look at the best ways of approaching self-management in the NHS."

Learning Disabilities division will be taking a lead in this priority as self-management features as an aspect of importance to all of their service users.

Ambitions

There will be a framework and guidance tool to support clinicians developing crisis contingency plans with patient and carer / family input and supported by training.

All Divisions will create patient participation / involvement forums to provide assurance that patients and service users and their families are consulted on the design of plans and how they are completed to ensure there is true understanding and partnership working.

How we will measure and monitor progress

Progress will be measured on a monthly basis against agreed performance targets. Results will be discussed at the Quality Improvement Delivery Meeting on a monthly basis and be formally monitored on a quarterly basis internally through the Quality and Safety Committee and externally at the Clinical Quality Review Meeting chaired by our Commissioners. Patient and family participation forums will be supported by the Head of Patient Experience and Engagement and their activities will be reported to the Caring Group which reports to the Quality and Safety Committee.

Priority 3: Domain - Improving Patient Safety, Improving Patient Experience

Outcomes related to the Serious Incident and Mortality Improvement Action Plan

A substantial amount of work has been prioritised in 2016/17 in creating and embedding processes to meet the recommendations of the Mazars report thus improving the way we manage investigations into serious incidents and deaths. In 2017/18 it is important to be reassured that the outcome of our activities provides positive outcomes both internally and externally to stakeholders such as families and commissioners. The associated priorities are:

Priority 3.1
Families and / or patients / service users are actively encouraged, where appropriate, to participate in serious incident investigations and are supported to do so by the investigating officers and the family liaison officer.

Priority 3.2
Families and / or patients / service users receive a copy of the investigation report in all cases where it is appropriate to do so.

Priority 3.3
The views and opinions of families / or patients / service users will be gathered after the investigation has occurred to ascertain ‘just how it felt?’ as key evidence to assist improvement for future investigations.

Priority 3.4
Evidence of improvement in key areas highlighted by the serious incident investigation process will be reported quarterly to the Board through a ‘what have we done to improve’ section.

Why have we chosen these priorities?

Whilst a substantial amount of improvements in our reporting and investigation processes have been undertaken during 2016 / 2017 there is a need to ensure that improvements are not only maintained but also continue to advance. Key stakeholders wish to be assured throughout 2017 / 2018 of the continued success of the improvements. Key stakeholders requesting this priority are:

- The ‘Family First’ group
- Mortality Forum
- The Commissioners of our services (CCG’s)
- NHS Improvement
- Care Quality Commission

Ambitions

Our ambition is that families are involved in the serious incident investigation process and feel supported and informed during the process by staff who have received bespoke training from the Family Liaison Officer as part of the investigating officers course.

How we will measure and monitor progress

Progress will be measured on a monthly basis against agreed performance targets. Results will be discussed at the Quality Improvement Delivery Meeting on a monthly basis and be formally monitored on a quarterly basis internally through the Quality and Safety Committee and externally at the Clinical Quality Review Meeting chaired by our Commissioners.

Priority 4: Domain – Improving Clinical Outcomes.

The role of the community team working in partnership with General Practitioners

Within the development of the new models of care to provide 'better local care' there is a requirement that all clinical staff regardless of their employer work together to form cohesive locality driven teams to provide a quality service to all patients and service users.

Priority 4.1 Clinical and care outcomes will be improved for people with complex health and care needs, through extended multi-practitioner care teams providing integrated care locally.

Priority 4.2 Patients’ experience will be improved by a team-based approach to the delivery of their care, and holistic assessment and joint care planning to achieve their own health and care goals, and to stay independent for longer.

Priority 4.3 Safety, quality and systems will be safeguarded as shared care records and team working across organisations provides high quality evidence based care to people with complex health and care needs.

Why have we chosen these priorities?

The priority has been chosen in communication with the Chief Quality Officer from the South East and North Hampshire Clinical Commissioning Groups as an assurance to underpin the new models of care which are in development across Hampshire. Gaining assurance that all health care professionals are committed to working together in their locations will improve service access and cross professional communication. This will benefit patients ensuring that there is access to the appropriate professional, in the appropriate location, local to the patient.

Ambitions

To gain assurance that all health care professionals are committed to working together in their locations will improve service access and cross professional communication. This will benefit patients ensuring that there is access to the most appropriate professional, in the most appropriate location, local to the patient.

How we will measure and monitor progress

Progress will be measured on a monthly basis against agreed performance targets. Results will be reported directly to the Southern Health Integrated Service Division business unit meetings and shared with the Clinical Commissioning Groups.

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 reports. They help demonstrate that we are actively measuring and monitoring the quality and performance of our services, are involved in national initiatives aimed at improving quality, and are performing to quality standards.

Review of services

During 2016/17 the Southern Health NHS Foundation Trust provided and/or subcontracted 49 relevant health services.

The Southern Health NHS Foundation Trust has reviewed all the data available to it on the quality of care in 49 of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by the Southern Health NHS Foundation Trust for 2016/17.

Clinical audits and national confidential enquiries

During 2016/17 nine national clinical audits and no national confidential enquiries covered relevant health services that Southern Health NHS Foundation Trust provides.

During that period Southern Health NHS Foundation Trust participated in 89% of the national clinical audits which it was eligible to participate in.

The national clinical audits that Southern Health NHS Foundation Trust were eligible to participate in during 2016/17 are as follows:

National Clinical Audit	Eligible
Learning Disability Mortality Review Programme (LeDeR)	Y
Sentinel Stroke National Audit Programme	Y
Society for Acute Medicine Benchmarking Audit (SAMBA)	Y
Prescribing Observatory for Mental Health (POMH) – Rapid Tranquillisation.	Y
Prescribing Observatory for Mental Health (POMH) – Monitoring of Patients Prescribed Lithium	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing high dose and combined antipsychotics	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing for substance misuse: alcohol detoxification	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing antipsychotic medication for people with dementia	Y
National Audit of Intermediate Care	Y

The national clinical audits that Southern Health NHS Foundation Trust participated in during 2016/17 are as follows:

National Clinical Audit	Participated in
Learning Disability Mortality Review Programme (LeDeR)	Y
Sentinel Stroke National Audit Programme	Y
Society for Acute Medicine Benchmarking Audit (SAMBA)	Y
Prescribing Observatory for Mental Health (POMH) – Rapid Tranquillisation.	Y
Prescribing Observatory for Mental Health (POMH) – Monitoring of Patients Prescribed Lithium	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing high dose and combined antipsychotics	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing for substance misuse: alcohol detoxification	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing antipsychotic medication for people with dementia	Y
National Audit of Intermediate Care	N

The national clinical audits that Southern Health NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Clinical Audit	% of required cases submitted
Learning Disability Mortality Review Programme (LeDeR)	100%
Sentinel Stroke National Audit Programme	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	100%
Prescribing Observatory for Mental Health (POMH) – Rapid Tranquillisation.	In Progress
Prescribing Observatory for Mental Health (POMH) – Monitoring of Patients Prescribed Lithium	100%
Prescribing Observatory for Mental Health (POMH) – Prescribing high dose and combined antipsychotics	In Progress
Prescribing Observatory for Mental Health (POMH) – Prescribing for substance misuse: alcohol detoxification	100%
Prescribing Observatory for Mental Health (POMH) – Prescribing antipsychotic medication for people with dementia	100%

The reports of three national clinical audits and one confidential inquiry were reviewed by the provider in 2016/17 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Clinical teams should use local networks and the new Early Intervention in Psychosis Network to share good practice and implement changes needed to increase the proportion of people who are engaged with services within a two week period.
- Electronic Doctors' worklist will be employed to enable us to identify and record the times of consultant review and clerking times to aid data collection.
- Falls and fractures have a major impact on people with Parkinson's and so it is vital that services consider how bone health may be adequately addressed within the clinic setting. The Parkinson's Excellence Network is developing structures to support improved management of bone health in Parkinson's. These improvements will hopefully be reflected in future audits.
- Implementation of the mortality action plan to improve our learning following serious incidents.

The reports of 43 local clinical audits were reviewed by the provider in 2016/17 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit title	Actions
Bruising Protocol (Children & Families)	• Training on different types of skin marks and hyperpigmentation • To produce an up to date leaflet which is available to staff

Track and Trigger (Specialised Services)	• Competencies to be revisited in how to accurately record physiological observations onto the Track and Trigger chart. • For all concerns raised / escalated to be clearly documented and for an incident form to be completed. • For internal regular spot checks to be undertaken by the Clinical Ward Manager and Modern Matron.
Dysphagia Referrals (Learning Disabilities)	• Offer opportunities for new adult services colleagues working in Learning Disabilities to shadow/meet with the Speech and Language Therapist (SLT) to increase their awareness of eating and drinking difficulties and when to refer.
Seclusion (Mental Health)	• The Trust, in conjunction with Health Education Wessex, should carry out a review of the adequacy of on-call trainee doctor cover. • It is recommended that the seclusion module on the electronic record is enhanced and used for recording and monitoring of seclusion.
Sepsis (SWISD)	• The handover from General Practitioners and the Ambulance Service should include consideration that the patient could be septic. • On call medical staff should be made aware of an incoming patient with suspected sepsis. • The “Sepsis Clock” should be used as a communication aid.
Discharge Summary MIU Petersfield (SEISD)	• All discharge summaries to be sent electronically. • All discharge summaries to be sent within 24 hours, even if over a weekend or bank holiday.

Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Southern Health NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 1350. CHECK NUMBER END APRIL

Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Southern Health NHS Foundation Trust income in 2016/17 was conditional on 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 2016/17 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-. In 2016/17 income totalling £ 4,894,312 was conditional upon

Southern Health NHS Foundation Trust achieving quality improvement and innovation goals.

In 2015/16 income totalling £4,546,184 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals, of which payment of £4,355,782 was received.

Our CQUIN schemes for 2017-2019 follow the national guidance also available at the link above. Within mental health service contracts there is scope within the national guidance to agree a single local scheme.

We are therefore currently in the process of agreeing a local scheme in the Hampshire wide mental health service contract for the introduction of Personal Health Budgets.

In addition to this in the NHS England contract there is a single specialised services CQUIN for Reducing the Length of Stay in Specialised Mental Health services (Medium and Low Secure version).

There is also a proposed scheme for the Child Health Information Services (CHIS) and Immunisations element of this contract for increasing participation and reducing inequalities in coverage (School Aged Immunisations). There is no scheme yet agreed for the Oxford City CCG Learning Disabilities contract.

Care Quality Commission Registration and Actions

Southern Health NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is: registered in full with no conditions. Southern Health NHS Foundation Trust has 30 locations registered with CQC under the Health and Social Care Act (2008).

The Care Quality Commission has not taken enforcement action against Southern Health NHS Foundation Trust during 2016/17.

Southern Health NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2016/17: Health and Safety investigation.

Southern Health NHS Foundation Trust has not yet received the final response from this investigation although the Trust has been notified of Care Quality Commission's intention to prosecute.

Southern Health NHS Foundation Trust has not yet received the final response for this investigation and will finalise any action plan to address recommendations once

received. Immediate safety concerns with respect of the estate have however been rectified.

The Care Quality Commission and Warning Notice

The Care Quality Commission undertook a comprehensive inspection of the Mental Health, Learning Disability and Community Health services of the Trust in 2014. The Trust was rated as Requires Improvement.

The Care Quality Commission has carried out four inspections during 2016/17. Each of these was a follow-up inspection to review progress against the actions from the 2014/15 inspections. Three inspections were within the Trust's social care services and these services received individual ratings of 'Good' for two of them and 'Requires Improvement' for the third. Action plans have been developed to address areas for improvement that were identified.

A further Care Quality Commission inspection at the Trust took place in September 2016. The inspection focused on improvements made since their inspection in January 2015 where an enforcement action was issued. The Care Quality Commission found that that the trust had taken sufficient action to meet the requirements set out in the warning notice, however, further improvements were still required. The Care Quality Commission did not re-rate the Trust following this inspection as this can only be done as a result of a full comprehensive inspection.

A further focused Care Quality Commission inspection took place in late March 2017. The inspection this time focused on the completion of all of the action plans created from 2014 onwards, assessment against the well-led key line of enquiry and improvements made in governance processes inclusive of the management of serious incidents and learning lessons from both incidents and complaints. Within this inspection physical health, mental health and older persons mental health in-patient hospitals and community services were visited.

Quality of Data

Southern Health NHS Foundation Trust submitted records during 2016/17 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:
  #% for admitted patient care
  #% for out patient care and
  #% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was:
  #% for admitted patient care;
  #% for out patient care; and

#% for accident and emergency care. *NB data available 15th May*

Southern Health NHS Foundation Trust Information Governance Assessment Report overall score for 2016/17 was 88% and was graded green ‘satisfactory’.

Southern Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

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

- Data quality has continued to have a significant focus over the last 12 months and will continue to be prioritised within the Trust to ensure our reported performance is of a sufficiently high standard;
- Regular data quality updates are given to the Trust Board via the Service Performance and Transformation Committee and members of the Trust Executive Board have been closely involved in ensuring this work programme continues to be delivered;
- The Trust ensures that data collected within the Electronic Patient Record is used to report performance, avoiding the need for manual collection of performance information. Developments within Open RiO have continued to support better recording practices across the Trust;
- The Trust invested in a new business intelligence tool ‘Tableau’ which has been in place since August 2015. The use of Tableau has made reporting of data quality more accessible and easier to understand for colleagues throughout the Trust. This has led to improvement in the data quality of some key areas and will continue to support the Trust in further improving the level of data quality.

2.3 Reporting against core indicators

Since 2012/13 NHS Foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

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

Price Waterhouse Cooper have considered two mandated indicators against NHS Improvement’s requirement. Their opinion is detailed in Annex 3 and complete definitions are within Annex 4.

- The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.

- The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the period.

Our patients on a Care Programme Approach who were followed up within 7 days of discharge from psychiatric inpatient care

The data made available to the National Health Service trust or NHS foundation trusts by NHS Digital with regard to the percentages 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 that this data is as described for the following reasons; this is taken from the national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing performance information that is easily available to clinicians through the business intelligence tool, 'Tableau'.
- Monitoring the target at monthly performance meetings

Indicator	The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.				
	Q1 2016-17	Q2 2016-17	Q3 2016 -17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	97.1%	98.1%	97.3%	97.0%	97.2%
Average Scoring Trust	96.2%	96.8%	96.7%	97.0%	available after 12.04.16
Highest Scoring Trust	100%	100%	100%	99.8%	
Lowest Scoring Trust	28.6%	76.9%	73.3%	82.8%	

Our crisis resolution teams

The data made available to the National Health Service trust or NHS foundation trusts by NHS Digital with regard to the percentages 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 that this data is as described for the following reasons; this is taken from the national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing performance information that is easily available to clinicians through the business intelligence tool, 'Tableau'.
- Monitoring the target at monthly performance meetings.

These activities have proven the sustainability of this indicator.

Indicator	The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the period				
	Q1 2016-17	Q2 2016-17	Q3 2016 -17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	99.7%	99.6%	100.0%	99.0%	99.4%
Average Scoring Trust	98.1%	98.4%	98.7%	97.2%	available after 12.04.16
Highest Scoring Trust	100%	100%	100%	100.0%	
Lowest Scoring Trust	78.9%	76.0%	88.3%	64.7%	

Our readmission rate for children and adults

The data made available to the National Health Service trust or NHS foundation trusts by NHS Digital with regard to the percentage of patients aged –

(i) 0 to 15; and

(ii) 16 or over,

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.

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

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Accurate monitoring at division, service and team level showing areas where improvements may be made.
- Discharge planning processes involving carers and families to ensure improved home support.
- Providing performance reports to board.

Indicator	The percentage of patients aged 1-15 years readmitted to a hospital which forms part of the Trust with 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	0%	1.9%

Indicator	The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust with 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	12%	17.5%

Patient experience of community mental health services

The data made available to the National Health Service trust and NHS Foundation Trust with regard to the trust's 'Patient experience of community mental health services' indicator score, and with a focus on a patient's experience of contact with a health or social care worker during the reporting period.

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

The Southern Health NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Improving the collaboration between the service user and practitioner when planning care.
- Ensuring that service users know who to contact in a crisis. Introduction of My Crisis Plan and the new My Safety Plan provide opportunities for service users to describe what they would find helpful in a crisis and can include the contact details for the out of hours service.
- A focus on physical health within Adult Mental Health, to improve the identification and support of a person's physical health needs. This will include the use of a physical health screening tool.
- Development of patient information, as led by patients. This includes information about medicines.

Indicator	Patient experience of contact with a health or social worker*

	2014 - 2015	2015 - 2016	2016 - 2017
Southern Health	6.8	6.7	7.1
Average Trust score	Not available		
Highest Scoring Trust	7.5	7.4	7.5
Lowest Scoring Trust	6.5	6.2	6.1

*Data is based on responses on a 0-10 scale where 0 is 'I had a very poor experience' to 10 'I have a very good experience'

Our rate of patient safety incident reporting

This reporting requirement is the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in harm.

Indicator	Number of patient safety incidents reported to the National Reporting and Learning Service (NRLS)*			
	15/16 Total – 12,295		16/17 Total – 12,460	
	Apr 2015 – Sept 2015	Oct 2015 – Mar 2016	Apr 2016 – Sept 2016	Oct 2016 – Mar 2017
Southern Health	6,723	5,572	6,072	6,388
Average Trust Score	2,587	2,613	N/A	N/A
Highest Scoring Trust	6,723	5,572	N/A	N/A
Lowest Scoring Trust	8	25	N/A	N/A

Indicator	i) Number and ii) percentage of such patient safety incidents that resulted in severe harm or death			
	15/16 Total – 156 (1.3%)		16/17 Total – 140 (1.1%)	
	Apr 2015 – Sept 2015	Oct 2015 – Mar 2016	Apr 2016 – Sept 2016	Oct 2016 – Mar 2017
Southern Health	i) 76 ii) 1.1%	i) 80 ii) 1.4%	i) 64 ii) 1.1%	i) 76 ii) 1.2%

Average Trust Score	i) 27 ii) 1.1%	i) 30 ii) 1.3%	N/A	N/A
Highest Scoring Trust	i) 97 ii) 3.7%	i)119 ii) 6.0%	N/A	N/A
Lowest Scoring Trust	i) 0 ii) 0%	i) 0 ii) 0%	N/A	N/A

The 2016/17 totals are based on data extracted from the Trust's incident reporting system Safeguard Ulysses on Patient Safety Incidents submitted to the NRLS during the time period, whereas the 2015/16 totals are based on recently published NRLS datasets.

The percentage of staff who would recommend the Trust as a provider of care to their family and friends

In 2013/14 NHS England asked NHS providers to consider reporting on the staff element of the Friends and Family Test, although it did not make this a mandatory requirement for community trusts.

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 of friends	
	April 2015 - March 2016	April 2016 - March 2017
Southern Health	66%	62% (Q1 and Q2)
Average Trust Score	78%	74% (Q1 and Q2)
Highest Scoring Trust	100%	100% (Q1 and Q2)
Lowest Scoring Trust	45%	47% (Q1 and Q2)

The percentage of patients who would recommend the Trust as a provider of care to their family and friends

In 2013/14 NHS England asked NHS providers to consider reporting on the patient element of the Friends and Family Test, although it did not make this a mandatory requirement for community trusts.

Indicator	The percentage of patients during the reporting period who would recommend the Trust as a provider of care to their family of friends	
	April 2015 - March 2016	April 2016 - March 2017

Southern Health	94.3%	93.9%
Average Trust Score	94.5%	93.3%
Highest Scoring Trust	98.8%	98.3%
Lowest Scoring Trust	86.6%	67.5%

The figures for the percentage of patients who would recommend the Trust as a provider of care are calculated by combining the published results for the Trust's community and mental health services. Comparison figures include other Trusts where they have both community and mental health services.

Part 3 Other Information

Further Information

Please refer to the Annual Report and the Annual Governance Statement for further details on the quality of services and the quality governance frameworks in place within the Trust.

Progress made in meeting our priorities for improvement in 2016/17

Details of the progress made to meet our priorities for improvement in 2016/17 are given below.

Priority 1: Improving Patient Safety

Priority 1.1 To develop a framework to share learning from serious incidents leading into a reduction in recurrent themes.

Aim

Learning from incidents is extremely important to the Trust. The independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 conducted by Mazars recommended improvements to the review and investigation of deaths process including an emphasis on learning. These improvements would need to be fully compliant with the NHS England Serious Incident Framework.

Achievements

We developed a framework for learning which is published within our Organisational Learning strategy and includes a variety of different methods which can be used:

- Clinical supervision
- Learning Network meetings / Case Study review
- Hotspot and Learning Matters publications
- Immediate Trust-wide learning alerts

Learning has been an active part of policy review and change within the Trust. Early in the year there was a theme of clinical disengagement being a contributory factor in our serious incident reports and it was apparent that the policy was not providing the guidance which clinicians required. Through a working group approach the policy was rewritten and launched in October. Since this launch and retraining of the staff a reduction in this theme has been seen.

Use of the Trust-wide Track and Trigger tool for recognising a deteriorating patient was highlighted as an emerging theme however further investigation proved that a policy change was not required but retraining and competency assessment of clinical staff which is now underway.

Immediate Trust-wide learning alerts were used to share information that required instant practice changes linked to preventing patient safety incidents. Examples were:

- ensuring that correct sling sizes were selected for patient hoists to prevent falls from equipment
- horizontal laying of home oxygen cylinders to prevent injury from toppling.

