Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 26th April, 2018
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Council Chamber - Civic Centre

This meeting is open to the public

Members

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

Contacts

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PUBLIC INFORMATION

ROLE OF HEALTH OVERVIEW SCRUTINY PANEL (TERMS OF REFERENCE)

The Health Overview and Scrutiny Panel's responsibilities and terms of reference are set out within Part 3 of the Council's Constitution: Responsibility for Functions

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.

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.

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent lives
- Southampton is an attractive modern City, where people are proud to live and work

CONDUCT OF MEETING

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 2017/2018

2017	2018
29 June	22 February
24 August	26 April
26 October	
7 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)

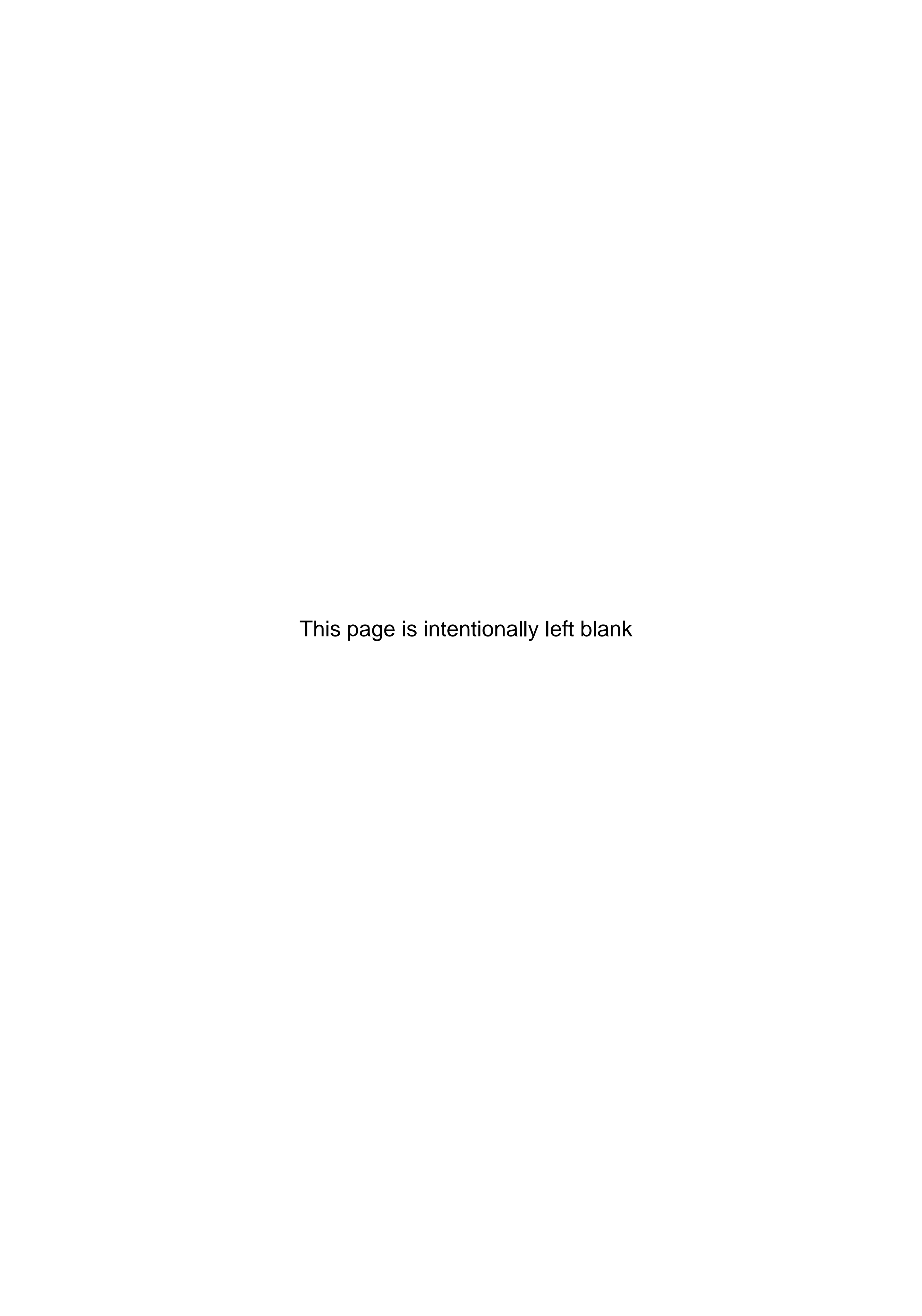
To approve and sign as a correct record the minutes of the meeting held 22 February 2018 and to deal with any matters arising, attached.