Monitoring the success of the learning activities is complex but has been achieved through the bi-annual thematic review of serious incident reports. We have over the year seen a reduction in certain themes although it is felt that only twelve months is not statistically robust and improvements should be judged over a minimum of eighteen months.

There is no national benchmarking or historical data available.

Future plans

Organisational learning will continue to be a priority to the Trust and will be monitored through the next year as part of the new priority Outcomes related to the Serious Incident and Mortality Improvement Action Plan.

Priority 1.2 Inpatients in community hospitals will have a venous thromboembolism (VTE) assessment on admission

Aim

Venous thromboembolism (VTE) is a serious, potentially fatal, medical condition. Patients who are unable to move around very much are more at risk of developing blood clots and so it is important to complete a risk assessment on admission to hospital. Lymington New Forest Hospital submits data to Unify on the percentage of patients who have a VTE risk assessment completed on admission and consistently meets the 95% target set nationally (for acute trusts). However, results from clinical audit in October 2015 showed less consistent results across the Trust with 69% of patients having a VTE risk assessment form completed on admission.

We therefore repeated a similar indicator for 2016/17 which aimed to ensure consistent good practice across the Trust.

National benchmarking data is not available.

Achievements

We are pleased that a repeat clinical audit in November 2016 which measured current practice against the standards in NICE (The National Institute for Health and Care Excellence) clinical guidance 92 ‘Venous thromboembolism: Reducing the risk’ showed significant improvement. This audit found 92% of patients audited had a VTE risk assessment form completed on admission and 8% had the form completed at a later date. This met our target of 90% of patients having the assessment on admission and compares favourably to the previous audit results.

Data collection for a further clinical audit is underway in March 2017. The results will drive further improvement actions as required.

A new process to collect VTE risk assessment and treatment (prescription of medication) information on a daily basis from community hospital wards was introduced in October 2016. This enables a more timely review of data with any ward not meeting standards identified and actions put in place to address.

A mini review of the Trust’s VTE policy and procedures has identified some minor changes are required to reflect new organisational structures within the Trust. A full review will be undertaken when the new NICE guidance is circulated.

The training package provided to junior doctors at Lymington New Forest Hospital is being circulated to all doctors across the Trust.

Future Plans

This indicator will not be repeated in 2016/17 as the target has been met. Work will continue, however, with a focus on ensuring our practice meets the new NICE guidance due out in January 2018.

Priority 1.3 To reduce the number of pressure ulcers

Aim

Pressure ulcers can be painful, increase the risk of associated infection and seriously affect the quality of life for a patient.

In 2015/16 focused actions led to a significant reduction of over 35% in the numbers of avoidable grade 3 and 4 pressure ulcers reported as serious incidents with 71 reported in 2015/16 compared to 116 in 2014/15. Although we were pleased with this improvement, we recognised that pressure ulcers continue to be the most commonly reported serious patient safety incident in our community services. We therefore

repeated a similar indicator for 2016/17 with the aim of sharing best practice and learning across the Trust to reduce pressure ulcers following national guidelines.

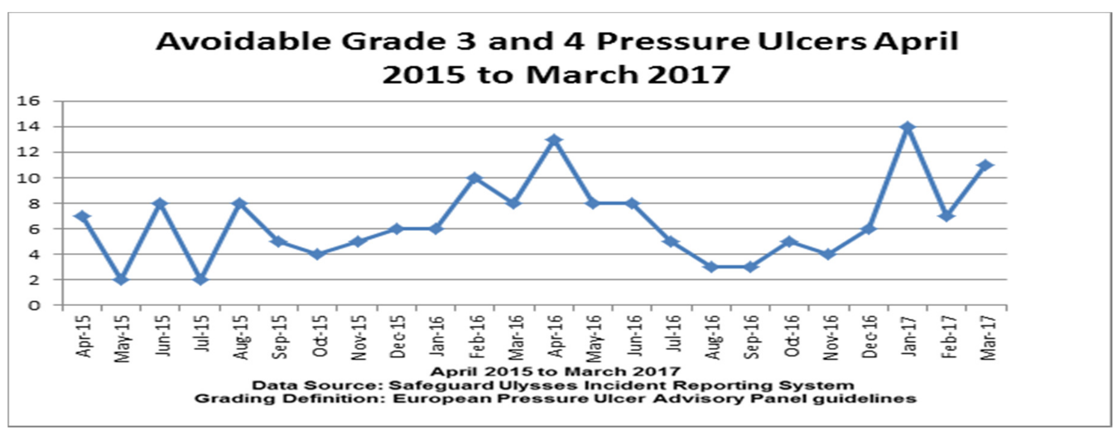
The definition of 'avoidable' pressure ulcer has changed in the National Serious Incident Framework 2016/17 which makes comparison difficult between this year's figures of pressure ulcers and previous year's.

National benchmarking data is not available.

Achievements

This year there were 87 grade 3 and 4 pressure ulcers reported onto StEIS, the national reporting system. This did not show a reduction compared to previous years however this is not directly comparable, due to changes in the definition but we are able to evidence robust monitoring, investigating and learning processes.

Numbers of grade 3 and 4 pressure ulcers reported and confirmed on StEIS April 2016 to March 2017 (StEIS - strategic executive information system)



There are weekly pressure ulcer panels, chaired by a senior clinical lead with a tissue viability nurse attending, which review all pressure ulcers reported by teams and makes a decision as to whether a full serious incident investigation to identify the cause and any contributory factors should be completed. Themes from these panels are collated and fed back to teams on a monthly basis so that actions to address any shortcomings can be implemented.

The tissue viability team also complete 'deep dives' into pressure ulcers every quarter in order to identify themes and learning further. Key issues are circulated to teams via 'Learning Matters' newsletters so that best practice can be shared across the Trust leading to a reduction in pressure ulcers.

A new e-learning training module was launched in November 2016 as part of 'Stop the Pressure week' activities.

A comprehensive audit was completed in partnership with a university which analysed the results. Actions to address these findings were added to individual

teams' quality improvement plans which are monitored monthly by the matrons to ensure progress made.

The tissue viability team are leading a clinical supervision day for team leaders so that they can make best use of the weekly panels and are better able to support their teams to identify and care for pressure ulcers.

Intensive support to clinical teams with the highest number of reported pressure ulcers is in place.

A representative from the tissue viability team continues to attend the NHS England Pressure Ulcer Strategy group which reviews national strategy and best practice, supports collaborative working and gives direction on new initiatives.

Future Plans

We will continue to focus on reducing the numbers of pressure ulcers developed by patients in our care, but will not include this as a specific indicator for 2017/18.

Priority 1.4 Implement robust governance processes to effectively identify, manage and reduce ligature risks in all out impatient units

Aim

Some patients within our services have complex mental health needs and we need to ensure that our care environments are the safest possible for them. We need to provide care in settings where ligature risks are identified and action is taken to mitigate these risks, with appropriate remedial work undertaken within individual services and across the Trust as a whole.

A Care Quality Commission inspection in early 2016 found that improvements could be made to the processes used to identify, manage and reduce ligature risks and therefore this indicator was included in 2016/17.

Historical and national benchmarking data is not available.

Achievements

We have met this aim with an annual ligature risk assessment programme and a building works programme in place for inpatient sites.

The Ligature Management Group (LMG) has led on the development of a ligature assessment programme with a project manager appointed to support the clinical teams, provide a link to the estates services and ensure that all actions are completed.

All inpatient sites were assessed for ligature risks between April – October 2016 and community sites assessed by February 2017. Action plans and programmes of

building work were developed where necessary. The project manager supported the clinical areas to develop mitigation plans for those risks that remained.

The LMG reviews the results of all the ligature assessments and checks that all actions are completed.

All information is saved on a central 'sharepoint' so that it is easy to review information, check progress made on the schedules of work and identify any areas where additional action is required.

The LMG has led on the review and updating of policies and procedures relating to ligature risks.

There is a three year capital investment programme in place which has prioritised the building works to be completed and monitors the schedule of works to ensure they are on track.

Ligature training is mandatory for relevant staff with 98% training compliance in March 2017. There is online information for staff about ligature risk assessment and management with the project manager providing scenario based training to teams if requested.

'Back to the floor 'site visits by senior staff check that ligature assessments have been completed and that staff understand ligature risks and the actions in place to address any issues. Posters display relevant information as reminders to staff.

Next steps

Although this indicator is not included as one of the priority improvements in 2017/18, the ligature assessment programme will continue with inpatient sites revisited throughout 2017 and building works implemented.

Priority 2: Improving Clinical Outcomes

Priority 2.1 To embed care planning frameworks in our clinical services

Aim

We aim to put patients at the heart of everything we do. We want to involve them and their carer's in the plans of care developed to ensure continuity of care, improved clinical outcomes, enhanced patient safety and a positive experience of our services.

This priority builds on the 2016/17 indicator which focused on developing a care planning framework and creating care plans in partnership with patients that best meet their needs and goals. In 2017/18 we want to continue with this work and fully involve patients and carers in their own care and ensure that staff are equipped with the skills they may need to ensure this is available for all.

The data source for this indicator is progress made against divisional work plans which are reported to and monitored by the Record Keeping work stream.

Achievements

We are making good progress towards meeting this target in many areas but there remain some inconsistencies across the Trust.

Clinical audit results demonstrate that whist there has been an overall increase in the numbers of patients with care plans in place, the number of patients involved in designing these has fallen in some areas.

Peer reviews are carried out within all clinical areas of the Trust and during these the clinical records are reviewed and patients are asked about their experiences. From looking at 56 of the reports created following visits that were undertaken during 2016/17 there are still areas where the quality contained within the care plan is inconsistent. There were also times when the patient and/or their carer was not as involved in their care planning as they would have liked to be.

In April 2016 analysis was undertaken to identify gaps in the provision of care planning training and this has led to the development of an education pathway. Further plans are in place for 2017/18 to strengthen the training available, with a suite of best practice guidance and competencies to be launched in April 2017 for all clinical staff. The focus of this training will be on the expected quality that staff must adhere to when completing a clinical record, including care plans. The suite will be supported by an integrated standard operating procedure (SOP) which will provide detailed guidance to staff on all actions to complete.

Care planning forms and templates on RiO were reviewed with requests for change made to RiO Change Board. As a result of this new care planning templates were launched on RiO in January 2017.

A quick reference guide for staff when co-designing care plans has been created with plans for a more detailed pocket guide to cover all areas of clinical record keeping. A video guide is also being produced and this will be accessible via the intranet site.

Future Plans

We will be repeating a similar indicator in 2017/18 with a focus on patients and carers actively encouraged to participate in creating their own care and management plans.

Priority 2.2 The physical health needs of inpatients in Learning Disability and Mental Health services are appropriately assessed, monitored and treated with action taken if there is any deterioration in physical health

Aim

A holistic approach is essential to all aspects of good physical and mental health care and this includes the active identification and management of physical health needs. People with an existing physical and/or mental illness are more prone to physical illness than the general population, may not receive the optimum physical healthcare that they need and have an associated higher morbidity and mortality rate than the general population. Physical illness can have a significant impact on a person's mental health and conversely mental illness can seriously impact on a person's physical health. The Trust aims to ensure that patients and service users are appropriately assessed in relation to their physical health needs.

The data source for this indicator was an audit undertaken in November 2016 in mental health, learning disabilities, specialised services and older peoples mental health services to assess whether the physical health needs of patients are being assessed, monitored and treated appropriately.

In addition to this, physiological track and trigger systems should be used to monitor all adult patients in hospital settings. This was also audited in mental health inpatient settings.

Achievements

Physical health monitoring

In October/ November 2016 in Adult Mental Health and Specialised Services data collection was completed on 173 patients. This demonstrated that 94% of patients had a full physical health review within 7 days of admission or a reason recorded why it was not appropriate.

In Learning Disability services in October/November 2016 data collection was completed on 18 patients. (72%) of patients had a full physical health assessment carried out on admission. In the 5 cases where this was not completed (2/5 40%) recorded why this was not possible and the plan in place to monitor physical health. Care plans were in place for all patients where applicable.

The Trust is continuing to monitor the compliance and improve the physical health assessment of patients and has participated in the Royal College of Psychiatrists physical health assessment tool in February/ March 2017. The results of this are awaited.

Track and Trigger

The aim of this audit was to identify how many of the patients/service users who require care in mental health clinical inpatient settings, were assessed using an early warning score.

The audit demonstrated that 99% of patients were assessed using the Track and Trigger tool. This audit demonstrated however that further training is needed to ensure staff follow the correct process where the patient required further action.

The training package has been reviewed and modified with components mapped to single day training which is easier for clinical staff to attend. Staff competencies have been developed for the various clinical grades of staff. An extensive training programme is now available. In January 2017, 87% of staff in adult mental health and older peoples mental health had been assessed and verified as competent to assess physical health of patients. Further work is being completed on this and a more detailed staff survey is currently underway to establish the competencies in relation to staff grades.

A strategy to meet physical health needs of patients in mental health and learning disability has been developed and is being implemented.

Future plans

The Trust will be re-auditing the assessment of physical health in 2017/18 The Physical Health policy and procedures are currently being reviewed and will include details of improved staff training packages.

Priority 2.3 Risk assessments and appropriate risk management plans are in place for all community and inpatients Mental Health, Specialised, Older Person's Mental Health and Learning Disability services

Aim

The Trust aims to ensure that effective and updated risk assessments and corresponding risk management plans are in place for all patients to safeguard them from harm and allow them to benefit maximally from the support offered by clinical services.

This priority builds on the 2016/17 indicator which focused on reinforcing the importance of up to date and accurate risk assessments.

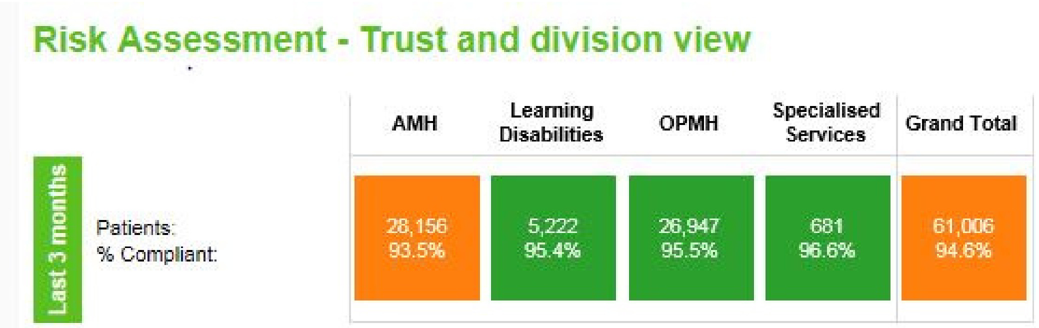
The data source for this indicator is progress made against divisional work plans which are reported to and monitored by the Record Keeping work stream.

Achievements

We are making good progress towards meeting this target in many areas but recognise this is not consistent across the Trust and that there is more still to do.

Risk assessments completed in RiO are reported via Tableau and the chart below demonstrates that levels of compliance with risk assessment completion are over 95% in all divisions, except for adult mental health. This is an improving picture from

the baseline audit conducted in June 2016 when the majority of teams had compliance figures of less than 90%.



Risk Assessment - Trust and division view

Last 3 months	AMH	Learning Disabilities	OPMH	Specialised Services	Grand Total
Patients:	28,156	5,222	26,947	681	61,006
% Compliant:	93.5%	95.4%	95.5%	96.6%	94.6%

Peer reviews are carried out within all clinical areas of the Trust and during these the completion of risk assessments is reviewed. From looking at 17 of the reports created following visits that were undertaken during 2016/17 it was identified that some patients (12%) did not have sufficient risk assessments or these had not been updated as frequently as they should have been.

A working group called "My Safety Planning" has been established, co-facilitated with representation from acute services, adult mental health and service users. Ongoing work is planned for 2017/18 with the aims to:

- Ensure risk assessments are co-produced and owned by the patient
- Enable honest conversation about risks
- Develop co-created plan which lists how the person and service will improve the safety of the patient

The 'My Safety Plan' is a new approach to collaborative management of people's safety who use our services. We want to work collaboratively with people to identify things in their life which may cause someone to be unsafe, be that due to lifestyle choices, where someone lives, desires to hurt themselves or difficulty walking upstairs and work with them to agree a plan which will help them to stay and remain safe. To support the implementation of this training is currently being developed with lead Psychologists and LEaD training department.

Future Plans

We will be repeating a similar indicator in 2017/18 with a focus on further improving the number of patients with updated risk assessments and corresponding risk management plans.

Priority 3: Improving Patient Experience

Priority 3.1 Our complaints process provides satisfaction to the complainant

Aim

Patient experience is extremely important to the Trust; receiving complaints shows we haven't got something right for the patient or their carers.

We made improvements in meeting the agreed timeframe to send final response letters to complainants with 88% successfully sent overall in 2015/16. However, there was variation across services in their ability to meet the 90% target and therefore the indicator is repeated in 2016/17.

We also aimed to achieve 90% of the standards in the 'Assurance of Good Complaints Handling for Acute and Community Care' published by NHS England in November 2015.

Complaints are recorded as per the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009. National benchmarking data for percentage of final response letters sent within agreed timeframes is not available.

Historical data is shown below.

Table: Percentage of final response complaint letters sent within agreed timeframes. Data source: Safeguard Ulysses Reporting System

2013/14	2014/15	2015/16	2016/17
55%	**58%**	**88%**	**79%**

Achievements

We have partially achieved this indicator, meeting the target of having 90% of the standards in the 'Assurance of Good Complaints Handling' in place, but did not meet the 90% final response target.

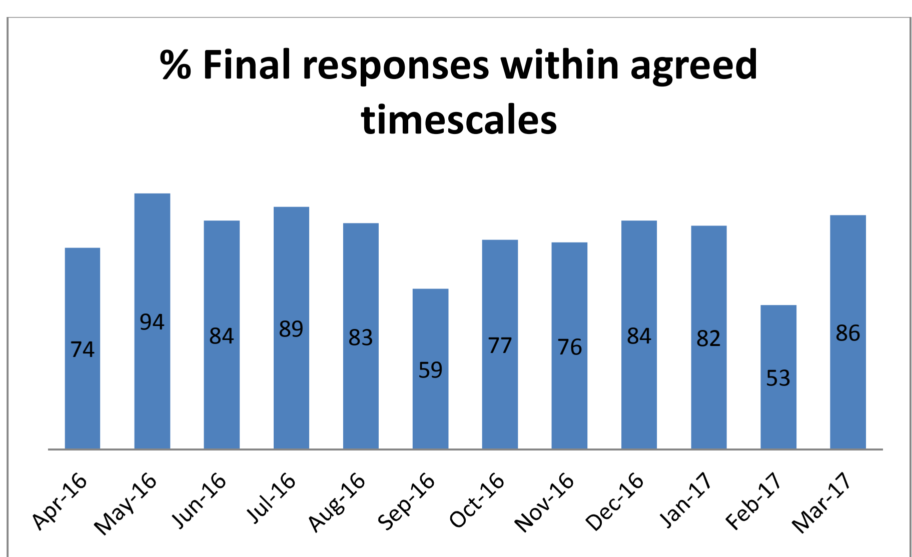
As part of the process when someone makes a complaint, the customer experience advisor discusses with the complainant a timeframe for the complaint to be investigated and a response letter to be sent. We are disappointed that improvements made in 2015/16 were not sustained with overall 79% sent within agreed timeframes.

We have taken several actions to address this decline in performance, introducing a more detailed focus on tracking the progress of all complaints, developing closer links between the customer experience team and clinical services and introducing an escalation process to senior managers if the agreed timeframe is at risk of not being met.

We are also piloting a process whereby complaints will be considered initially at a panel chaired by a clinical lead with clear dates set for the investigation to be

completed and a letter written which will be approved by a divisional panel before sign off by the Chief Executive.

Table: Percentage of final response complaint letters sent within agreed timeframes
Data source: Safeguard Ulysses Reporting System



A review of the complaints pathway within the Trust was completed in June 2016 with good practice identified and recommendations made for improvements. These recommendations were considered by a working group which contained both staff and members of the public. The group reviewed and made comments on the 'have your say' leaflet, information on the website, current policy and proposed what they considered to be the ideal process to deal with complaints. The latter informed the pilot mentioned above.

The customer experience team provide training to investigators within clinical services to develop their skills to investigate and identify reasons underlying the complaint and make recommendations as to actions required to address any shortcomings. Learning from complaints is shared at team meetings with themes identified and shared.

Future Plans

We will continue to focus on improving our timely response to complaints but will not include this as a specific indicator in 2017/18.

Priority 3.2 To involve patient and carers in the development of services

Aim

We aim to put patients at the heart of everything we do. We want to involve them and their carers in the development of services so that we can best meet their needs and provide a positive experience of our services.

This priority builds on the 2015/16 indicator which focused on developing the involvement of patients in the design of specific services identified by the Care Quality Commission in October 2014. In 2016/17 we want to build on this work and involve patients and carers in the development of services across the whole Trust.

The data source for this indicator is progress made against divisional work plans which are reported to and monitored by the Patient Experience and Engagement work stream. There is no historical or national benchmarking data.

Achievements

We are making good progress towards meeting this target in many areas but recognise this is not consistent across the Trust and that there is more still to do.

In May/June 2016 70 clinical teams completed self-assessments which mapped how they were involving patients, carers and families in services being provided. The self-assessments identified both elements of good practice and areas where increased engagement was required.

'A best practice guide to working with the people who use our services' was developed following the above self-assessment. The guide showcased examples of best practice within the Trust which staff could use as a resource to develop further the way they work with patients. It also described the different levels of engaging and involving others with a description of what 'good looked like'.

The Quit 4 Life service has adapted their service following feedback from patients who requested help in cutting down their tobacco use before quitting. This service, in partnership with other local healthcare services, has delivered rapid access and treatment plans for patients suffering with respiratory diseases and has won the 'Leading Service Improvement and Innovation' award at the NHS Thames Valley and Wessex Leadership Academy Recognition Awards 2017.

Service users are involved in peer reviews of our Learning Disabilities services. They provide feedback and suggestions for improvements based on their observations.

Adult mental health services have involved service users and carers in the development of clinical pathways with training and workshops being delivered jointly. The Early Intervention in Psychosis teams have involved carers in the development of carer support packs. A carer is a member of the steering group which is implementing the psychosis pathway to make sure services best meet the service user's needs.

Health visitors, mums with experience of antenatal and/or postnatal mental health problems, and their partners, have worked together to understand what it is like to experience mental health problems and to co-design a support group, 'Knowing me, Knowing you', A short film has been made that is used with both parents and staff to

help explain the illness and the services available. A more acceptable leaflet is being designed to address stigma and to encourage parents to talk about how they are feeling.

Patients, carers and the public have been involved in writing an Experience, Involvement and Partnership strategy which will be launched later in 2017. The strategy sets out the principles and standards for the involvement of patients and carers in the future development of services.

Future Plans

We will be repeating a similar indicator in 2017/18 with a focus on patients and carers actively encouraged to participate in creating their own care and management plans.

Priority 3.3 To have a strategy to reduce restrictive practice in adult mental health services

Aim

Our aim was to develop and implement a reducing restrictive practice strategy in our Adult Mental Health Services.

We want to provide environments for patients and staff where they feel safe and supported and where use of restrictive practices such as restraint are minimised. One of the highest categories in patient safety incident reporting on Ulysses Safeguard, our electronic incident reporting system, is assault, abuse and threat to staff.

We wanted to build on existing actions and continue to work collaboratively with patients to reduce restrictive practices and improve patient experience.

Achievements

Over the year the Safer Forum has focused on three main areas of work;

- development of a comprehensive suite of policies and documents for the wider mental health division incorporating adult mental health, specialised services and learning disabilities
- review of restraint training provided by the Trust
- liaison / relationship with the police.

Although the Trust has had policies on management of violence and aggression, seclusion and rapid tranquillisation, it did not previously have an overarching policy which described its approach towards the use of restrictive practices. Under the guidance of the Deputy Director of Nursing for the Mental Health division an overarching policy was devised. This has been further revised and is intended as a position statement regarding the use of restrictive practices in Southern Health. In

addition, a more detailed policy describing the use of various individual restrictive interventions, including seclusion, restraint and rapid tranquillisation, has also been developed.

A number of clinical services within the trust have raised concerns over the last few years regarding the suitability of the contents of our training known as PRISS. For instance, PRISS, in the form that has been taught so far, does not explicitly make links with moving and handling training, rapid tranquillisation training, or basic life support training; and it is felt that it did not have enough emphasis on de-escalation or trauma-informed care. A formal review of PRISS has been completed, which recommended that any training in manual restraint provided by Southern Health would need to meet some clear specifications. This review also recommended that the Safer Forum should meet with a team from Mersey Care NHS trust, which has implemented a program called "No Force First", which has resulted in a significant decrease in the use of restrictive interventions in that organisation. The team from Mersey Care NHS Trust will visit Southern Health in April, and the learning from the presentation will be incorporated into the formal review of PRISS.

The other important area of focus for the Safer Forum has been liaison with the police. Following case law some years ago, Hampshire Constabulary, in common with other police forces across the country, has stated to mental health providers that its officers are no longer able to routinely attend mental health units in order to provide support when patients present with high risks to other patients and staff. The police have stated that it is the responsibility of mental health providers to make arrangements for managing such high-risk incidents, and that the police will only attend if there is immediate danger to life or limb. This has resulted in a number of incidents in the Trust, particularly in specialised services, where patients have threatened, or actually inflicted harm, on staff with everyday items used as opportunistic weapons, and police have refused to attend, or in some instances, have attended but have refused to be involved. Whilst all of these incidents have been managed by staff teams so far, this presents a real risk to the trust.

Future Plans

We have met the indicator requirement of developing policies to support a reduction in restrictive practice. This has led to highlight further work that needs to be completed in 2017/18. Although not described as a specific indicator for 2017/18 the Safer Forum will be continuing this progressive work to ensure that services are as safe as they can be for both patients and staff.

Single Oversight Framework Indicators

These indicators are taken from the NHS Improvement Single Oversight Framework and were not mandated to be in part 2 of this report.

Meeting commitment to serve new psychosis cases by early intervention teams

This indicator was replaced with the EIP Waiting indicator listed below as of 2016.

Care Programme Approach

The data for the following two was obtained from the nationally published NHS England (NSHE) figures that are based upon trust's Mental Health Service Data Set (MHSDS) submissions. Southern Health is not responsible for the data quality of the data reported from other Trusts but has seen an improvement in performance for both indicators this year.

Indicator	The percentage of patients on care Programme Approach who had a formal review within 12 months.				
	Q1 2016-17	Q2 2016-17	Q3 2016 -17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	96.8%	97.1%	97.4%	96.4%	96.7%
Average Scoring Trust	73.1%	78.7%	83.7%	64.3%	Not yet available
Highest Scoring Trust	100%	100%	100%	98.9%	Not yet available
Lowest Scoring Trust	4.2%	12.5%	12.7%	3.6%	Not yet available

Figures published by NSH England – Mental Health Service Dataset

Early Invention in Psychosis (EIP)

Indicator	Early Intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care within two weeks of referral.				
	Q1 2016-17	Q2 2016-17	Q3 2016 -17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	84.7%	88.7%	82.1%	71.1%	Not yet available
Average Scoring Trust	68.7%	76.2%	76.3%	62.9%	Not yet available
Highest Scoring Trust	94.7%	100%	100%	100%	Not yet available

Lowest Scoring Trust	9.1%	0%	33.3%	12.0%	Not yet available

Improving Access to Psychological Therapies (IAPT)

The data made available to the National Health Service trust or NHS foundation trusts by NHS Digital with regard to the percentages of access times to psychological therapies.

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

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing performance information that is easily available to clinicians through the business intelligence tool, 'Tableau'.
- Monitoring the target at monthly performance of both 6 and 18 weeks at meetings

Indicator	Improving access to psychological therapies: people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral				
	Q1 2016-17	Q2 2016-17	Q3 2016 -17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	87.8%	85.7%	87.0%	86.2%	
Average Scoring Trust	not available	not available	not available		available after 12.04.16
Highest Scoring Trust	not available	not available	not available	100.0%	
Lowest Scoring Trust	not available	not available	not available	15.0%	

Indicator	Improving access to psychological therapies: people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral				
	Q1 2016-17	Q2 2016-17	Q3 2016 -17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	100%	99.9%	99.8%	99.9%	

Average Scoring Trust	not available	not available	not available	89.4%	available after 12.04.16
Highest Scoring Trust	not available	not available	not available	100.0%	
Lowest Scoring Trust	not available	not available	not available	33.0%	

Our Quality Improvement Strategy 2016 – 2021

Our key priority is to give patient centred care which is safe, effective and provides a positive patient experience. Achieving this is the responsibility of every single member of staff. Everyone should be focused on our vision and committed to continually improving the services we provide.

The Quality Improvement Strategy was developed to give a clear picture of our aims and ambitions, giving our staff the focus to provide the best possible care and patient experience. We are committed to investing in employing the right staff to deliver the best care. Through our appraisals, training and team business planning activities we will ensure each member of staff knows the role they have to play. We are also developing new ways for staff to truly understand the experiences of people who use our services so this insight is used day by day to further improve our services.

The Quality Improvement Strategy sets out what quality care looks like for our patients and service users and states our commitment to listening to them and their support networks, acting on their feedback to continually improve and share this learning throughout our Trust.

To measure the quality of our services we use the Care Quality Commission (CQC) five key lines of enquiry - Is it safe? Is it effective? Is it responsive? Is it caring? Is it well-led? We have worked to develop a quality scorecard which enables the Board, senior managers and all staff to understand whether the care we are giving to our patients is as good as it can be. We also have a well-established programme of peer reviews which are used to assess services against the CQC's five key lines of enquiry.

Every team has developed a quality improvement plan. These plans describe how they will provide high quality, safe care for their patients and services users looking at improvements and changes that need to take place. Through these plans teams are able to measure their effectiveness and benchmark themselves against others in the Trust, encouraging the sharing of best practice and learning.

From 1 April 2016 we have also been embedding a new Quality Structure within the Trust to provide assurance to our Board on quality issues. The Trust has an established Quality and Safety Committee (QSC) to measure and monitor clinical quality and the health and safety of our patients, service users, visitors and staff. The

committee is chaired by a Non-Executive Director and is responsible for overseeing the development of this Quality Improvement Strategy and ensuring the quality priorities are met.

To help keep us on track and to drive quality improvements on the front line we are looking to appoint Quality Ambassadors in every team during the summer months of 2017/18. These will be staff at support worker level (Health Care Support Worker/Health Care Assistant) who will be responsible for: attending a quarterly development day; developing a team quality noticeboard to display quality improvement initiatives, innovations and best practice; sharing learning with their team; and facilitating team quality improvements utilising the PDSA (Plan, Do, Study, Act) model.

Our Organisational Learning Strategy 2017-2022

To support the implementation of the Trust's Quality Improvement Strategy, the Organisational Learning Strategy builds on improvements and achievements made by our Trust in the safety and quality of care that people who use our services have received over the last few years. It reflects national developments underpinning the importance of organisational learning and the approach to be taken to further support and embed learning within the Trust.

Our Trust Organisational Learning Strategy supports the overall Trust strategic vision and goals. It aims for the organisation to be one in which all staff will understand and embrace their role in learning to deliver and improve quality and safety for our patients, service users and their families as part of their working practice. The strategy defines quality and governance processes to ensure comprehensive and effective systems are in place to learn from our mistakes as well as sharing excellence and innovations to embed a learning culture across the Trust. This will support our services to operate at the high standards that we, our patients, service users, families and stakeholders expect.

It aims to ensure that we are an organisation where people continually expand their capacity to improve, learning from mistakes as well as sharing best practice and knowledge. As a teaching and learning organisation, Southern Health supports medical, nursing and therapy students and trainee doctors as well as delivering continuous professional development opportunities for all staff. Our people development programme empowers staff to achieve their potential and deliver high quality care. Our Team Viral education programme enables teams space to develop, and time to consider how they address the unique challenges they face.

We are passionate about creating an open and listening culture where people who use our services contribute to the running of the organisation. Listening to and engaging patients, service users, children and their families in their care decisions and developing care plans in partnership is the foundation stone for excellent care. Truly hearing the person's voice is a key focus for the Trust over the next year and a

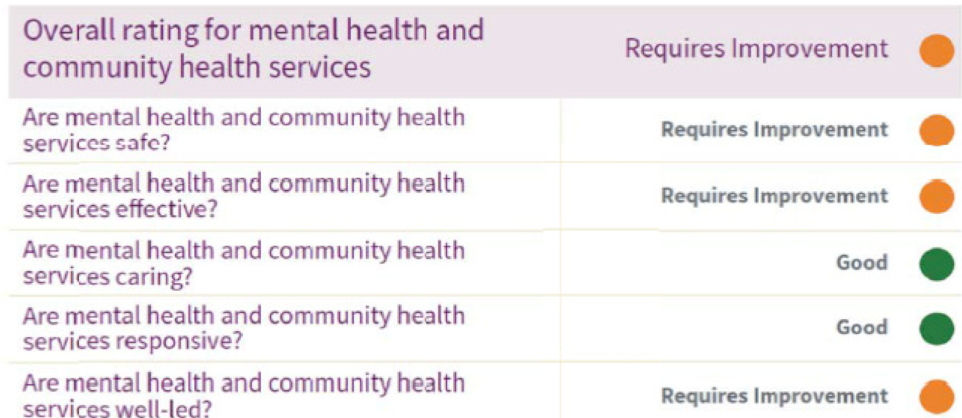
Patient Engagement, Involvement and Partnership Strategy has been developed and will be launched this year.

The Strategy sets out how learning is shared at different levels within the Trust depending on its nature (Team, Area, Divisional or Trust-wide) and describes the tools which are in place to support staff. Our mechanisms for sharing learning for improvement which will be developed as part of this strategy include:

- Quality Ambassadors in every team
- Quality Noticeboards in every team
- Could it Happen Here? presentations
- Central Alert System Internal alerts to share immediate learning from serious incidents
- One to Ones and Clinical Supervision
- Hot spots, Learning Matters Posters and Divisional learning posters displayed across the division and wider
- Learning Networks and Quality, Safety and Professional Conferences; a number of these are already in place across the organisation.

Our Care Quality Commission ratings

Although the Trust has had numerous focused inspections since the 2014 comprehensive inspection, the CQC ratings which were applied in 2014 remains unchanged. It is anticipated that these will be reviewed late 2017/18 through the process of a full comprehensive inspection.



Overall rating for mental health and community health services	Requires Improvement
Are mental health and community health services safe?	Requires Improvement
Are mental health and community health services effective?	Requires Improvement
Are mental health and community health services caring?	Good
Are mental health and community health services responsive?	Good
Are mental health and community health services well-led?	Requires Improvement

Further information regarding these inspections can be found earlier in this report.

Using a programme management approach all CQC related improvement action plans are monitored through the weekly Quality Improvement Development Group and progress is reported to the Quality and Safety Committee and Trust Board on a

monthly basis. Progress is externally shared with the Quality Oversight Committee attended by all commissioners and NHS Improvement.

Reporting and Investigating Deaths

Significant work has continued over the past year to consolidate previous work to improve the quality of investigations and to ensure that relatives/carers are afforded the opportunity to be fully involved in these.

The central lead investigators team continues to provide support to our frontline clinical staff and to lead the improvements. The team comprises four senior specialist nurses who have an interest in, and the skills to support, complex investigations.

This team work to ensure that investigations are carried out:

- in a timely manner as required by the NHS Serious Incident framework document
- Efficiently, with the involvement of family members and loved ones in an open and transparent manner with a full explanation and apology provided when things have gone wrong; and
- In a way that ascertains root causes and contributory factors to aid the development of effective action plans.

The training of frontline staff via the Investigating Officers (IO) training continues with 151 staff trained in the 2016/17 period. The training the IO's receive is regularly refreshed following feedback and any legislative changes.

Deaths are now consistently reviewed by a panel of staff, chaired by a senior clinician, in order to establish whether the death requires an investigation, and if so, at what level this should be. This process also determines whether a death meets the criteria for external reporting and also whether an internal investigation should be undertaken. The process takes into account how much involvement the Trust, as a community service provider, has had in the care of service users who die in the community and whether a commissioner-led, multi-agency investigation would be more appropriate.

Divisional and Trust-wide mortality reviews continue on a regular basis with a focus on ensuring learning and service improvement takes place. These groups also monitor compliance to process which has improved over the past year and is shown in the Tableau report below.

Mortality reviews - Compliance analysis

Southern Health NHS Foundation Trust

Analysis of compliance against the Mortality Policy - IMA and Review and Timeliness of Review completion since the implementation of the process (December 2015)

	Number of deaths reported as per Trust Mortality Procedure (Incidents reported)	IMAs completed (Number overdue)	Reviews completed (Number overdue)	Review panel timeliness analysis: Reviewed - Within 48 working hours	Review panel timeliness analysis: Reviewed - Exceeded 48 working hours	Review analysis for the last 6 Months (review due date): 1/10/16	1/11/16	1/12/16	1/1/17	1/2/17	1/3/17	1/4/17
Children's	39	100%	100%	100%		100% / 0% / 2	100% / 0% / 2	100% / 0% / 2	100% / 0% / 1	100% / 0% / 1	100% / 0% / 2	100% / 0% / 1
East ISD	306	100%	100%	79%	21%	95% / 5% / 20	100% / 0% / 16	100% / 0% / 14	100% / 0% / 24	100% / 0% / 15	100% / 0% / 13	100% / 0% / 2
Learning Disabilities	88	100%	100%	83%	17%	100% / 0% / 3	100% / 0% / 12	100% / 0% / 4	100% / 0% / 5	100% / 0% / 2	100% / 0% / 1	
Mental Health	206	100%	100%	82%	18%	100% / 0% / 11	100% / 0% / 15	79% / 21% / 14	93% / 7% / 28	100% / 0% / 10	100% / 0% / 8	100% / 0% / 1
Non-Shft Service	5	100%	100%	80%	20%							
North East Ios	19	100%	100%	68%	32%	100% / 0% / 1			100% / 0% / 1			
Southampton And West ISD	396	100%	100%	81%	19%	88% / 12% / 17	93% / 7% / 29	95% / 5% / 19	96% / 4% / 27	100% / 0% / 26	100% / 0% / 20	100% / 0% / 3
TQtwentyone	3	100%	100%	67%	33%							
Grand Total	1,062	100%	100%	81%	19%	94% / 6% / 54	97% / 3% / 74	92% / 8% / 53	97% / 3% / 86	100% / 0% / 54	100% / 0% / 44	100% / 0% / 7

How we are implementing Duty of Candour

We are continuing to support and encourage our staff to be open and honest with patients and their families when things go wrong. We are committed to the principles outlined in the Duty of Candour regulations and are striving to ensure that we engage with patients and their families in a way that is meaningful to them.

In the past year there have been several developments to support this:

- We have reviewed our Duty of Candour policy and procedure to provide greater clarity to staff on their responsibilities;
- We have developed a series of tools to support staff in properly and consistently demonstrating the behaviours and practices that are required.
    - This includes an e-learning training package for staff on the requirements of Being Open and Duty of Candour – which we are in the process of rolling out;

    - Having reviewed our Ulysses Safeguard Risk Management system, where Duty of Candour compliance is recorded, we routinely carry out a review of any moderate and above incidents where staff have indicated that duty of candour could not be undertaken to ensure that this there is a valid reason for this (for example the patient/family has explicitly asked for no contact);

    - Audits have also been undertaken to confirm compliance with each step of the Duty of Candour requirements. This is aided by our Business Intelligence System, Tableau, which enables all staff to see Duty of Candour compliance data (at team level and above). This gives immediate oversight of compliance to the three stage process, enabling managers to see incidents that need urgent attention to validate whether Duty of

Candour has taken place, or where it hasn't to ensure that this is promptly actioned.

- We have continued to provide 'face-to-face' training within our bespoke investigator's training course which focuses on how to involve service users and families in serious incident investigations – we have run the investigating officers course 6 times throughout 2016-17 and trained 151 investigating officers.

We have included Duty of Candour as a standing item on our executive-led corporate panels which sign-off serious incident investigations. This ensures that it is not only the quality of the investigation which is reviewed but also the requirements of the Duty of Candour policy.

Role of the Family Liaison Officer (FLO)

The Family Liaison Officer was a new post in December 2015. The post holder is a very experienced individual who has worked as a Coroner's Officer and was active within bereavement services. The position was put in place to support families who have suffered bereavement with an emphasis towards providing guidance through the investigation process but remaining independent of the investigation. The role was initially based on similar roles seen within police forces although a family do not need to be part of an investigation process to gain support, just have had a loved one or relative die whilst in the care of the Trust. External to the Trust the Family Liaison Officer is an active member of the Southampton and Hampshire Suicide Prevention Groups.

To date there have been 51 referrals made for those wishing to have support. As of 31st March 2017:

- 15 families are receiving support on a regular basis
- 25 families have received less intensive support
- 11 families have received an initial engagement contact.

As part of family engagement work an initial task was to design and implement a feedback questionnaire to reflect the experience of families in the investigation process. The general consensus from the responding families (one third of those contacted) was that the timing of contact from the Investigating Officer was acceptable and that a clear explanation of what the investigation process involved was given. It was also evident that sharing a draft copy of the report should be considered best practice. Half of the responders felt that the reports were difficult to understand which highlights the need for better communication to families regarding the report structure, content, conclusions and future actions. This will be a focus of the continued improvement work during 2017/18.

There is currently an emphasis on training design and implementation with the focus on improving communication with families. A communication masterclass for clinical staff is being jointly developed by the Trust Chaplain and the Family Liaison Officer and will run in the summer of 2017.

Sign up to Safety Campaign

Southern Health continues to participate in the national Sign up to Safety campaign and we are pleased to report the successful end to year two of the programme. The philosophy of the campaign is locally led, self-directed safety improvement and as we enter year three of the campaign we will be refreshing our improvement ambitions through the Patient Safety group.

One of priorities which we have achieved is the complete redevelopment of our serious incident investigation process. We have achieved:

- rewrite of policies and procedures for incident reporting and being open (Duty of Candour)
- permanent recruitment of dedicated Lead Investigating Officers
- two day training course for investigating officers
- establishment of corporate assurance panel for all serious incident reports with executive level Chair
- involvement of families in the investigation process
- compliance to the NHS England Serious Incident Reporting Framework

Staff Survey

The NHS staff survey is one way that the Trust can hear directly from staff about their experience at work. We activity encourage all staff to participate.