7 SOUTHAMPTON PROVIDER DRAFT QUALITY ACCOUNTS 2017/18

(Pages 5 - 256)

Report of the Service Director, Legal and Governance introducing the 2017/18 draft Quality Accounts for NHS providers operating within Southampton.

Wednesday, 18 April 2018 SERVICE DIRECTOR, LEGAL AND GOVERNANCE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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 22 FEBRUARY 2018

Present: Councillors Bogle (Chair), White (Vice-Chair), P Baillie, Houghton, Mintoff, Noon and Savage

20. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panel meeting on 7 December 2017 be approved and signed as a correct record.

21. **LOCAL SAFEGUARDING ADULTS BOARD (LSAB) ANNUAL REPORT - 2016/17**

The Panel considered the report of the Independent Chair of the LSAB introducing the 2016/17 Annual Report.

Robert Templeton (Independent Chair of the LSAB), Emma Gilhespy (Business Coordinator, Local Safeguarding Children Board), Francesca Mountfort (Information Analyst) and Joe Hannigan were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel noted that the Board's Chair had changed within the last 12 months and requested that the new Chair review and discuss a number of matters including:

- The new Independent Chair of the Board's initial comments on the position of adult social care and safeguarding provision within the City;
- The increasing possibilities for interaction and information exchange between the regions Local Safeguarding boards;
- Increasing the involvement of service users to develop the Board's Plans and Strategies and a need for Adult Social Care Packages to reflect and support the cultural heritage of clients;
- The style and format of the report. The Panel encouraged the authors to use a more consistent and plainer English within future reports, but acknowledge that parts of the report had been written under a different Chair. The Panel acknowledged that there was still an issue with the quality of some of the data collected but indicated that the use of specific data sets within the report would support the narrative of the report;
- The Panel's concerns over the terminology used with the report to describe financial abuse of those in care. The Panel recognised the difficulties supporting clients to make their own financial choices was balanced against the possibility of the client making poor choices. The Panel questioned officers on what levels of safeguarding existed to reduce the risk of vulnerable adults being taken advantage of financially;
- The Panel's concerns over the issue of neglect and isolation. The Panel recognised the dangers caused by isolation, particularly for older members of society outside of formal care, and noted that there had been a scrutiny inquiry into the matter in 2017;

- The Panel sought clarification on whether there were any noticeable impacts that could be attributed to recent changes within the benefit system. Officers responded that there was no strong evidence at this stage; and
- The value of the work undertaken by different agencies such as the Hampshire Fire and Rescue Service in reaching out to clients.

RESOLVED that the Panel

(i) Noted the Local Safeguarding Adult Board report;
(ii) Recommended that for future reports care be taken to ensure that a clearer and more consistent use of plain English is used and that findings are supported by data;
(iii) Noted the involvement of agencies such as the Hampshire and Fire and Rescue Service;
(iv) Recommend that the Board seek to increase involvement of service users in the workings of the LSAB, and find a way to report their voice within the report; and
(v) Recommended that the Board review how the cultural requirements of its service users could be better reflected in their care packages.

22. **SUBSTANCE MISUSE SERVICES IN SOUTHAMPTON**

The Panel considered the report of the Director of Quality and Integration providing the Panel with an update on the development of substance misuse services in Southampton