The most recent indicators for KF26 – percentage of staff experience harassment, bullying or abuse from staff in the last 12 months and KF21 percentage believing that the Trust provides equal opportunities for career progression or promotion are shown below:

KF 26	percentage of staff experience harassment, bullying or abuse from staff in the last 12 months	20%↓
KF 21	percentage believing that the Trust provides equal opportunities for career progression or promotion	88%↔

Freedom to Speak Up

A dedicated Freedom to Speak Up Guardian has been appointed during the year following from the recommendation of Sir Robert Francis, following his review and subsequent report into the failings in Mid-Staffordshire.

The guardian, who was recruited from a clinical background has a key role in helping to raise the profile that staff are able to safely raise concerns. She provides confidential advice and support to staff in relation to concerns they have about patient safety, the way they are investigated and responded too. As the role has dedicated time for this responsibility, she is able to offer opportunities through team visits and face-to-face sessions rather than being just contactable by phone which we believe will encourage a better reporting culture.

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

The opportunity to provide feedback on the Quality Account was offered to the following bodies:
Clinical Commissioning Groups - West Hampshire, South Eastern Hampshire, North Hampshire, Fareham & Gosport
Healthwatch organisations – Hampshire, Southampton, Portsmouth.
Governors
Overview and Scrutiny Committees – Hampshire, Southampton, Portsmouth,

Feedback that has been received is included in this annex.

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.

NHS Improvement 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 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 2016/17 and supporting guidance
- 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 2016 to the date of signing the limited assurance statement

    papers relating to quality reported to the board over the period April 2016 to the date of signing the limited assurance statement
    feedback from commissioners dated xxxxxxx

    feedback from the governors dated xxxxxxx

    feedback from local Healthwatch organisations xxxxxxx

    feedback from Health Overview and Scrutiny Committee dated xxxxxxxxx

    the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xxxxxxxx

    the national patient survey 2016

    the national staff survey 2016

    the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017

    CQC inspection report dated xxxxxx

    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 effectively in practice

the data underpinning the measures of performance reported 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 NHS Improvement's annual reporting manual and supporting 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………………………………………..Chairman

………………………Date………………………………………..Chief Executive

Annex 3: External Auditor's Limited Assurance Report

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 percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.

Data definition
Numerator
The number of people under adult mental health illness specialities on CPA who were followed up (either by face to face contact or by phone discussion) within seven days of discharge from psychiatric in-patient care during the reporting period.

Denominator
The total number of people under adult mental illness specialities on CPA who were discharged from psychiatric in-patient care. All patients discharged from psychiatric in-patient wards are regarded as being on CPA during the reporting period.

Details of the indicator
All patients discharged to their usual place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. The seven-day period should be measured in days not hours and should start on the day after the discharge.

Exemptions include patients who are re-admitted within seven days of discharge; patients who die within seven days of discharge; patients where legal precedence has forced the removal of the patient from the country; and patients transferred to a psychiatric inpatient ward.

All CAMHS (child and adolescent mental health services) patients are also excluded.

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

Detailed Guidance
More detail about this indicator and the data can be found within the Mental Health Community teams Activity section of the NHS England website.

Admissions to inpatient services had access to crisis resolution home treatment teams

Detailed descriptor
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period.

Data definition
In order to prevent hospital admission and give support to informal carers, CRHT are required to gatekeep all admissions to psychiatric inpatient wards and facilitate early discharge of service users.

Numerator
The number of admissions to the trust's acute wards that were gatekept by the CRHT during the reporting period.

Denominator
The total number of admissions to the trust's acute wards.

Details of the indicator
An admission has been gatekept by a crisis resolution team if it has assessed the service user before admission and was involved in the decision-making process which resulted in an admission. An assessment should be recorded if there is direct contact between a member of the CRHT team and the referred patient, irrespective of the setting, and an assessment is made. The assessment may be via a phone conversation or by any face-to-face contact with the patient.

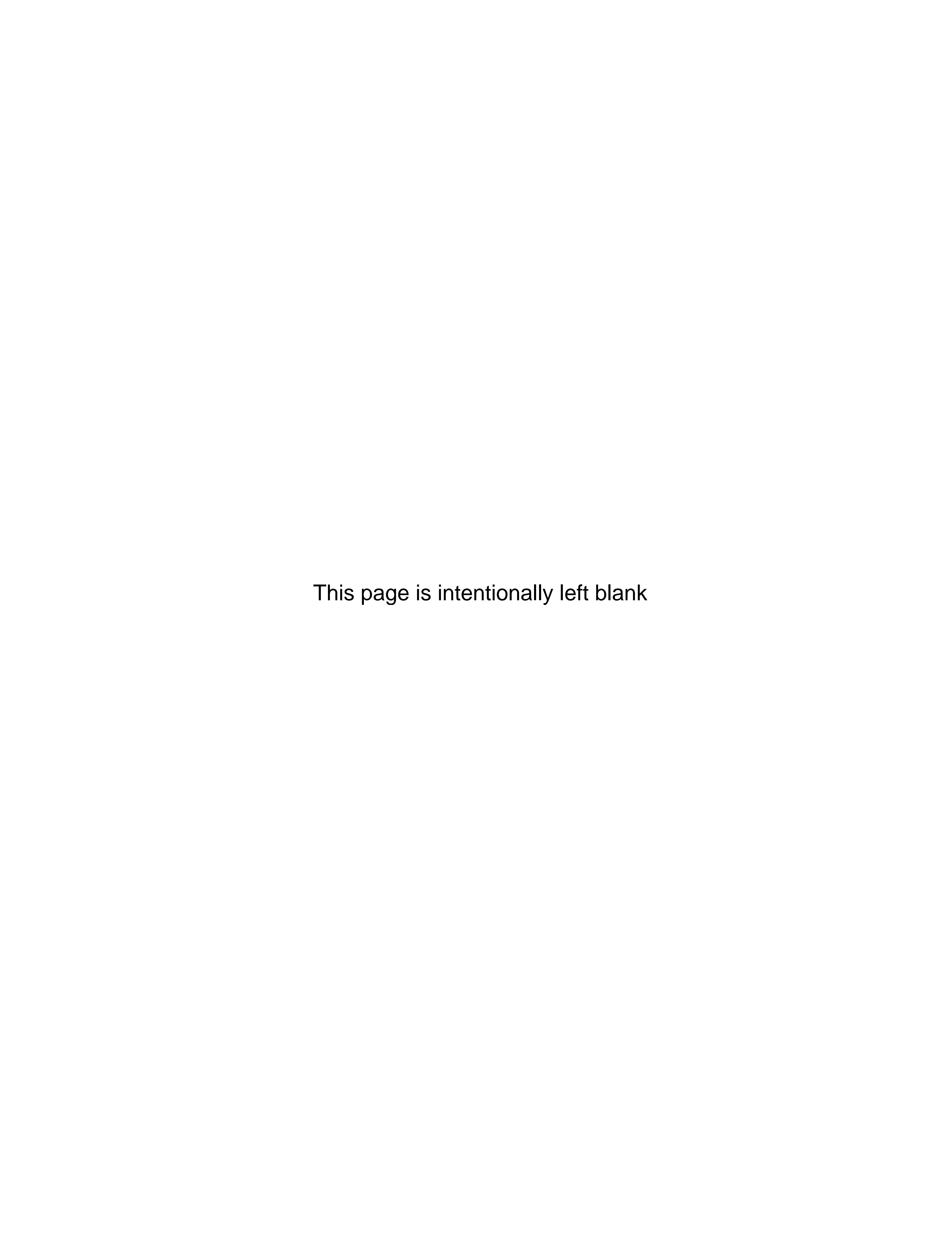
Exemptions include patients recalled on Community Treatment Order; patients transferred from another NHS hospital for psychiatric treatment; internal transfers of service users between wards in the trust for psychiatry treatment; patients on leave under Section 17 of the Mental Health Act; and planned admissions for psychiatric care from specialist units such as eating disorder units.

Partial exemption is available for admissions from out of the trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local area. Crisis resolution team should assure themselves that gatekeeping was carried out. This can be recorded as gatekept by crisis resolution teams.

This indicator applies to patients in the age bracket 16-65 years and only applies to CAHMS patients where they have been admitted to an adult ward.

Accountability
Achieving at least 95% of patients in the quarter.

Detailed Guidance
More detail about this indicator and the data can be found within the Mental Health Community teams Activity section of the NHS England website.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Southern Health NHS
NHS Foundation Trust

Southampton City Council
Health Overview and Scrutiny Panel
April 2017

Southern Health NHS Foundation Trust: Briefing on the Trust's Clinical Services Strategy

Introduction

Southern Health Foundation Trust is committed to providing the best possible care to the people of Hampshire and beyond, ranging from supporting self-help to specialised tertiary and quaternary services.

The Trust has been severely criticised over the last year, which has led it to focus on two priorities: to significantly improve its services; and to establish quickly how services need to change to be more effective for its patients and the public.

In response to the second priority, the Trust has carried out a fundamental review of its clinical strategy, with two purposes. The first is to identify how the services will be best delivered in the future and the second to look at whether the current organisational arrangements needed to change to support that clinical strategy.

This review has resulted in a new and dynamic vision for mental health and learning disability services, and an independent analysis of the development of the multispecialty community provider (MCP) model of care in Hampshire.

How was the review undertaken?

The clinical strategy work has not been a theoretical exercise, but a practical one. We have looked to clinical leaders in the Trust to develop the strategy, supported by an external expert reference group and working in partnership throughout with people who use our services and their families. It has involved a lot of work in a short time, so we have engaged Deloitte LLP to support this work. We are also working with experienced clinicians from Northumberland Tyne & Wear NHSFT, one of the largest mental Health and Learning Disabilities trusts in England recently rated outstanding by CQC.

Throughout we have been working closely with commissioners and system partners through a steering group led by the Chairman of the Trust, to ensure partners are fully involved and to encourage support for the strategy by our stakeholders. We have also adopted an inclusive approach, working with service users, families and carers, as well as our own staff, to gather their views on how services should be delivered.

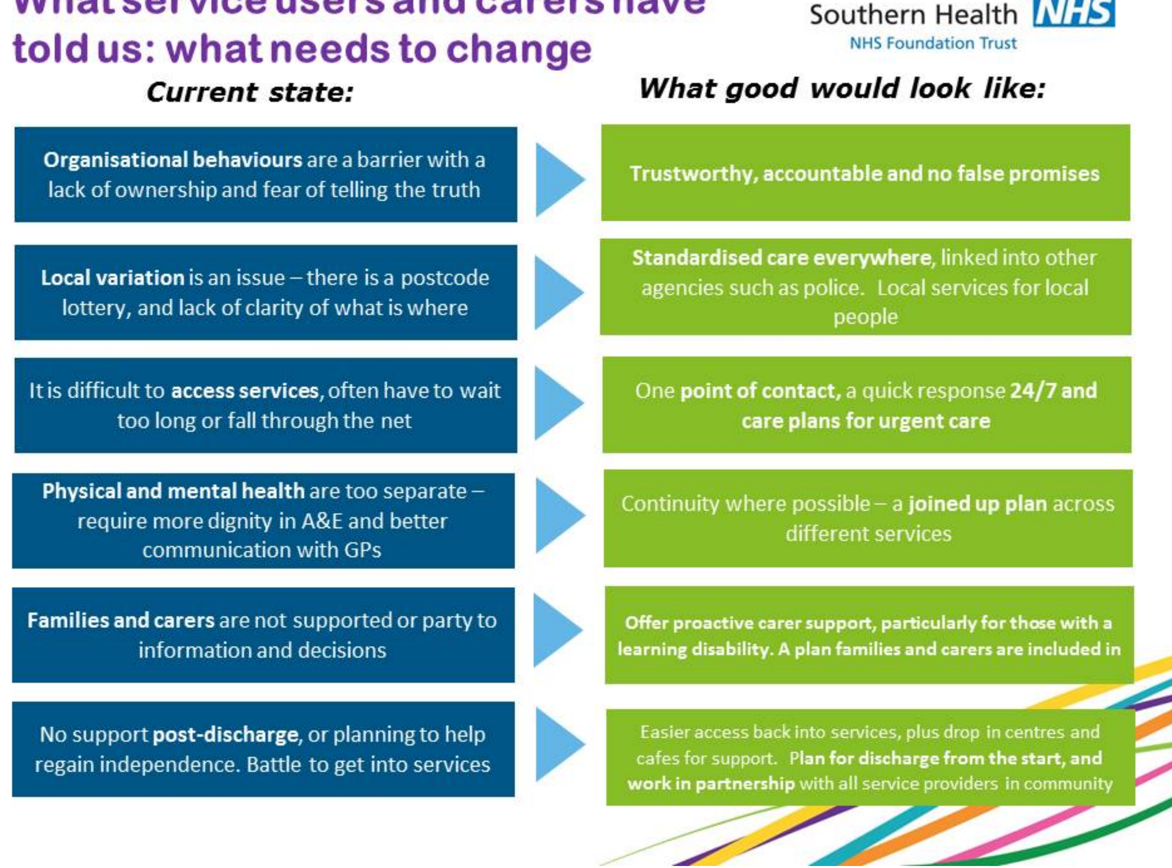
Initial findings

Following workshops with service users, families and staff, initial findings highlighted some things that work really well:

- Service users and carers cannot praise individual staff highly enough
- Examples of good practice are gathering national attention, such as perinatal services
- Staff demonstrate commitment and willingness to move forward – with service users and carers, and also each other

- Staff are excited by the opportunity to contribute to change

However, service users and carers also identified a number of issues where change was needed:



In addition, staff identified a number of challenges relating to communication with partners and duplication of work, increasing demand and financial challenges, fragmentation of the wider health system, culture, and service specific issues.

The new clinical services strategy for mental health and learning disability services

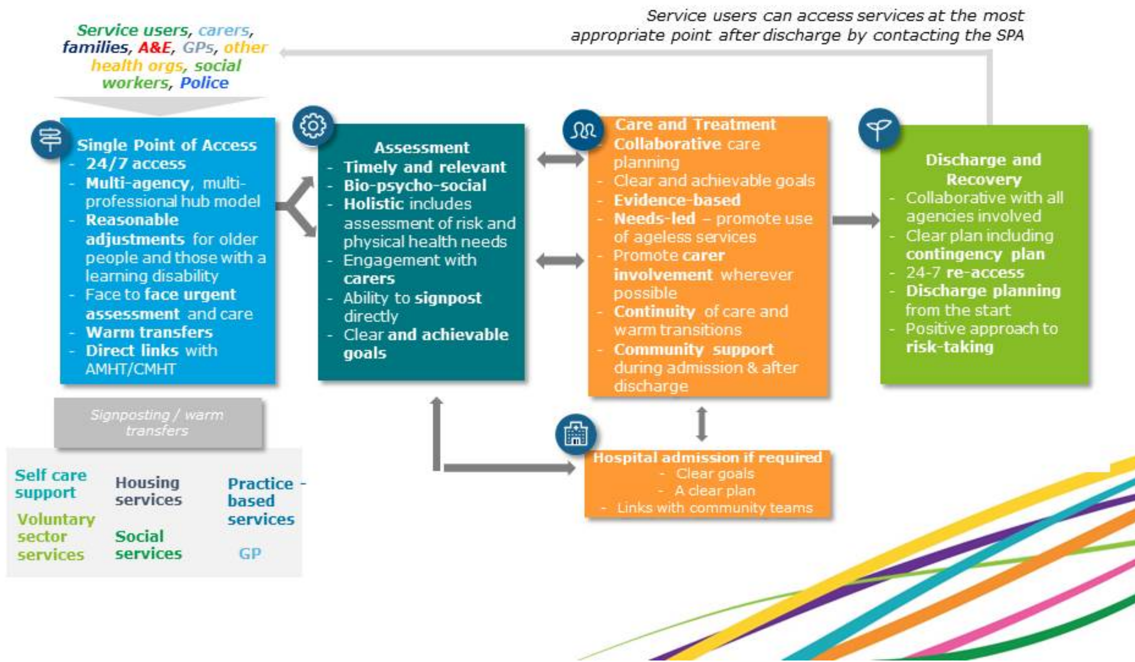
Based on the results of our engagement work, on 24 March the Trust published a Statement of Strategic Direction for its mental health and learning disability services.

This includes a set of principles to guide the Trust:

- To provide high quality, safe, person-centred and holistic services which improve the health, wellbeing and independence of the people we serve
- To deliver needs-led services, which are timely, proactive and easy to access, 24/7
- Having the right people doing the right job, taking ownership and pride in good communication
- A recovery-focused approach, with a positive attitude to strengths, resilience and risk taking, and which is adaptable to change
- Continuity across boundaries and transitions, removing the barriers

It also sets out a clinical pathway for mental health and learning disability services:

The developing pathway for mental health and learning disability services



From this we have defined seven priorities for mental health and learning disability services which are now the focus of our work:

1. We will actively involve, engage and include service users, families and carers in service delivery and design.
2. We will improve access to services via a single point of access for all requests accompanied by a culture of supporting requests for help and providing needs-led pathways.
3. We will transform the urgent care pathway to deliver responsive, reliable, high quality care 24/7 including developing alternatives to admission.
4. We will improve outcomes for those who use our services the delivery of needs-led, evidence based pathways reduce variation whilst linking into local delivery systems of care.
5. We will deliver consistent, purposeful, needs-led inpatient care across the trust when it is needed.
6. We will develop our tertiary (specialist mental health) services to provide care across a complete pathway with pathways that are consistent across the trust.

7. We will increase access to italk and work with the system to explore primary care based mental health services to keep people well.

Achieving the priorities set out above will require many months of ongoing engagement with the people we support, our staff and partners in the local health can care system. We will now be looking at the next level of detail of the mental health and learning disability pathway redesign. This will require close working with commissioners and other local providers which is being taken forward with the Sustainability and Transformation Plan Mental Health Alliance.

The future of community physical health services and the multispecialty community provider (MCP) model

We have also published a report on the development of the multispecialty community provider (MCP) care model in Hampshire in which Southern Health is a key partner. The report was produced by Deloitte LLP and represents an independent analysis of development to date and suggested next steps. It finds that clear progress has been made in trialling new ways of providing care and improving the way GPs and NHS trusts work in partnership.

On behalf of the health system Southern Health has led the development of the MCP model of care. The progress made in terms of how we work with GP and primary care colleagues is a result of the dedicated and innovative work of many hundreds of staff across all our services. Involvement and leadership from commissioners is now important to make sure the new ways of working continue into the future, aligned to the development local delivery systems described in the Hampshire and Isle of Wight sustainability and transformation plan (STP).

The next steps will involve building the existing pilot schemes into new services, and for Southern Health to develop a strategy for our community services which will determine the Trust's role in this. In time, we expect these services will become more integrated into the local delivery systems as these develop. We will support this to happen in the best possible way once the process and timescales become clear.

The next steps

We are now working to set up a comprehensive delivery hub which will ensure the necessary capacity, leadership, and improvement methodology to enable this work to be carried out effectively and at pace, with minimal disruption to existing services. We are committed to ongoing engagement with patients, staff and stakeholders as we implement this strategy.

The full published documents can be downloaded here:

http://www.southernhealth.nhs.uk/news/publication-of-clinical-services-strategy/

Quality Account 2016/17

(with our priorities for quality improvement in 2017/18)

DRAFT

Part 1

Welcome and introduction to the Quality Account

About our Trust

We provide community and mental health services to people living in Portsmouth, Southampton and in some parts of Hampshire. Our team of over 3,500 talented staff each individually make a difference to people's lives. We make over 1.5 million patient contacts each year.

We help people stay safe and well at, or close to, home. We do this by supporting families and working with partners to ensure children get the best start in life, providing services for people with complex care needs and helping older people keep their independence. We also provide screening and health promotion services which support people to lead a healthier lifestyle.

We actively promote strong out of hospital services, and we work closely with other trusts, primary care, social care providers and the voluntary sector to make sure care is joined-up and organised around the individual.

Our vision and values

Last year we refreshed our vision and values. Our shared vision is to ***provide great care, create a great place to work and deliver great value for money.***

Our 'HEART' values describe the way we would like our staff to work together and care for the people we serve, our patients, their families and carers.

Statement of Quality from Sue Harriman, Chief Executive

Thank you for taking the time to read our 2016/17 Quality Account.

Each year all providers of NHS healthcare services are required to produce an annual Quality Account for publication. We welcome the opportunity to share how we performed during 2016/17, as well as the opportunity to reflect on the areas for further improvement. I hope that you find this report a useful guide to our performance and achievements in quality, safety and patient experience over the past year, and our plans and priorities for year ahead.

I am proud to be the Chief Executive of a Trust that puts quality at the centre of everything we do. We have a team of dedicated and committed staff, who each make a difference and strive to deliver consistently great care.

We always endeavour to maintain our focus on providing safe, effective and quality services, whilst meeting the challenges of rising demand for healthcare services with limited financial resources. Our commitment to quality is strengthened by our Quality Improvement Programme. We are creating a culture of continuous improvement, providing our staff with the tools, capability and capacity to continuously improve to ensure we provide people with the best, and most effective, services we can.

During 2016/17, we welcomed a team of inspectors from the Care Quality Commission who, as a result of the inspection, have helped us on our quality improvement journey. As well as highlighting areas of good practice, they also identified areas for improvement. They awarded us an overall rating of 'Requires improvement'. However, we were delighted that many of our CQC domains were rated as 'Good' and our Learning Disability Service was rated as 'Outstanding'. The inspection outcomes drew our attention to some areas for improvement. Whilst we have already acted to make changes, we recognise that real sustainable change will take time. Our quality priorities have been developed using the outcomes from our inspection, as well as feedback from the people who use our services and our learning from incident and concerns.