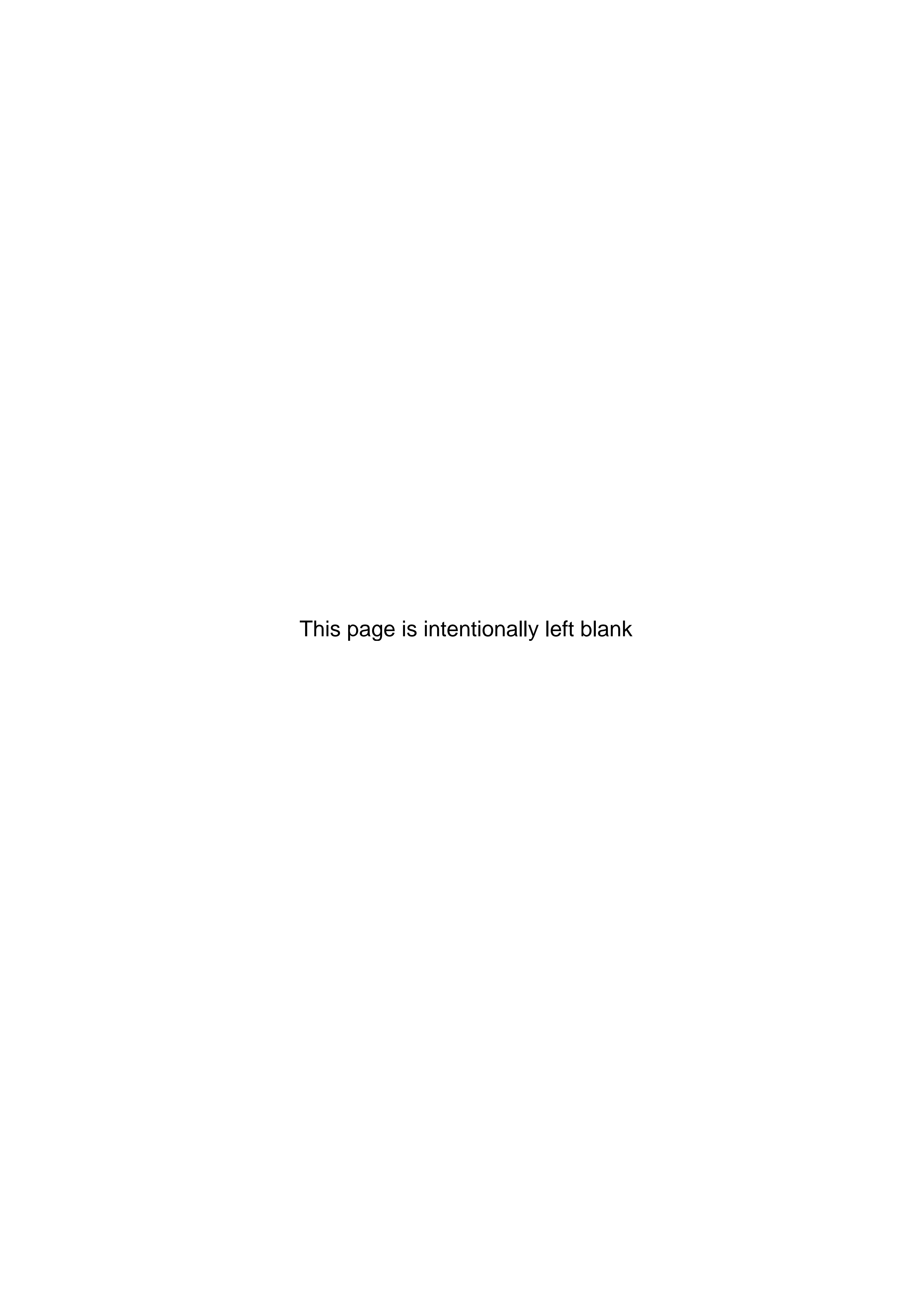
Katy Bartolomeo (Senior Commissioner - Integrated Commissioning Unit (ICU)), Jackie Hall (Commissioner ICU) Charlotte Matthews (Public Health Consultant) and Stephanie Ramsey (Joint Associate Director of the ICU and Director of Quality and Integration) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters including:

- The effects of the 2017/18 budgetary adjustments. Officers explained that a review and redesign of the service had mitigated to a large extent the effects of the budget savings. The Panel was informed that it seemed that were no detrimentally significant effects of the budgetary amendments;
- How the Council's drugs and alcohol strategies had informed the redesign of the service and how the latest review of the service aimed to further align the aims of the strategies and the continued drive for improvement;
- How the Council's performance compared with the performance of the City's comparator authorities. The Panel noted that the Council's service performance was in line with its comparators;
- The Panel noted that the review of the substance misuse services had combined two services and that the budgetary savings came from back office costings and had little effect on the service users. It was explained that figures indicated that there had been some decrease in the numbers of cases undertaken but, there was a strong indication that quality of the support offered had continued to reduce the numbers of clients being re-referred to the service;
- The Panel sought a better understanding of the timetable for the forthcoming review;

- The Panel noted that there was a significant level of data that supported the service that was not circulated at the time of the report and thanked officers for their offer to circulate the Dashboard's for the strategies;
- It was noted that the report's use of the phrase "confidence intervals" referred to the measure of certainty of the information. It was explained that the collection of information had varied levels of accuracy and that the confidence interval referred to a measure of the likelihood of a statistic or measure being accurate;
- The Panel discussed how the strategies reflected the increasing age range of those dependent on drugs and noted the process undertaken to help those with a dependency. It was further noted that a clarity from Central Government on good practice could enable more dynamic and effective strategies; and
- The Panel discussed how partnership working locally and nationally had responded to potential threats to the City from new and dangerous drugs such as Fentanyl.