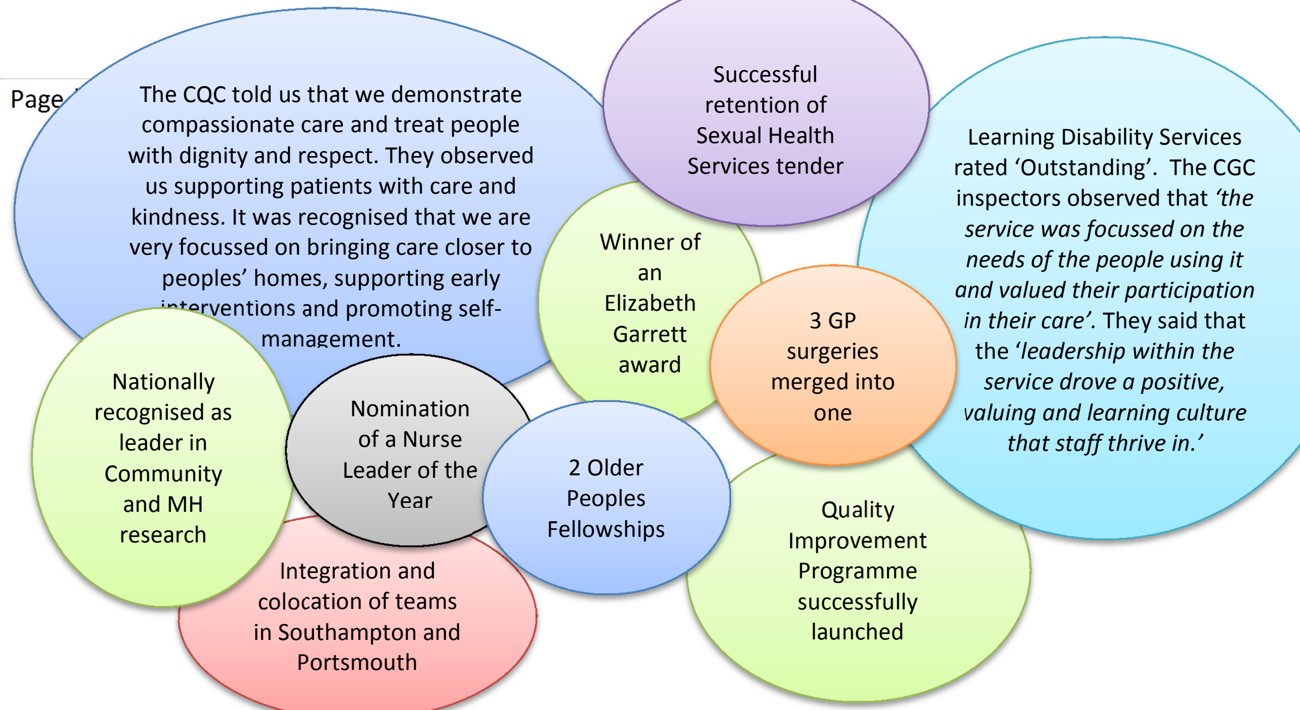
I would like to reiterate our unwavering commitment to continually improving the quality and safety of the care we provide. We recognise that much of our learning can come from listening to our service users, their carers and families, and our partners and in care. A key priority going forward will be to ensure that we continue to involve people in the development and improvement of our services, and we will continue to work with other organisations to make a difference together.

I hope you will find the information in the document useful.

Sue Harriman

Chief Executive

Some of our 2016/17 achievements:



Statement from Mandy Rayani, Chief Nurse, and Dr Dan Meron, Chief Medical Officer

As a Trust we are committed to providing care that is safe and effective. It is important that people are assured of the quality of our services and can see easily the ways in which we strive, year on year, to improve what we offer to those who need our services. To help us continue to improve our services we gather feedback using a variety of mechanisms, including the Friends and Family Test (FFT).

Using this feedback, we have identified a number of quality priorities for 2017/18. Some of these are new for this year and some are a continuation of our 2016/17 priorities which have been embedded into our day-to-day ways of working. The priorities we set each year are intended to help us achieve the five quality goals we set ourselves in 2016.

Looking ahead we will maintain our focus on the quality of care, safety and the wellbeing of our staff and the people who use our services. This remains our highest priority. The purpose of this Quality Account is to re-confirm this pledge and demonstrate how we have achieved this to date. It holds our organisation to account to ensure we deliver these standards across all those services we directly provide and in those services where we work in partnership with others.

Our approach to quality improvement

In May 2016 the Board agreed a three year Quality Improvement Strategic Framework. This Framework sets out our ambitions for quality improvement. We identified five quality goals which we aim to demonstrate achievement against over a three year period (2016-2019):

Quality goal 1: No avoidable deaths

Quality goal 2: To reduce patient harm

Quality goal 3: To reduce duplication and eliminate waste in the care process

Quality goal 4: To reduce variation and improve reliability

Quality goal 5: To focus on what matters to our patients/ service users and carers

Each year we set a small number of quality priorities to help us achieve our quality goals. We measure achievement against the annual quality priorities, and we also reflect upon the impact our work has had on delivering our overarching quality goals. Therefore, as well as setting out our priorities for next year, this Quality Account examines our achievement against both our quality priorities and our quality goals.

Part 2a

Looking ahead – Our Quality Priorities for Improvement 2017/18

How we choose our priorities

We identify our priorities in partnership with staff and based on feedback from the people who use our services, their carers and families. We also use information from incidents, complaints and patient experience measures. They are developed in line with our Quality Improvement Strategic Framework and our Trust vision: ***to provide great care, create a great place to work and deliver great value for money***

We are fully committed to achieving our priorities. Some are similar to last year's as many of our priorities are major areas of work which will take several years to fully implement and embed.

Priority 1: We will implement the Trust's professional frameworks so that our nurses and allied health professionals continue to deliver great care.
Priority 2: We will deliver the Quality Improvement Programme to enhance patient experience and make a difference to people's health and wellbeing.
Priority 3: We will continue to improve our services by using the learning from incidents, complaints and feedback.
Priority 4: We will implement the Trust's competency assessment framework to support our staff to consistently deliver safe and effective care.
Priority 5: We will have a consistent approach to involving people in the development of our services.

These priorities guide the work of our services and are used to set service-specific quality activities.

Part 2b

Looking back – A review of our performance in 2016/17 against our Quality Priorities

Our 2016/17 Quality Account included five quality priorities:

- **Priority 1:** Develop a culture of continuous quality improvement, building workforce capacity and capability through a focussed programme of quality improvement skills development.
- **Priority 2:** To provide services which ensure that mental health and physical health needs are assessed and given equality of consideration when planning and delivering care.
- **Priority 3:** We will create the environment in which service users/patient and carer involvement (co-production) is embedded at all levels: from individual care planning to service transformation change.
- **Priority 4:** To provide agreed tools for use within the Trust which enable nurses to manage staffing levels and respond to the changing complexity and levels of the care of patients on their caseload or in their ward.
- **Priority 5:** To support staff, within the Trust, to deliver care and services which demonstrate our values and enable clinical staff to meet the professional standards set by their regulatory body.

Details of our progress against each of our 2016/17 priorities are shown in the following tables.

Priority 1		Met
Quality Domain	Patient safety and effectiveness	
Priority for Improvement	**Quality Improvement (QI)** Develop a culture of continuous quality improvement, building workforce capacity and capability through a focussed programme of quality improvement skills development.	
Aim	To enable and empower staff to identify opportunities for improvement and implement changes. To enable and empower staff to demonstrate improvement via a range of formal measurement techniques.	
Progress	During 2016/17 we implemented our Quality Improvement Programme. Seven teams (70 members of staff) joined Cohort 1 in July 2016 and seven teams joined Cohort 2 in December 2016.	

Continuation for 2017/18 – aligned to Priority 2	In total, five cohorts of teams will participate in the Quality Improvement Programme over the course of three years. This is a priority for 2017/18, the programme for which includes: • Regular "Pocket-sized Quality Improvement" training available to all • Developing a Trust quality improvement hub • Supporting teams to use the online British Medical Journal (BMJ) quality tool to publish their work • Developing a network of quality improvement champions, coaches and trainers.

	Priority 2 — **Partially met**
Quality Domain	Effectiveness
Priority for Improvement	**Parity of Esteem:** To provide services which ensure that mental health and physical health needs are assessed, and given equal consideration, when planning and delivering care.
Aim	For patients/service users to experience services which provide holistic care, ensuring that physical and psychological wellbeing needs are recognised.
Progress	During 2016/17 patients accessing mental health services have been screened for physical health needs and their care has been planned in-line with guidance. **Adult Mental Health wards** An audit of patient records showed that, during October – December 2016, our adult mental health wards screened between 95-100% of patients to identify their physical health needs and care for these alongside their mental health needs. **Health and Wellbeing team (adult mental health community team)** The Health and Wellbeing team includes seven nurses who monitor the physical healthcare needs of patients at specific clinics. They contact the patient's GP if there are concerns and also undertake home visits to patients who find it difficult to attend clinics. Through monitoring of patients, the team has detected undiagnosed hypotension, diabetes and heart problems. The team will build on this next year by working with GPs and consultants to review patients on specific medication and those living in supported accommodation. **Older Persons Mental Health wards**

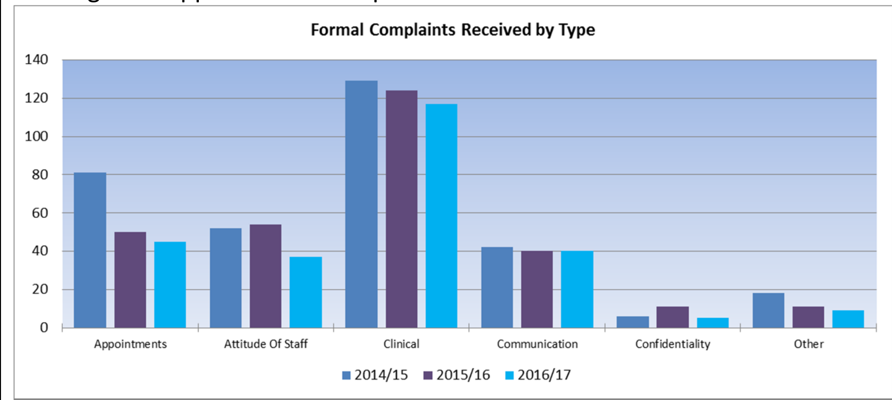
	An audit of patient records showed that, during October – December 2016, 100% of patients admitted to the ward were assessed for physical health needs within 48 hours of admission. **Dementia screening** We have experienced a number of recording and reporting challenges throughout the year relating to dementia screening. The service and the performance team have made joint recommendations for improvements to the clinical templates to ensure compliance can be accurately demonstrated. The service has also identified areas where the staff could benefit from some additional training and education around screening for patients. Audits completed during the year have produced varied results with some localities achieving 100% compliance. However the most recent audit highlights the need for additional support to ensure dementia screening is part of the core offer to all eligible patients.
Continuation for 2017/18	The physical health needs of patients will continue to be monitored within mental health services and this screening is being incorporated as part of our routine care for those accessing the services. We will continue to implement the dementia screening action plan to ensure all items are implemented and an improvement can be seen in Portsmouth and Southampton during the coming year.

Priority No 3	**Partially met**
Quality Domain	Service user experience
Priority for Improvement	We will create the environment in which service user/patient and carer involvement (co-production) is embedded at all levels, from individual care planning to service transformation change. We will promote a culture where the value, contribution and rights of carers are recognised and respected by our staff.
Aim	• To ensure that the service user/patient/carer voice is heard and used to inform service delivery • To support staff to be confident in engaging service users / patients / carers in service change • To enable patients to be equal partners in care • To have a mechanism for identifying and signposting carers so that support can be accessed

<table>
<tr><td>Progress</td><td>Palliative Care:
One of our Community Sisters for Palliative Care was nominated for a national WOW award for her outstanding customer service and was one of 75 finalists to be shortlisted from nearly 20,000 nominations. She was selected in the Judges' Choice Category and attended the Gala Awards Ceremony in November 2016.

Sexual Health Service:
At the beginning of December 2016, our Sexual Health Service rolled out an email pilot for capturing patient feedback and the friends and family test (FFT) responses. December 2016 showed a 50% increase in responses for the service compared to November 2016. Of those responding, over 95% said they would recommend the service to their friends and family.

Childrens' Services:
Our Children's Services have increased their friends and family test (FFT) response rate with the role out of 'Monkey', a pictorial survey specifically designed for children to encourage them to share their own views. This approach has strengthened the voice of the child/young person in their care.

Complaints regarding communication (YTD)
We regularly review the complaints and concerns we receive looking for common themes and trends. 'Communication / providing information to patients' remains in the top five categories of complaints received however this reflects national trends and a slight reduction has been seen over the past three years. Where any common themes are identified within this category, learning is shared across services. A number of teams have received additional training and support to address particular areas of concern.

</td></tr>
<tr><td>Continuation in 2017/18 – aligned to</td><td>During 2017/18 we will:
Demonstrate the involvement of users and carers in different aspects of our work
Refresh the patient experience action plan</td></tr>
</table>

Priority 3 and 5	• Implement recording of carer identification and signposting within our patient records system • Launch our volunteer strategy and a website for volunteers.

Priority 4	Partially met
Quality Domain	Patient Safety and Effectiveness
Priority for Improvement	To provide agreed tools for use within the Trust which enable nurses to manage staffing levels and respond to the changing complexity and levels of the care of patients on their caseload or in their ward.
Aim	To provide safe, effective and responsive care to patients whilst supporting staff, and reporting safe staffing levels.
Progress	We have piloted a workload/acuity tool within the Adult Mental Health services to support nurses to manage staffing levels within inpatient wards. An escalation framework has also been established in our Adults Portsmouth and Southampton service lines. Reports on our staffing position continue to go to Board, however our approach to staffing has continued to develop as new guidance and resources/tools have been published by the National Quality Board (NQB) during 2016/17. In-line with this new guidance, we have started to benchmark our position against the duration of care we provide to patients in a day (i.e. care hours per patient day).
Continuation in 2017/18 – linked to Priority 3 and 5	During 2017/18 we will: • Make a catalogue of acuity and dependency tools available to services. The tools for mental health services will be available by June 17 and the community tool will be available by September 17. • Continue to review national guidance as issued by NQB, amending our reporting/tools where applicable.

Priority 5	Met
Quality Domain	Experience
Priority for Improvement	**Professional standards** To support staff to deliver care and services demonstrating the Trust values, whilst enabling clinical staff to meet the professional standards set by their regulatory body.
Aim	• To embed our values in all aspects of work • To support clinical staff to demonstrate compliance with regulatory standards

	• To receive feedback from patients / service users / carers that staff have acted professionally, demonstrated honesty, valued and respected them, and engaged them in all aspects of their care and treatment
Progress	All our clinical staff are aware of who their professional lead is with clear professional escalation routes for reporting any regulatory matters. We have also established a Professional Advisory Group which is a forum for professional leads to escalate and discuss matters associated with professional standards and regulations. We have commenced the review and standardisation of nursing and allied health professionals (AHP) job descriptions. We have created strategic frameworks for the nursing and AHP workforce which set out the contribution our nurses and allied health professionals make in delivering quality care and improving patient experience. These frameworks focus on competencies relating to interventions to ensure standardised practice within each professional group. We have introduced tools to support nurses to revalidate, maintaining their registration with the Nursing and Midwifery Council (NMC). A series of road shows has given further support in reinforcing professional standards to clinical, and in particular nursing, teams. We have supported students on the NMC approved return to practice course in partnership with the local universities allowing former nurses to re-join the NMC register and start working with us as qualified practitioners. As part of their inspection, the Care Quality Commission (CQC) reflected on the caring nature of our staff commenting that we treat patients with care and kindness.
Continuation in 2017/18	In 2017/18 we will incorporate this into our day-to-day ways of working and: • Continue to use the tools introduced to support revalidation • Continue to support students on the NMC approved return to practice course • Embed the Nursing and Allied Health Professionals Strategic Frameworks • Continue to review and standardise nursing and allied health professional job descriptions, developing competency frameworks to support this

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Part 2c

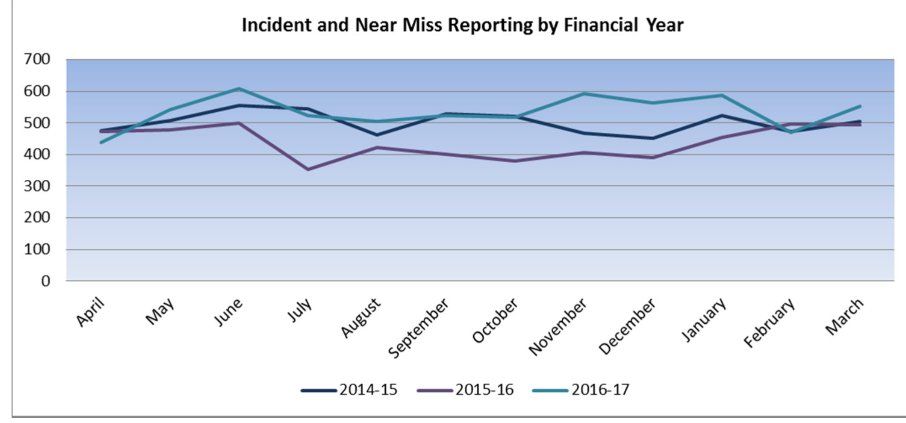
Looking back – A review of our performance in 2016/17 against our Quality Goals

The progress we have made against each of our five quality goals is shown below. For each goal we have indicated the work we will undertake in 2017/18, and the quality priority this links to, to help us further work towards achieving the goal.

No avoidable deaths	
What it means in practice	We have recognised the importance of mortality reviews and are actively engaged in developing innovative processes for identifying, reviewing, investigating and learning from deaths. We participated in the national work led by the Care Quality Commission (CQC) which led to the production of the first national guidance on learning from deaths (National Quality Board, March 2017). In line with this report we are further developing a range of processes including the: - criteria for selecting deaths to review and investigate - recording of mortality reviews - involvement of families - extraction, dissemination, and implementation of learning - reporting on mortality in-line with latest national guidance. The emphasis of this work is to ensure there is a culture and focus on learning, family experience and proportionality.
Progress and successes so far	• Our Learning Disability Service is participating in a national pilot for a Learning Disability Mortality Review process. This is coordinated by the University of Bristol and commissioned by NHS England. • In the last six months of 2016/17 every unexpected, unnatural death has been reviewed, either through the mortality review process or as a Serious / High Risk Incident (SI/HRI). • Our Chief Medical Officer is contributing to the expert team with the Department of Health and the Care Quality Commission. • Learning from serious and high risk incidents is shared every month, across all services, at Serious Incident panel meetings.
Our Quality Improvement actions for 2017/18 (linked to Priority 3):	In 2017/18 we will: • Further develop Board-level leadership in the area of learning from deaths. We will explicitly designate an executive director as the patient safety director and a non-executive director to take oversight of the process.

	• Develop and adopt a Mortality Review Policy which incorporates the National Quality Board (NQB) recommendations on learning from deaths • Develop our approach for engaging with bereaved families and carers to improve the experience of families who experience loss or where harm has occurred as a result of care or treatment provided by the Trust. This work will involve service users and their families, the Patient Experience team, the Trust's legal services manager, clinical directors and clinical governance leads. • Further embed the principles of shared learning: we already identify learning from mortality reviews and serious incident (SI) and high risk incident investigations through the SI process; however we need to further develop processes to ensure the learning is embedded across all relevant services, and action plans are audited and delivered. This will be considered in light of the national guidance. • Develop quarterly mortality reporting in-line with national guidance.

Reducing Patient Harm	
What it means in practice	We are committed to reducing patient harm and, as such, continue to develop a positive incident reporting culture to ensure lessons can be learned from all incidents and near misses and appropriate changes to practice made. Particular focus has been given to reducing unavoidable harm through improved reporting, shared learning and appropriate interventions. Further work is required to streamline the incident reporting system and strengthening the lessons learnt mechanisms.
Progress so far	• **Incident Reporting:** we use an electronic system to report and review incidents and near misses. During 2015/16 we experienced significant issues with this system resulting in a reduction in the number of low harm incidents and near misses reported. Incidents resulting in harm continued to be reported during this time, either through the electronic system or via contingency arrangements. During 2016/17, with the issues having been resolved and training and support for staff re-introduced, reporting has increased.