RESOLVED that the Panel noted the report and stated that it would continue to monitor the performance of the service and would review the forthcoming strategies at an appropriate meeting.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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON PROVIDER DRAFT QUALITY ACCOUNTS 2017/18		
DATE OF DECISION:		26 APRIL 2018		
REPORT OF:		SERVICE DIRECTOR - LEGAL AND GOVERNANCE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**Mark.pirnie@southampton.gov.uk**		
Director	**Name:**	**Richard Ivory**	**Tel:**	**023 8083 2794**
	E-mail:	**Richard.ivory@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

This report introduces the 2017/18 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 2017/18 and highlight priorities for 2018/19.

The Panel are requested to review the appended draft quality accounts from Solent NHS Trust, Southern Health NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust (UHS) and Care UK, and agree any feedback for the NHS providers to consider prior to publishing final Quality Accounts by 30 June 2018.

RECOMMENDATIONS: That the Panel

	(i)	Review the appended 2017/18 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 26 April 2018 representatives from each of the NHS providers operating within Southampton will briefly outline their key achievements against plans for 2017/18 and highlight their priorities for 2018/19. 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.
RESOURCE IMPLICATIONS	
Capital/Revenue	
9.	None.
Property/Other	
10.	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
11.	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:	
12.	None
RISK MANAGEMENT IMPLICATIONS	
13.	None.
POLICY FRAMEWORK IMPLICATIONS	
14.	None

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

<table>
<tr><th colspan="3"><u>SUPPORTING DOCUMENTATION</u></th></tr>
<tr><td colspan="3">Appendices</td></tr>
<tr><td>1.</td><td colspan="2">Solent NHS Trust - Draft Quality Account 2017/18</td></tr>
<tr><td>2.</td><td colspan="2">Southern Health NHS Foundation Trust – Draft Quality Report and Quality Account 2017/18</td></tr>
<tr><td>3.</td><td colspan="2">University Hospital Southampton NHS Foundation Trust – Draft Quality Account and Quality Report 2017/18</td></tr>
<tr><td>4.</td><td colspan="2">Care UK – Draft Secondary Care Quality Account 2017/18</td></tr>
<tr><td colspan="3">Documents In Members' Rooms</td></tr>
<tr><td>1.</td><td colspan="2">None</td></tr>
<tr><td colspan="3">Equality Impact Assessment</td></tr>
<tr><td colspan="2">Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.</td><td>No</td></tr>
<tr><td colspan="3">Data Protection Impact Assessment</td></tr>
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<tr><td colspan="3">Other Background Documents
Equality Impact Assessment and Other Background documents available for inspection at:</td></tr>
<tr><td colspan="2">Title of Background Paper(s)</td><td>Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)</td></tr>
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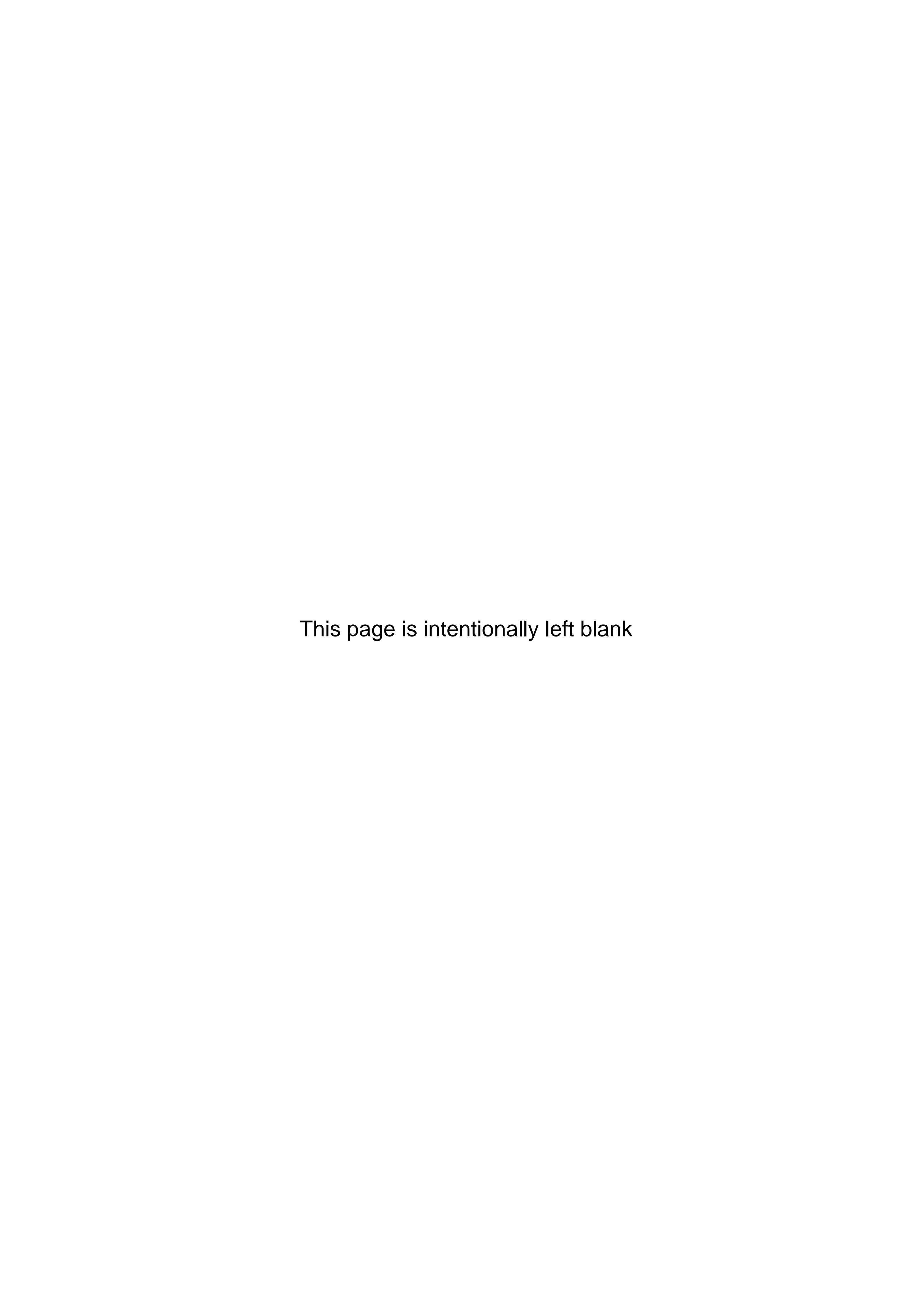
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DRAFT SOLENT QUALITY ACCOUNT