- **Lessons Learnt:** The serious incident (SI) process and panels have been further developed to ensure lessons learnt from SI and high risk incidents (HRI) are shared across the services and that staff feel able to report and learn from mistakes.
- **NHS Safety Thermometer:** We have maintained 95% compliance in harm free care as measured by the NHS safety thermometer tool. This monitors the proportion of patients that are 'harm free' from pressure ulcers; falls; venous thromboembolism; and urine infections for those with a catheter.
- **Development of quality dashboards:** This year we have further developed the monthly quality dashboards to allow service lines access to service line, sub-service line group, department and team level data within the same report through drop-down menus. These reports can be used by services individually, or in governance meetings to identify and discuss trends or outliers. Each month the reports are accompanied by raw datasets so these trends or outliers can be reviewed in detail if required. In addition, new graphs are being introduced, where applicable, to better display the data and allow more meaningful comparison, such as the number of compliments received compared to complaints, and benchmarks with similar trusts are being explored as a next step.
- **Service Line Quality Newsletters:** Please see Appendix B for examples of quality newsletters from our service lines.
- **Participation in the Wessex Patient Safety Collaborative Breakthrough Series Collaborative on the (Physically) Deteriorating Patient**: The aim of the collaborative is to enable all staff, involved in the pilot, to identify and recognise the deteriorating patient, to implement preventable measures and to improve outcomes.
- **The following Quality Improvement Projects have also contributed towards a reduction in patient harm:**

	○ Urinary catheter quality improvement project (Trust-wide). More information about this is available in Part 5, page 45. ○ Improving ward processes to support timely, safe and effective patient discharge within the Adults Southampton inpatient wards.
Our Quality Improvement actions for 2017/18 (linked to Priorities 1, 2 and 4):	During 2017/18 we will: • Adopt the new competency framework for nurses and Allied Health Professionals across all of our services • Complete the following quality improvement projects: ○ **Primary Care Musculoskeletal services** – ensuring the outcomes of all patients receiving physiotherapy treatment from the musculoskeletal services are evaluated. ○ **Mental health services (The Limes)** – reducing rates and severity of falls. ○ **Mental health services (community services**) – ensuring all patients prescribed olanzapine receive appropriate physical health checks. ○ **Sexual health services** – standardising brief interventions for ChemSex patients ('ChemSex' is a term commonly used by gay men and men who have sex with men to describe the use of certain drugs in a sexual context).

Reducing duplication and eliminate waste in the care process	
What it means in practice	In order to reduce duplication and waste we need to empower our staff. Through leadership we need to build staff confidence to challenge when they can identify that a change in process is needed.
Progress so far	During the year we have seen a reduction in complaints regarding the efficiency of our staff and have received positive feedback, from our staff, within the staff FFT and Annual Staff Survey- 5% more staff said that they would recommend our services to friends or family that needed treatment than in the previous year. Our latest FFT results can be found on page 37.
Our Quality Improvement actions for 2017/18 (linked to priority 2)	During 2017/18 we will: • Continue to improve upon the response rate and satisfaction levels within our staff friends and family test (SFFT) and national Annual Staff Survey. • Continue to reduce the number of complaints we receive about the efficiency of our staff by embedding lessons learnt • Undertake the following Quality Improvement projects ○ **Sexual Health Services –** Improving accessing to the Fareham and Gosport services to reduce the number of patients who do not attend appointments ○ **Nursing** – Creating effective team processes

	○ **Primary Care Musculoskeletal services** - Evaluation of musculoskeletal diagnostic imaging utilisation across Musculoskeletal Specialist Services

Reduce variation and improve reliability of care	
What it means in practice	To realise this goal we need to have clear, evidence based pathways and models of care within each service, and to reduce variation we need to review and develop pathways and develop care bundles.
Progress so far	The following quality improvement projects have helped us make progress toward achieving this goals: • **Specialist Dental Services** – improving processes for recalling patients for follow up appointments • **Children's services** – streamlining the process for health contributions to Education Health Care Plans
Our Quality Improvement actions for 2017/18 (linked to priority 2)	In 2017/18 we will: • Complete the following quality improvement projects: ○ **Adults Southampton (community neurological)** – improving the new patient referral process ○ **Children's services (looked after children's service**s) – improving processes to ensure all new referrals for assessments are conducted in a timely fashion

To focus on what matter to our patients/ service users and carers.	
What it means in practice	We will seek to understand what matters to our patients, service users and carers so we can better meet their expectations. As well as engaging with users of our services, we will seek to involve them in service design.
Progress so far	• We have implemented Accessible Information (AI) standards – more information can be found in out Spotlight on AI in Part 5, page 46. • We have introduced web-based feedback in our Sexual Health Services so patients can now provide feedback online. This has seen a significant increase in response rates. • We drafted our volunteer strategic framework which will be issued for consultation in quarter 1 of 2017/18.
Our Quality Improvement actions for 2017/18 (linked to priority 2)	**In 2017/18 we will:** • Implement the recording of carer identification and signposting in our electronic patient record. • Introduce 'Always Events' in primary care. Always events are aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every

	time. This can be linked to the quality improvement programme for rollout. • Maximise the use and development of volunteers.

Part 2d

Openness and honesty when things go wrong

Duty of Candour

All healthcare professionals have a duty of candour. This is a professional responsibility to be honest when things go wrong with a patient's treatment or care which causes, or has the potential to cause, harm or distress. This responsibility extends to service users, carers, advocates and families. Professionals are expected to:

- tell the service user or, when appropriate, the service user's carers/advocates when something has gone wrong
- apologise and offer an immediate appropriate remedy or support to put matters right (if possible)
- explain fully any short or long term effects (if appropriate)

The Duty of Candour responsibilities are explained to staff during their induction and when they start working for us. Being open and honest is an integral part of our incident reporting culture - all staff are encouraged to discuss incidents with patients, services users and carers as they occur.

In 2016-17, we have complied with the duty of candour regulation for all appropriate serious incidents (SI) and high risk incidents (HRI) reported through the SI panel in 2016/17. In those instances where the Trust has not had the appropriate contact details or patients have explicitly declined receipt of a written letter following an incident this has been clearly recorded. In addition we have:

- ensured that duty of candour is considered at every strategy meeting
- ensured the duty of candour requirements have been met
- considered the service user/family's involvement in the serious incident report
- shared all findings and lessons learnt from incidents across the Organisation - an example of how we have done this can be found in the Quality Newsletters in Appendix B

Complaints

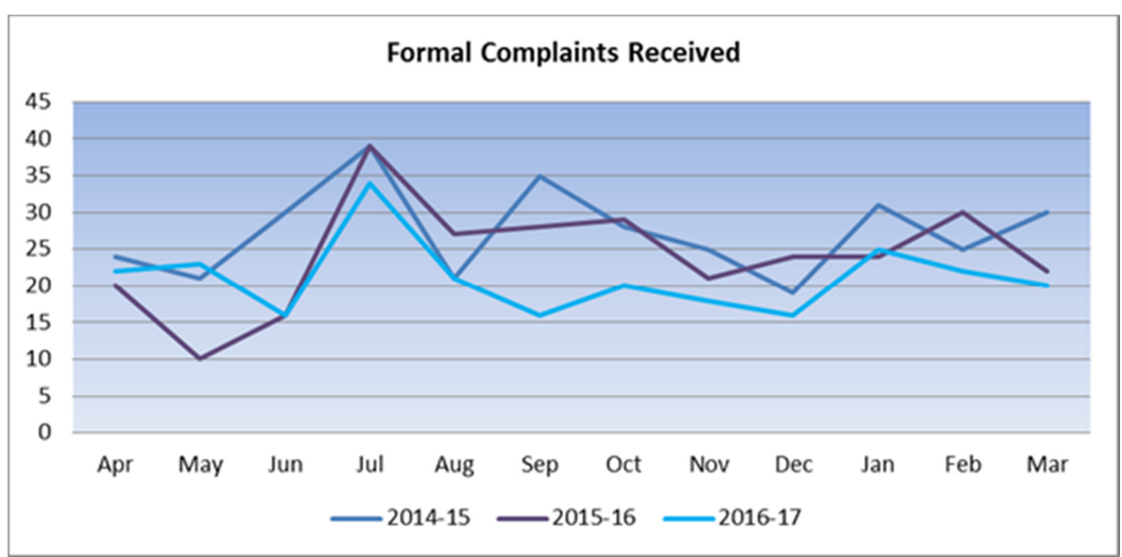
The Trust encourages the staff closest to the people receiving our services to, wherever possible and with the service users' consent, to deal with concerns and problems as they arise so that issues can be resolved quickly and in a way that is responsive to the service user's needs and circumstances. Timely intervention can prevent escalation of issues raised and achieve a more satisfactory outcome for all concerned. The approach to complaints handling in the Trust is based on the principles published by the Parliamentary and Health Service Ombudsman (PHSO).

These are:

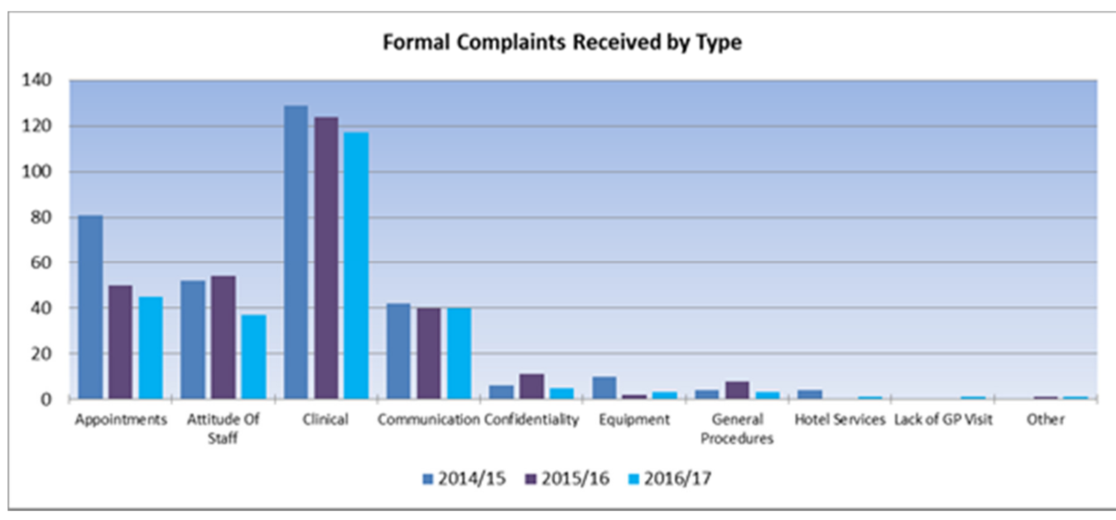
- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement.

Training has been provided to staff to ensure that anyone making a complaint is supported; receives honest, timely communication; and is clear about the actions we are going to take next.

By working with staff, closest to the person receiving the service, to help them to respond to concerns and problems as they arise we have seen a reduction in the number of formal complaints received (from 290 in 2015/16 to 253 in 2016/17). We have also seen an increase in the number of issues resolved as 'service concerns' (from 201 in 2015/16 to 251 in 2016/17). During 2016/17 we also saw an increase in the number of people making contact with our Patient Advice and Liaison Service (PALS) for advice, signposting and general queries. We received approximately 682 calls this year compared to 479 last year.



Our Trust Board receives regular reports on the number, themes and learning from complaints and our Chief Executive personally reviews all complaint responses. In addition our quarterly patient experience report, which includes details of complaints received and the associated learning and outcomes, is made available to the public via our website.



We strive to embed and sustain the changes made as a result of complaints and concerns to enable long term improvement. These changes are monitored within the services concerned and via our complaints review panel which was introduced to drive quality improvement and act as a mechanism for Trust-wide learning. This panel is chaired by one of our non-executive directors and our Chief Nurse with members including a Healthwatch colleague (the consumer champion for health and social care) and senior clinical representatives from each of our service lines.

Some examples of learning shared through the panel include:

- Sharing Accessible Information about the services patients are referred to
- Offering a meeting with the service, known as a local resolution meeting, at the earliest opportunity after a concern is raised. This may allow concerns to be resolved early, improving both the patient and staff experience.
- Terms used in complaint response letters should be clear and specific, for example instead of stating something is ‘rare’, the letter should provide context such as the number of times this has occurred in the past year.

Part 3

Mandatory statements relating to the Quality of NHS services provided

Participation in clinical audits and national confidential enquires

Clinical audit

During 2016/17, we participated in 15 national clinical audits and national confidential enquiries covering health services that we provide. We participated in 100% of the national confidential enquiries and all, but one, of the national clinical audits which we were eligible for. The audits and enquiries that we were eligible to participate in during 2016 /17 are included in Appendix A, together with the number of cases submitted to each audit or enquiry.

Examples of some of the outcomes of our local audits are detailed below:

Audit title	Improvement as a result of the audit
Re-audit: Dementia screening	Improvement in assessment of memory, functioning and care needs and care plan documentation as a result of actions from previous audit.
Bimanual examination prior to intrauterine contraceptive device fitting	100% compliance but further actions identified to maintain this compliance
Bare Below The Elbows	Compliance has increased to 95% Since the audit was undertaken further work has been completed regarding jewellery
Regional re-audit: Podiatry use of PGD (Patient Group Directions) for the provision of antibiotic therapy	During the audit, informal training occurred as staff started to apply what they had learnt even before the audit was fully completed.
Re-audit: Discharge and Disengagement Pathways 2016	An improvement on the previous audit was seen due to child and parent friendly discharge letters introduced by service as well as good documentation
Re-audit with initial audit: Use of patient identifiers in handover on rehabilitation wards	The use of patient ID stickers in the job book resulted in 98.5% compliance rate.
Looked after Children Review Audit; Consent and information submitted prior to Initial Health Assessment	Since the first re-audit in 2014, we have introduced a new consent form for young people with capacity, and a “blue card” process. The blue card captures basic consent from parent at the point of the child’s care entry. This now also includes permission for the statutory

Audit title	Improvement as a result of the audit
	health assessment (meaning that as a team we are covered to see the child); although this doesnot cover us for gathering and sharing information. In addition, since the last audit, the proportion of health assessments attended by Social workers has improved significantly which means information is available to us at the appointment in more than half of cases.
Parent Experience of Therapy SPA	A keyword image is generated from the comments/quotes received from parents about the service. This provides a visual 'snap shot' of the feedback obtained. These results demonstrate a positive response from parents participating in the audit, with the highest frequency descriptors including "helpful", "friendly" and "happy".
Child Protection Case Conference attendance	An audit on the effect of service attendance at child protection case conferences was undertaken. This revealed the process for inviting clinicians to the conferences had broken down. The audit also found that clinician attendance at the panel was significant to the outcome for the child. These findings resulted in a review of the administration process for inviting clinicians to conferences, not just within the department but also within Children's Services and there is now a robust system in place.
Was Not Brought (WNB)	This audit found that not every parent was contacted with a WNB letter when an appointment was missed and, while most late cancellations had a further appointment arranged, not all had a reason recorded for the cancellation. However the audit also found that all patients under 18 who were noted as requiring safeguarding steps had the appropriate action recorded. As a result of these findings a local operating procedure was written and the actions identified in the audit incorporated. A flowchart outlining the recommended steps has been sent to all clinicians.
Acceptability of Digital Ano-Rectal Examination (DARE) as anal cancer screening in HIV positive Men who have Sex with Men (MSM)	All MSMs are now offered this as part of standard screening and the service has produced a leaflet to explain the benefits.
Re-audit: Management of Pelvic Inflammatory Disease (PID) in GU (NICE PH 3 & BASHH standards)-	Identified that documentation was below standard, areas of concern noted-clinicians identified and messaged via their LM's; service wide sharing of lessons learned from audit and reminder of importance (and regulatory obligation) to ensure good standard of record keeping
Management of Gonorrhoea	To improve the management of gonorrhoea guidance and training was developed to enable health advisors to undertake a test of cure.
Vasectomy operations including failure rate	The service is exploring a new postal method to improve the return rate of post-operative samples for analysis (to confirm the operation has been a success). The current process is too patient intensive and time consuming. It has been identified that the current failure rates are within national guidance.
Impact of combined intervention of physical activity and cognitive	The two objectives of this audit were achieved with the result that the 'Ethogram' tool is being used for all patients taking part in the group

Audit title	Improvement as a result of the audit
stimulation on the wellbeing of patients admitted in older people mental health services	during admission as this was found to result in a higher level of engagement with tasks, more smiles and more laughter.

To date (awaiting final figure) 71 local projects have been completed from our service audit plans. These projects are determined by each service, based on their priorities, and are as a result of business plans, complaints investigations, and serious incident and high risk incident investigations. Details can be found in Appendix A.

Research

Participation in clinical research

The number of patients receiving NHS services, provided or sub-contracted by us in 2016/17, recruited to participate in research, approved by a research ethics committee, was 1,181. We have recruited to 41 studies on the National Institute of Health Research portfolio, across a range of services. We have been identified as the most research active care trust in the National League tables this year. Our research culture, and its impact on patient care, was listed by as an area of outstanding practice in our CQC inspection report.

Our research priorities:

Increasing access

We aim to make it easier for staff and patients to be involved in research, and to work in partership with our team

Developing capability

We run a number of training programmes to support research. This includes workshops and masterclasses, and a clinical academic career pathway

Working in partnership

We work in partnership with universities across the country on research studies. We also have formal partnerships for research with care homes, schools and charities

Supporting growth

We ensure that we can continue to grow via new grants and opportunities to generate income. We are also supporting staff to build an evidence base to support increased care in the community/ at home

Examples of research activity

Investigating antibiotic resistance – the Solent SMART study

This year, we have worked with the University of Southampton to look at levels of bacterial transmission in different populations and implications for antibiotic resistance. We have taken samples from volunteers, in all age groups, and in a specific care home population. This has given us the opportunity, not only to work on a key public health issue, but to work with partners around Southampton and Portsmouth. We have extended the number of homes in our Research Care Home Partnership and started to work with a number of schools and colleges. This helps us to educate young people on antibiotic use, and also on the science behind clinical research. The university have been running education workshops in schools. We will continue to build on this programme next year.

Celebrating Success – the Solent Research and Improvement Conference 2016

"Knowledge is Power: Using evidence to improve care"

In July we held a conference for patients and staff to celebrate the research that had taken place throughout the year, and how this had changed the ways we deliver our care. The conference was planned in partnership with people who use our services, and we ran a number of interactive workshops to demonstrate research in practice. For instance, we have been looking at singing therapy as a way to improve breathing techniques for people with COPD. We have also been looking at dance to reduce falls for people with Parkinson's disease. During the conference, which was attended by over 100 people, we ran singing and dancing workshops.

More information can be found on our research website pages: www.solent.nhs.uk/research.

Goals agreed with commissioners

The Commission for Quality & Innovation (CQUIN) framework aims to embed quality improvement and innovation at the heart of provider commissioner discussions. It also ensures that local quality improvements are discussed and agreed at Board level, and enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to the achievement of local quality goals.

A proportion of our income in 2016/17 was conditional upon achieving quality improvement and innovation goals, agreed between ourselves and any person or body we enter into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework. For 2016/17 the value of the CQUIN payment was £2.698m.

We are pleased to report that we achieved a significant number of our agreed CQUIN schemes. This is a reflection of the hard work of staff across the organisation.

The CQUIN schemes agreed with our CCG commissioners for 2016/17 are detailed below (awaiting final data):

CQUIN Compliance Summary

	Status Summary											
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Portsmouth CCG												
Local												
Total Contact Cast			Met			Met			Met			Met - TBC by service
COBIC	?	?	?	?	?	?	?	?	?	?	?	Met - TBC by service
ECR Case Management			Met			Met			Met			Submission Pending
Respiratory (6 months)	Partially Met	Met	Met	Met	Met	Partially Met	Met	Met	Met	Partially Met	Met	Met
In Reach (6 months)	Met	Met	Met	Met	Met	Met						
National												
Improving the health and wellbeing of NHS Staff			Met						Not Met			Met
Physical Health of People with Serious Mental illness (PSMI)			Met				Met			Met		Submission Pending
Southampton / West Hants CCGs												
Local												
Implementing Making Every Contact Count (MECC)			Met			Met			Met			Submission Pending
Frequent Users of Acute & Urgent Services			Met			Met			Met			Met
Supported Discharge			Met			Met			Met			Met
Stroke						Met			Met			Submission Pending
National												
Improving the health and wellbeing of NHS Staff			Met						Not Met			Met
NHS England												
GE2 Activation System for Patients with Long Term Conditions			Met			Met			Met			Met - TBC by service

Registration with the Care Quality Commission (CQC)

We are required to register with the Care Quality Commission (CQC). Our current registration status is “registered without conditions”; we are therefore licenced to provide services. The Care Quality Commissioner has not taken any enforcement action against us during 2016/17.

The CQC registers and licences us as a provider of care services as long as we meet the fundamental standards of quality and safety. In June this year we welcomed a team of inspectors from the CQC who highlighted areas of good practice and identified areas for improvement. We were awarded an overall rating of ‘Requires Improvement’, however we were delighted to be rated as ‘Good’ for providing caring and responsive services and our Learning Disability Service was rated as ‘Outstanding’. The inspectors observed that *‘the service was focussed on the needs of the people using it and valued their participation in their care’.* They said that the ‘*leadership within the service drove a positive, valuing and learning culture that staff thrive in.’*

The CQC told us that we demonstrate compassionate care and treat people with dignity and respect. They observed many of our staff supporting patients with care and kindness. It was recognised that we are very focussed on bringing care closer to peoples’ homes, supporting early interventions and promoting self-management. The inspectors also said that we work well with people from other organisations to help keep people out of hospital. Lots of innovative practice was found across the Trust, especially in our adults and children’s community services.

During the inspection the CQC provided daily feedback on their key findings, drawing our attention to any areas requiring improvement, enabling us to take immediate action where possible. Areas requiring more detailed response and the ‘Must Do’ and ‘Should Do’ actions identified by the CQC in the final report were included in a comprehensive action plan which is embedded within services. Whilst we have already acted to make these changes, we recognise that real sustainable change will take time and this is reflected in our quality priorities.

This action plan is reviewed regularly within services and through our governance structure at the Quality Improvement and Risk Group (QIR) and our Assurance Committee, a sub-committee of Trust Board. Actions taken to date include:

- refreshing our medicine management arrangements, including in special schools
- achievement of 95% compliance in documenting risk assessments of children and young people within the child and adolescent mental health services (CAMHS)
- completing home visits for all Substance Misuse service users with replacement drug therapy in the home who have children resident in or visiting the home
- working with our commissioners to identify opportunities for improvement in the provision of the external wheelchair services
- working with our commissioners and partners to ensure that the provision of the 136 Suite (a place of safety for those who have been detained under Section 136 of the Mental Health

Act by the police following concerns that they are suffering from a mental disorder) is robust and accessible

- ensuring that Substance Misuse Services have signed patient group direction forms (PGD) in place
- reviewing our safeguarding training
- developing our chaperone policy and training for staff in primary care
- reviewing our clinical and safeguarding supervision arrangements
- appointing a new Resuscitation Officer and reviewed the standardisation of training and equipment.

Solent community service ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires Improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Inadequate	Requires Improvemen t	Good	Requires Improvement	Requires Improvement	Requires Improvemen t
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Sexual Health	Good	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Solent mental health ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units (PICU's)	Requires Improvement	Good	Good	Good	Good	Good
Long stay/rehabilitation mental health	Requires Improvement	Good	Good	Good	Good	Good

wards for working age adults						
Wards for older people with mental health problems	Requires improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Requires Improvement	Good
Specialist community mental health services for children and young people	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community-based mental health services for older people	Requires Improvement	Requires Improvement	Inspected but not rated	Good	Requires Improvement	Requires Improvement
Community mental health services for people with a learning disability or autism	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Community Substance Misuse	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Solent Primary Medical services ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Portswood Solent GP Practice	Good	Good	Good	Good	Requires improvement	Good
Adelaide Health Centre	Good	Good	Good	Good	Good	Good
Royal South Hants Hospital - Nicholstown	Requires improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Solent NHS Trust overall ratings

Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

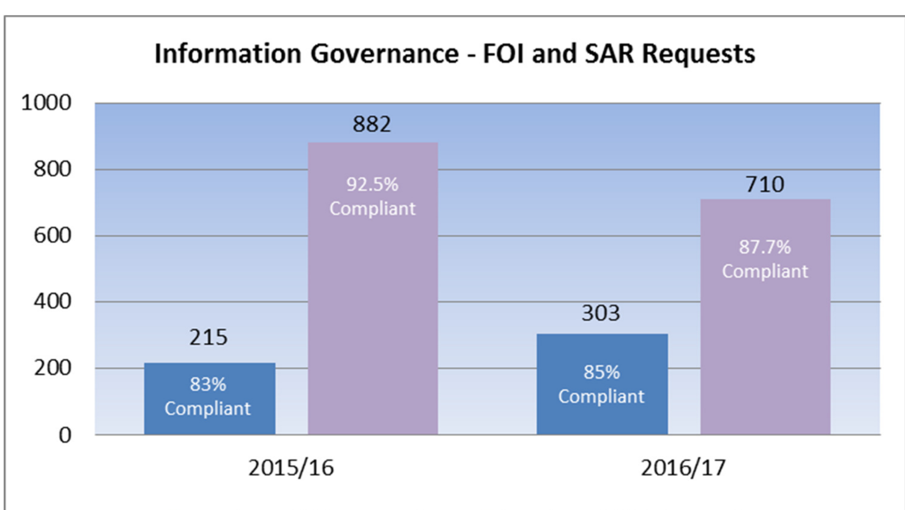
Information Governance

Information Governance Toolkit attainment - the organisation has completed an annual Information Governance Toolkit Assessment achieving 70% compliance, which has been graded as 'Green – Satisfactory'. Further information about the IG Toolkit can be found www.igt.hscic.gov.uk

Freedom of Information (FOI) Requests – the number of FOI requests received within a financial year has increased by 41% when comparing 2016/17 to 2015/16. This year we have achieved 87.7% compliance with the 20 working day response target. This is a reduction on 2015/16 when we achieved 92.5% compliance. At this time, 10 requests are not currently due and have therefore been excluded from these figures. This reduction in compliance is due to the increasing number of requests which have also increased in complexity. The Trust will be reviewing the processing of requests to improve compliance.

Subject Access Requests (SARs) – the number of subject access requests received within a financial year has decreased slightly as the Trust no longer manages the Walk in Centre and Minor Injury Unit which were previously subject to a high volume of requests. At this time, 91 requests are not currently due and have therefore been excluded from these figures.

This year we achieved 85% compliance with the 40 day response target which is a slight increase on 2015/16 when we achieved 83% compliance. The Information Governance Team is currently reviewing the process of handling these requests to continue to increase compliance.



Clinical coding

Clinical coding is the translation of written medical terminology into alphanumeric codes. Each code is a set of characters that classify a given entity. Clinical coders extract the relevant information from a source document and assign the appropriate codes that represent the complete picture of a patient spell in hospital. This is in accordance with the NHS Data Dictionary and World Health Organisation standards set out in the Clinical Coding Instruction Manual - International Classification of Diseases version 10.

Clinical coding is important for local and national monitoring of incidence of diseases and in acute trusts is used in the development of reference costing for contractual purposes. We are responsible for providing accurate, complete, timely coded clinical information to support commissioning, local information requirements and the information required for the Commissioning Data Set (CDS) and central returns.

Each year the coding process is audited by an external accredited auditor. The audit examines the quality and completeness of clinical information available for coding as well as the completeness and accuracy of the coding itself. We have achieved a top level three rating for the past two years.

Department of Health Mandatory Quality Indicators

We have reviewed the required core set of quality indicators which we are required to report against in their Quality Accounts and are pleased to provide you with our position against all indicators relevant to our services for the last two reporting periods (years).

Preventing people from dying prematurely - Seven day follow-up

The data made available with regard to the percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care. This allows us to ensure our servicer users' needs are cared for and they remain safe following discharge from hospital to community care.

NHS Organisation(s)	2015-16	2016/17 (Q2 for info awaiting year end figure)	National Average	Other Trusts – Highest	Other Trusts – Lowest
Solent NHS Trust	99%	100%	96.5% *(Q2 16-17)*	100% *(Q2 16-17)*	76.9% *(Q2 16-17)*

Enhancing quality of life for people with long-term conditions – Gatekeeping

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment team acted as a gatekeeper during the reporting period. The crisis resolution teams provide prompt and effective home treatment for people in mental health crisis and quickly determine whether service users should be admitted to hospital, or if suitable for home treatment. It is important to our service users that they are treated effectively and promptly in the most appropriate settings of care.

NHS Organisation(s)	2015-16	2016/17 (Q2 for info awaiting	National Average	Other Trusts – Highest	Other Trusts – Lowest

		year end figure)			
Solent NHS Trust	100%	100%	98.2% *(Q2 16-17)*	100% *(Q2 16-17)*	76.0% *(Q2 16-17)*

Ensuring that people have a positive experience of care – Community Mental Health Patient Survey

The Health and Social Care Information Centre (HSCIC) provides patient experience indicator data for the annual national Community Mental Health (CMH) Survey. The CQC does not provide a single overall rating for each trust for this survey, as it assesses a number of different aspects of people's care and results vary across the questions and sections.

In the patient survey report published by the Care Quality Commission (CQC), the results are presented as standardised scores on a scale of 0 to 10. The higher the score for each question, the better the Trust is performing. As can be seen from the table below, we have been rated as 'about the same' as most other trusts in the survey by the CQC.

We consider that this data is as described as this Care Quality Commission (CQC) national survey was developed and coordinated by the Picker Institute Europe, a charity specialising in the measurement of people's experiences of care.

	2015-16				2016/17	
Survey Section	**Solent Patient Responses**	Lowest Trust Score	Highest Trust Score	*CQC Comparison with Other Trusts*	**Solent Patient Responses**	*CQC Comparison with Other Trusts*
Health & social care workers	**7.4/10**	6.8	8.2	*About the same*	**7.4/10**	*About the same*
Organising Care	**8.4/10**	7.9	9.0	*About the same*	**8.7/10**	*About the same*
Planning Care	**6.8/10**	6.1	7.6	*About the same*	**6.8/10**	*About the same*
Reviewing Care	**7.3/10**	6.8	8.2	*About the same*	**7.3/10**	*About the same*
Changes in Who People See	**5.8/10**	4.7	7.3	*About the same*	**6.0/10**	*About the same*
Crisis Care	**5.8/10**	5.1	7.2	*About the same*	**6.1/10**	*About the same*
Treatments	**7.0/10**	6.3	7.9	*About the same*	**7.1/10**	*About the same*
Support & Wellbeing					**5.0/10**	*About the same*

Overall Views of Care & Services	**7.2/10**	6.5	7.8	*About the same*	**7.2/10**	*About the same*
Overall Experience	**6.9/10**	6.2	7.3	*About the same*	**6.8/10**	*About the same*

We have implemented an action plan to improve the quality of our mental health services this includes:

- Writing Care plans in the first person - care plan training commenced in March
- Making the CRHTT service more accessible by opening up to direct referrals from the police and ambulance services
- Talking about our customers in team meetings
- Reviewing the Friends and Family Test (FFT), analysing comments and identifying any issues requiring investigation - every month in our Governance Group, we ask a service to go through recent results and look at any issues
- Improving patient involvement: our patient forum has been running for two years providing a conduit for patient engagement in service developments and is consulted on for a number of issues such as going Smoke free
- Recruiting to the post of a physical health nurse to provide education and advice to service users and staff in the community teams
- Increasing the number of whole time equivalent (WTE) staff in our physical health and well-being team by one
- Ensuring all clinic rooms have physical health monitoring equipment available
- Co-locating Solent Mind with the community teams
- Continuing to review housing provision placements and the local housing available through the transformation project
- Reviewing the pathway for people who use our services to ensure interventions happen in a timely way

Treating and caring for people in a safe environment and protecting them from avoidable harm – Patient safety incidents

The purpose of this indicator is to help monitor shifts in the risk of severe harm or death to patients and to identify new emerging risks so that we are able to proactively identify potential impacts on patient care. Trusts that have high reporting figures have a better safety culture.

Patient safety incident data is collected centrally by the National Reporting and Learning Service (NRLS). Two measures are reported below for the rate of incidents reported per 1000 bed days and the rate of incidents which are categorised as causing severe harm or death.

The NRLS considers high levels of incident reporting by Trusts to be an indicator of a positive reporting culture. Consequently, high numbers of incidents are viewed positively, particularly when the proportion of serious incidents is low and the proportion of no harm incidents is high.

Please note that the full report for April-September 2016 is not currently available due to a delay of six months from when data is submitted to the NRLS to it being published.

	October 2014 to March 2015	April 2015 to September 2015	October 2015 –March 2016	April 2016 to September 2016
Patient safety incidents per 1,000 provider bed days				
Solent NHS Trust	83.93	65.57	28.46	67.1
National Average *(Mental Health Trusts)*	38.92	42.00	42.03	42.45
Patient safety incidents resulting in severe harm or death				
Solent NHS Trust	1.34%	2.14%	6.01%	14.29%
National Average *(Mental Health Trusts)*	1.06%	1.14%	1.14%	Currently Unavailable

Part 4

Review of Quality Performance

In this section we report on the quality of the service we provide.

Same sex accommodation requirements
Why did we choose this measure? Reducing mixed sex accommodation is a national priority and Department of Health requirement
Performance: There have been no breaches during this year.

Patient Experience
Why did we choose this measure? The Friends and Family Test is a nationally mandated tool which allows services users and staff to give their feedback on NHS services
Performance:

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
16/17	**95.79%**	1.65%	15335	11711	2978	264	96	157	129
15/16	**94.95%**	2.17%	13927	10474	2749	263	116	186	139

The positive feedback from our service users last year has been sustained and improved this year, with an increase in the proportion of respondents who would recommend our services and a reduction in the proportion who would not recommend.

This shows that the majority of our service users are reporting a positive experience of care and the free text comments detail the complimentary feedback provided. Themes include comments related to our caring and professional staff. Services share the feedback with staff who are often personally named by service users and review comments for planning quality improvements.

Patient Led Assessment of the Care Environment (PLACE)
Why did we choose this measure? Department of Health requirements
Performance:

Results for PLACE 2015-2016

2015	Cleanliness	Food	Organisational food	Ward food	Privacy and Dignity	Condition and appearance	Dementia	**Disability was not scored until 2016**
Western Community Hospital	100.00%	99.76%	99.50%	100.00%	95.10%	100.00%	98.73%	
Royal South Hants Hospital	94.66%	98.36%	99.50%	97.32%	89.42%	90.91%	85.04%	
St Marys Hospital Health Campus	98.99%	93.27%	99.50%	88.85%	94.33%	93.71%	98.30%	
Jubilee House	100.00%	98.83%	99.50%	98.23%	94.05%	95.14%	95.10%	
St James Hospital	98.48%	98.81%	97.70%	100.00%	90.65%	94.59%	92.15%	

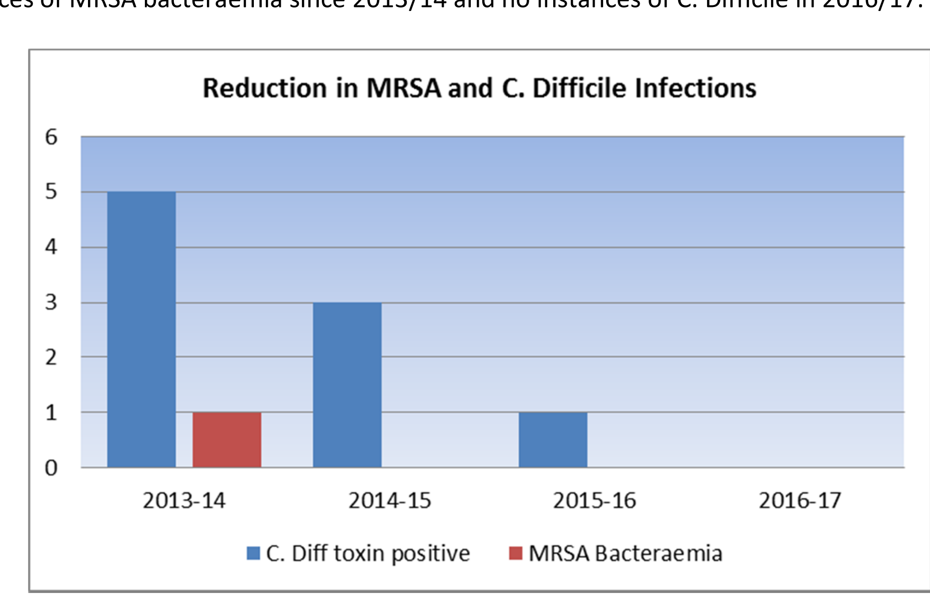
2016	Cleanliness	Food	Organisation Food	Ward food	Privacy and dignity	Condition and Maintenance	Dementia	Disability
Western Community Hospital	100.00%	98.77%	98.68%	98.84%	90.12%	100.00%	94.96%	98.53%
Royal South Hants Hospital	95.43%	94.02%	98.68%	89.62%	92.19%	90.45%	73.13%	82.69%
St Marys Hospital Health Campus	99.41%	95.71%	98.68%	92.25%	89.29%	94.86%	91.11%	87.11%
Jubilee House	99.50%	99.39%	98.68%	100.00%	89.17%	95.38%	90.83%	90.29%
St James Hospital	96.27%	98.38%	97.13%	100.00%	89.34%	94.84%	86.46%	89.66%

As the results above show we scored highly in most categories achieving 100% in a number of areas such as cleanliness, ward food and condition and maintenance. It should be noted that the dementia standard was not scored fully in 2015 and the disability standard was not scored until 2016.

The majority of the patient assessors for 2016 were also part of the 2015 team and reported being extremely impressed with the services' standards, particularly the food and cleanliness. They were pleased to see the changes that were already put into place due to their previous assessment and input.

The overall results of the PLACE visit demonstrate that there are high standards in cleanliness, condition, maintenance and food in the ward areas. There is a room for improvement in the disability and dementia scoring categories, which will be monitored. In those areas where we are tenants, or are co-located with other organisations, we work with the appropriate landlord if issues are identified and agree a joint action plan.

In order to maintain these standards, we will be re-introducing our local mini-PLACE assessments in 2017/18.

Infection control: reduction in MRSA and C. Difficile infections
Why did we choose this measure? Department of Health requirement
Performance: we are committed to a zero tolerance approach to any avoidable healthcare associated infections (HCAI's). Achieving this vision requires planning and a systematic approach to ensure the organisation has a culture where infection prevention and control is embedded in practice. We acknowledge that every member of staff needs to be involved in the process therefore making infection prevention part of everyone's job. There have been no instances of MRSA bacteraemia since 2013/14 and no instances of C. Difficile in 2016/17. 

Statutory and mandatory training for 2016/17

It is important that our staff are able to learn, develop their skills, and receive the training they need to carry out their roles safely. In 2016/17 we have supported the learning and development needs of staff linked to organisational priorities. We have:

- offered clinical learning and development opportunities
- delivered 20 leadership and Management development programmes across our framework, 61 members of staff achieved an accredited Institute of Leadership and Management qualification
- supported our newly qualified staff to make the transition from student to clinical professional through our Preceptorship programmes
- increased opportunities for our young apprentices, supporting 12 young apprentices in 2016/17

- embedded the new Practice Educator team into our service - Six Practice Educators have been helping to improve the experience placement students have whilst with us
- supported staff development including: mentoring and the delivery of clinical skills programmes
- ensured our staff are continuously developed - 91% of our staff have had an appraisal discussion with their manager, and have agreed a personal development plan
- developed a career framework to support our staff in their career planning, and to provide clear information on roles and associated training and development
- achieved 81% compliance with our Statutory and Mandatory training
- achieved 95% compliance with Information Governance training.

Mandatory Training Course	Compliance
Appraisals	91.8%
Corporate Induction	85.8%
Dementia	72.6%
Diversity	81.8%
Fire Safety	72.8%
Health & Safety	75.9%
Infection Control	78.9%
Information Governance	95%
Manual Handling	84.7%
Mental Capacity Act	72.6%
Resuscitation	95.5%
Safeguarding Adults	78.0%
Safeguarding Children	80.7%
Overall Mandatory Training	81.0%

Staff absence through sickness rate

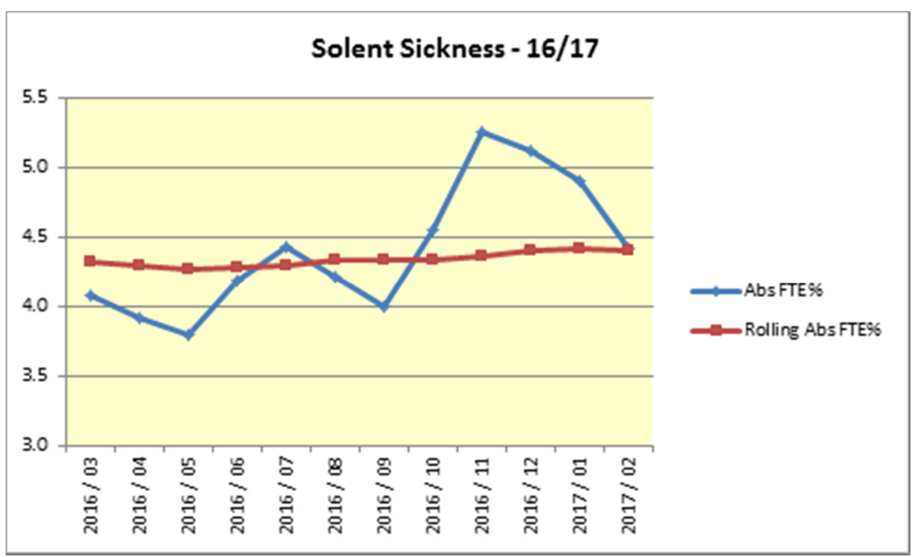
Recognising that our staff are our most valuable resource, the approach we have taken to reduce sickness absence in the last year goes hand in hand with promoting staff wellbeing. In response to sickness absence data various initiatives have been implemented and evaluated to improve staff health and wellbeing. These include the increased provision of self-referral and fast track physiotherapy, emotional resilience workshops and self-care at work. These are designed to motivate and empower staff promoting self-care approaches that will help them improve their lifestyle.

Managers are supported by the human resources and occupational health teams as well as through our Employee Assistance Programme (EAP) to manage sickness absence in-line with policy supporting staff to attend work regularly. Support is also available to sustain a return to work following a period of absence.

We hold a bi-monthly health and wellbeing steering group which is attended by key stakeholders involved in supporting staff.

In 2016, we saw our sickness absence fluctuate between 3.8% and 5.25% with usual seasonal trends occurring. Overall, the rolling sickness rate rose 0.1% to 4.42%. Stress is the main cause of sickness at 23%; this is down 1% on the previous 12 month period.

The following graph shows sickness absence rates for April 2016 to March 2017. Sickness rates have fluctuated throughout the period, with a peak of 5.25% in November 2016. The rolling absence rate however emphasises the rate based on the preceding 12 month rolling average, and we are presently 4.42%, with the trend slightly rising. The average for community and mental health trusts for 12 months to April 2017 was 4.86%.



Staff survey

We believe that the feedback we receive from our staff plays an important part in creating a great place to work. Throughout the year we encourage our staff to share what it is like to work for the Trust through formal and informal routes.

Annually, we ask our staff to take part in the Annual Staff Survey, a national survey undertaken by all NHS trusts. Our response rate to this survey was 55.3% in 2016/17, an increase of 10.9% from last year. The national average response rate was 46.5%. This is a good indicator of engagement and demonstrates that our staff value the opportunity to share their views. This continues the positive trend we have seen through the quarterly Friends and Family Test (FFT) results.

Key points from the 2016/17 survey:

- Compared to last year, we scored significantly better on 53 questions and significantly worse on only 2 questions.
- Compared to other Mental Health Community (MHC) Trusts surveyed by Pickers, we scored significantly better on 29 questions, average on 53 and worse on 6.
- Our overall engagement score, measured by NHS England, is 3.83 compared to 3.69 last year. The national average score for community trusts was 3.80.

The investment in the Great Place to Work Programme has yielded positive results with a greater focus on people through learning and development, leadership and health and wellbeing. Our collective effort to strengthen our culture through continued focus on values and behaviours is taking us in the right direction. Examples of initiatives include the Global Corporate Challenge, Dragons' Den, leadership development programmes and improved internal communications. We will need to maintain and strengthen our efforts in order to continue the positive improvements throughout the next year.

Have we improved since the 2015 survey?

A total of 88 questions were used in both the 2015 and 2016 surveys.
Compared to the 2015 survey, your organisation is:

- Significantly BETTER on 53 questions
- Significantly WORSE on 2 questions
- The scores show no significant difference on 33 questions

How do we compare to other organisations?

In this year's survey, a comparison can be drawn between your organisation and the average for all 'Picker' mental health community organisations on a total of 88 questions. The survey showed that your organisation is:

- Significantly BETTER than average on 29 questions
- Significantly WORSE than average on 6 questions
- The scores were average on 53 questions

Part 5: Quality improvement news from 2016/17

Freedom to Speak Up

This year we appointed seven *Freedom to Speak Up* guardians. These guardians are a visible resource within the Trust working to the national guardian office recommendations on issues relating to raising concerns by NHS workers.

All guardians have undertaken training from the national guardian office to enable them to review the handling of concerns raised by NHS workers. They also review the treatment of the person, or people, who spoke up if there is cause for believing that this has not been in accordance with good practice.

Developments since the introduction of these guardians include:

- implementing an on-call rota Monday to Friday
- launching a shared email account, although guardians can also be contacted on an individual basis
- embedding freedom to speak up within corporate induction
- raising awareness through articles in the weekly Staff News email, presentations at service line away days and at a variety of meetings including the Health Care Support Worker (HCSW) forum.

Quality Improvement Collaborative

July 2016 saw the launch of the Quality Improvement Collaborative. The programme is designed to support and encourage individuals and teams to develop the skills and capability to successfully develop and implement quality improvement projects within their workplace. Five cohorts of 7-8 teams will participate over the course of three years.

The programme comprises the following three core elements:

1. Individual team workshops to provide teams with support to carry out quality improvement projects within their workplace.
2. A series of 3 to 4 externally facilitated learning events on key quality improvement topics, delivered over eight months.
3. Optional master classes, delivered by external speakers and open to all staff, covering subjects such as Coaching for Improvement.

Seven teams joined Cohort 1 in July 2016, and a further seven teams joined Cohort 2 in December 2016. Work to date includes:

- Improving ward processes, such as the timing of a patient's medical review, to lower the risk of errors from rushed prescriptions so that all patients have a timely, safe and effective discharge
- Improving the process of recalling patients for follow-up dental appointments to reduce the risk of patients developing associated long-term health issues – the revised process will be launched in 2017/18

Spotlight on Catheter Improvement Project 2016/17

Urinary Tract Infections (UTI), particularly those that relate to urinary catheters, are the second largest group of Healthcare Associated Infections (HCAI) and are responsible for approximately 17.2% of all HCAIs. We have been working on improving the timely removal of unnecessary catheters, associated paperwork and ensuring this area of care is as safe as possible.

Due to inconsistencies with urinary catheter documentation in inpatient and community services, the aim of the project is to ensure that every patient with a urinary catheter will have the correct paperwork accurately completed by July 2017. Expected benefits include:

- facilitating the timely removal of unnecessary urinary catheters
- reducing the risk of HCAI and Sepsis
- reducing the use of unnecessary antibiotics
- reducing the demand on clinician's time
- reducing, pain and, increased mortality and expense.

Early in the project a baseline audit revealed that only 52% of patients had the correct paperwork completed accurately. For those patients assurance is provided that urinary catheters were appropriately placed. Six months into the project, the same audit was repeated and compliance was found to have risen to 80%, an improvement of 28%.

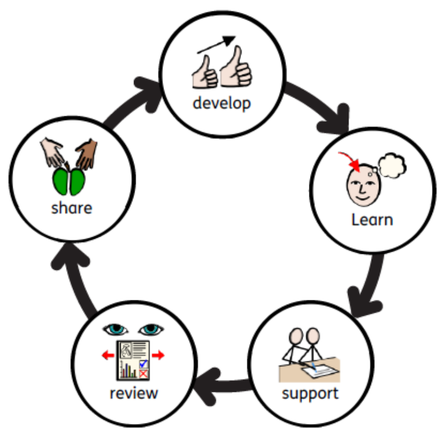
Lessons learnt, and the next steps, have been identified so we can continue to move forward and reach our aim by July 2017. This will contribute to plans from NHS England to reduce gram negative bloodstream infections by 2020, as many UTIs are caused by gram negative infections such as E.coli.

Spotlight on Accessible Information - *Supporting the communication and information needs for all*

Key developments with accessible information relate to the following five areas:

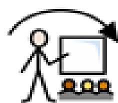
1. Introduction of a three-tiered accessible information training programme for staff
2. Development of an accessible information network

3. Recruitment of ‘Accessible Information Patient Volunteers’ and ‘Accessible Information Support Volunteers’
4. Electronic recording requirements on patient records systems and data reporting
5. Partnership working and national collaborations



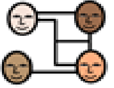
Accessible Information

Dr Clare Mander is our new lead for Accessible Information.



Clare has worked with our patients and staff to develop a programme of training.

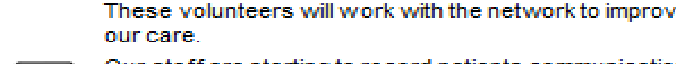
The training helps staff to support people with communication and information needs.



We now have a group of staff who are working together and learning from each other. This is called a ‘network’.

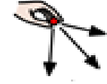
We are developing two types of volunteers that include patients and supporters.

These volunteers will work with the network to improve our care.



Our staff are starting to record patients communication and information needs on their electronic record.

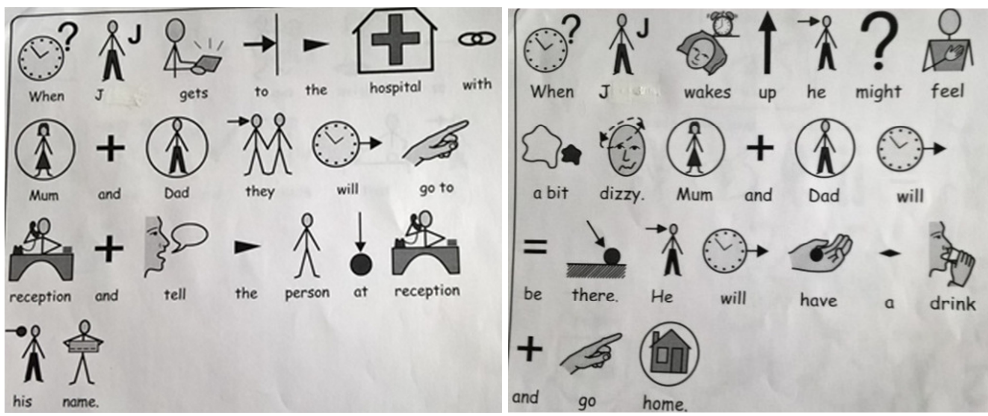
This is helping us to find out more about the level of need across the Trust.



To help others, we are sharing information about the work we are doing on accessible information.

Patient story – Dental Services

The specialist dental service had a referral for a child with autism who required an extraction under general anaesthetic (GA). The child's mum contacted the service for help in explaining the process to their child. The service was able to work with the mum using the 'At the Sleep Hospital' storyboard to help her prepare their child for the visit. The child's mum shared this information with their child's school and they developed a personalised story book that incorporated some of the 'widgets' from our storyboard as well as those the child commonly uses. This enabled the child to be familiarised with the process and their story in the run up to the appointment and was very successful in preparing the child for their GA in an unfamiliar setting and the whole procedure ran very smoothly. Just before they left, the family proudly read their 'story'. This is a section of the story (patient name removed):



This is the accessible information used by the service to explain the process of a general anaesthetic.

Spotlight on recovery and peer workers

The Recovery Approach has contributed to substantial improvements in Adult Mental Health services. The development of a Trust–wide Thematic Lead role is designed to take this learning to other areas, working with people who have long term conditions.

The approach promotes hope, self-management and opportunity to support people's adjustment to a life changing event or illness. We have learnt that a key element in this is to harness the expertise of people who have themselves used the service / had similar health conditions – called 'peers'. Using co-production to work equally with peers, we consider problems, develop solutions and deliver them together – creating a powerful, sustainable community to make improvements for individuals, services and staff. Key objectives and progress to date include:

Objective	Progress to date:
1. To increase our ability to learn from and work with people who access our services (Learning from Lived Experience LLE)	We are currently establishing a baseline, framework and learning network of services working in this way. Our aim is to share and build best practice. A few examples are shared below: - Service users in Adult Mental Health have developed a training package for staff about how to improve the experience of having their risk of suicide assessed. - Created a collection of films about service user's experience of services across the Trust. - Project to identify, trial, and embed a Patient Reported Outcome measure in Adult Mental Health including service-user led training and consultation with all staff groups. - Work-stream to engage adults with Learning Disabilities in recruitment of staff; service audits and evaluation.
2. To promote recovery principles – Hope; opportunity; self-management through – Coproduction; learning from lived experience & recovery education in services working with people with long term conditions.	- Re-launch of Solent Recovery College based in Portsmouth. In partnership with Solent Mind and Highbury Further Education College, we provide education courses about mental health for people who use mental health services, carers and staff. All courses are developed and delivered by adult mental health staff and peer trainers (people who have / have had mental health issues). We continue to host National and International visitors wishing to learn from our model. We intend to expand this model to people with other long term conditions. - Project underway to recruit peer volunteers who live well with diabetes to work with people accessing the diabetic foot clinic. Aim to improve wellbeing though improved self-management. - Work underway with Community Nursing team to enhance methods of gaining patient experience feedback from a vulnerable and disparate client group through projects to tackle social isolation and improve wellbeing.

Spotlight on Dementia Thematic Lead

We recognise the importance of ensuring that all our services and the environments in which we provide services are dementia aware and dementia friendly. In 2016 we introduced the role of Dementia Thematic Lead. This lead role works across the Trust in collaboration with frontline staff and support services teams to ensure that the necessary skills and knowledge are increased and standards are consistently achieved.

Working in partnership with Dementia UK, we began providing support and advice to a team of admiral nurses. As a consequence of our joint work, the Solent Dementia network was launched. The network is designed to give our dementia nurses and healthcare professionals easy access to quality information and support, which in turn will lead to better care for our dementia patients.

Objectives:	**Achievements to date:**
Identify training needs for staff and Implement tier two Dementia training for all relevant clinical staff.	Dementia tier two training was sourced. A 'train the trainers' day occurred in July 2016 and some of our clinicians are involved in rolling out the training. Training on offer to clinical staff since October 2016. We have offered 8 days so far with another 9 booked before end of March
Network with other agencies and local partners to share knowledge and expertise and look at collaborative working.	Networking has occurred with Wessex academic health sciences dementia programme. QAH dementia link workers, Solent Mind. Southampton Dementia Action Alliance and Portsmouth Dementia Action Alliance.
Provide expertise and advice in Dementia care across our services	Involvement in the development of trust guidelines for environmental design for people with dementia.
Develop a network of dementia champions to promote high quality dementia care.	Visits to services to offer support, including rehab wards Southampton, Community rehab teams Southampton and Portsmouth. District nursing teams Portsmouth.
Access additional learning/training to promote advanced practice and leading service improvements	This is in the early stages. Links have been made with some services. Liaison with Wessex Academic health sciences about their dementia networks

Spotlight on Falls

The Falls Thematic Lead is a Trust-wide role introduced in late 2016 to support frontline staff in delivering care in line with agreed standards. A particular focus of the role during the first year is to review the training made available to frontline staff as well as leading the updating of the Trust Falls policy in line with latest guidance. The post holder will also undertake a thematic review of falls that occur within the in-patient areas of the Trust so that further action can be identified to improve patient outcomes.

Objectives for 16/17	**Achievements to date:**
To establish a baseline of current Falls referral and management pathways across all adult services in both Southampton and Portsmouth	We have developed and disseminated two falls fact sheets, and a community post-fall protocol
To identify Falls training needs and to implement and monitor Falls training	Falls training is now on the our Learning & Development Compliance Matrix for all relevant staff
Long term objectives revise into outcome To reduce falls in our care by establishing Falls Champions , auditing the delivery of our Falls services, and provide additional information on our Intranet	Falls champions will be supporting the development a system of cascade training for falls for staff in 2017/18

Spotlight on End of Life Care

Every year, around half a million people in England die, and two thirds of them are people over the age of 75. For most people a 'good death' would mean pain free, in a familiar place with close family or friends and being treated with respect. 75% of people say they would prefer to die at home. Recently, the number of people dying at home has increased (42% in 2011), but over half of deaths still occur in hospitals.

We have appointed a part-time lead in End of Life Care. The aim of the role is to provide leadership for further development and improvement of end of life care across our Trust, ensuring patients are provided with safe, effective and high quality end of life care. This will be achieved through:

Objectives	**Achievements to date**
Networking and Collaboration: Scope and map services and identify key stakeholders and partners in relation to End of Life Care.	Networking has taken place with wider services by attending Wessex End of Life meetings. Relationships are being built with local hospices across Portsmouth and Southampton.

Network and establish relationships within the acute, primary, voluntary and private sector across the geographic areas of Portsmouth and Southampton Increase understanding and awareness of End of Life Services provided through meeting with other agencies and services within our area to enhance good practice, and improve skills and knowledge.	
Training: Identify End of Life training needs and gaps by developing and collating data through means of a training needs analysis. (Linked with departmental and organisation objectives). Re-in state and roll out of End of Life Case Management training. Introduce and roll out of the Individualised Care Plan	Training has been delivered in Communication in Advanced Decision Making and Case Management Training Individualised care plan developed and in process of being rolled out.
End of Life Link/expertise: To act as the link and subject matter expert on End of Life Care by offering guidance on service improvement and broaden End of Life Care process exposure Develop a network of Link Champions in End of Life Care to share practice and enhance End of Life Care Roll out End of Life Newsletter to share practice and inform staff	Champions in End of Life Care identified across Southampton teams and wider services
Policies and Audit: Identify a baseline policy for DNACPR and research guidance on difficult conversations in relation to CPR Develop an End of Life framework	Audit aims written and audit tool developed to identify decisions made in relation to DNACPR.

Part 6: Feedback from key stakeholders

Healthwatch Southampton comment on the initial draft Account

Healthwatch Southampton welcomes the opportunity to make formal comment on the draft of Solent NHS Trust Quality Account 2016/17.

In Southampton, the Solent NHS Trust provides in-patient care at the Western and Royal South Hants hospitals as well as GP practice surgeries and a number of outpatient clinics and community services. Healthwatch Southampton can therefore only comment on those services that apply to Southampton.

The tables given in the review of quality goals and priorities in 2016/17 section are clear and it is pleasing to see that progress has been made. We are particularly pleased to see a reduction in the complaints regarding communication although the way the bar chart is produced, starting with a base of 33, visually exaggerates the reduction.

However, further on in this section, the Quality Goals within the Strategic Framework are listed and include 'Quality Improvement actions for 2017/18' This is confusing and means that the reader is having to refer back to see how statements fit with the section entitled quality priorities in 2017/18. Despite this, the information given in these sections is clear and easily understandable. We are particularly pleased to see the proposal to introduce 'always events'.

We are pleased to see that the Trust is taking its compliance with the duty of candour very seriously and encourage an open and transparent policy.

The total number of concerns and complaints raised with the PALS and complaints service remains at about the same level but it is pleasing to see that many of these are now resolved within the services reducing the number of formal complaints. We know from our experience, and are pleased, that the PALS service is prominently advertised. The fact that the number of general contacts with the PALs service for advice and signposting has increased is evidence of its availability. Communication and information for patients is often a major cause of complaint to Healthwatch and it is good to see that this has reduced by 10% for the Trust. We applaud the establishment of a complaints review panel and that is has Healthwatch amongst its members.

The fact that Solent NHS Trust continues to be at the top of the National League tables for research activity in Care Trusts is good news not just to those immediately affected by the trials but much wider. We were pleased to see this recognised by the CQC.

The CQC rating of good for Community service accords well with our experience and the trust is to be congratulated on this rating. Patient feedback on the primary medical services is also in line with the CQC findings and we have worked with the management of the Nicholstown surgery.

Healthwatch Southampton was involved with the PLACE inspections revealing a high standard of cleanliness, and attention to patient dignity. The facility at the Royal South Hants hospital is collocated in premises managed by NHS property services and the inspection showed significant deficiencies in the maintenance of the premises controlled by them; fortunately, this does not reflect in the scoring for Solent NHS Trust.

The improvement in staff response to the survey is encouraging as there is no doubt that the impact of staff experience can affect the delivery of care and overall patient experience.

The quality priorities for 2017/18 are welcomed but given the importance of these priorities we would have wished to see a little clearer narrative rather than the bulleted statements. We look forward to continuing an effective relationship with the Trust and will do what we can to help the trust achieve its objectives.

H F Dymond MBE
Chairman Healthwatch Southampton

Appendix A

Eligible National Clinical Audits /National Confidential Inquiries	**Percentage Number of Cases Submitted**
(CQUIN 2016/17) Improving physical healthcare to reduce premature mortality in people with severe mental illness (Change to original requirement - EIP now excluded)	Awaiting final figures
Child Health Clinical Outcome Review Programme: Chronic Neurodisability	TBC from 31/3/17
Child Health Clinical Outcome Review Programme: Young People's Mental Health	TBC from 31/3/17
Learning Disability Mortality Review Programme (LeDeR)	TBC from 31/3/17
National Audit of Cardiac Rehabilitation	TBC from 31/3/17
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme: Pulmonary rehabilitation	TBC from 31/3/17
National Diabetes Audit - Adults: National Core	TBC from 31/3/17
National Diabetes Audit - Adults: National Footcare Audit	TBC from 31/3/17
Prescribing Observatory for Mental Health Quality Improvement Programme: 7e - Monitoring of patients prescribed lithium	TBC from 31/3/17
Prescribing Observatory for Mental Health Quality Improvement Programme: 11c - Prescribing antipsychotic medication for patients with Dementia	TBC from 31/3/17
Prescribing Observatory for Mental Health Quality Improvement Programme: 16a - Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour	TBC from 31/3/17
Prescribing Observatory for Mental Health Quality Improvement Programme: 1g & 3d - Prescribing highdose and combined antipsychotics	TBC from 31/3/17
British HIV Association (BHIVA): Audit and survey of "look back" reviews of previous health service use among late-diagnosed individuals	TBC from 31/3/17
Suicide, Homicide & Sudden Unexplained Death (NCISH)	TBC from 31/3/17

Maternal, Newborn and Infant: Maternal morbidity and mortality confidential enquiries (cardiac, early pregnancy, pre-eclampsia, psychiatric morbidity)	TBC from 31/3/17

Appendix B

Examples of quality newsletters used within clinical service lines to share key messages and lessons learnt

Adults Services Southampton Quality Newsletter

21st Edition
January 2017

Clinical Director - *Dr Hayden Kirk*
Clinical Governance Lead - *Kathryn Watson*
Operations Director - *Lesley Munro*

Welcome to the twenty first edition of Adults Services Southampton Quality News Letter. We want to use this to keep all our staff informed of all that is happening in our services. Many of you won't know about other services that are hosted within our SL and this is an opportunity for you to share with others what your team does and share good practice and learning from incidents, complaints, serious incidents and mortality reviews.

Ask Lesley

Sessions are on the first and third Tuesday of the each month from 1pm-2pm
Please feel free to send in your questions at any time. Lesley will pick them up on the next session.

Email asklesley@solent.nhs.uk

Adults Southampton HQ has moved to Highpoint in the hub, however, we still have hot desks in E27 at The Western Hospital

Follow the service line on twitter **or Facebook—just click on the logo**

Newsbites

What's in the March 2017 issue?

- What did our patients say about us?
- Other Plaudits received in March
- Dental Fees Increase
- Telephone Number & Fax Number changes
- Patient Story
- Research and Improvement Workshops
- UDAs
- Area Updates
- Request from Denise
- LD Health Screening Conference
- Quality Improvement Programme
- Corporate Email Signature
- BDA CDS Group Annual Meeting
- Heather's running to raise Funds
- Hot off the Press – Latest update from Heather
- Non Patient Facing Time
- Welcome to Anna and Katy
- Solent Summer Party
- Solent Quiz Night

Governance Edition

What's in the March 2017 issue?

- IS Reminders
- IS Cleaning Instructions
- Patient Safety Alert
- Denstsply Anaesthetic Announcement
- Information Governance Newsletter
- Message from Chief Nurse & Chief Pharmacy
- Taking Photos of Patients mouths
- QIP Programme
- Child Exploitation Guidelines
- Accessible Information Resource Pack
- Well Done & Thank You