Readers are asked to note the following

- *Year End figures will be added to the document w/c 20th April*
- *There are a small number of statements to be added but these do not affect the overall themes*
- *The format followed in this report is reccomended by the 'Detailed requirements for quality reports 2017/18' published by NHS Improvement*
- *Final photos and further presentational aspects will be added prior to final inclusion in the Annual Account*
- *During May the final Quality Account will be presented at Solents*
    - *Quality Improvement and Risk Group*
    - *Assurance Committee and*
    - *Board (for final sign off)*

DRAFT 18-19

Part One

Statement of Quality from Sue Harriman, Chief Executive

Thank you for taking the time to read our 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 2017/18, 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 the year ahead.

Why we exist - 'The Solent Story'.

At Solent NHS Trust we all share an ambitious vision to make a difference by keeping more people healthy, safe and independent in, or close to, their own homes.

People, values and culture drive us. The best people, doing their best work, in pursuit of our vision. People dedicated to giving great care to our service users, and great value to our partners.

We aspire to be the partner of choice for other service providers. With them we will reach even more people, and care for them through even more stages of their lives. Ultimately it is the people we care for who will tell us if we are successful and who will help shape our future care.

We know our vision is ambitious, but we have excellent foundations. Our priorities are what we do all of the time, they are how we:

Deliver great care

- Involving service users in shaping care and always learning from their experiences
- Working closely with partners to join up care
- Treating people with respect, giving equal emphasis to physical and mental health
- Ensuring we provide quality services, which are safe and effective

Make Solent a great place to work

- Supporting people to look after their health and wellbeing
- Improving the workplace by listening to ideas and acting on feedback
- Developing leaders to support and empower people in making a difference

Deliver the best value for money

- Spending money wisely and by working with partners
- Involving people in decisions about spending money
- Enabling services to have more time to provide care

To us **Great Care** means care that is safe, joined up, simple and easy to access, and based on the best available evidence.

DRAFT 18-19

We talk about **Great Care** in the context of:

- Patient Safety
- Patient Experience
- Clinical Effectiveness

Providing **Great Care** is at the heart of everything we do.

It's the most important thing to us and to our patients, and as part of the NHS family, the quality of the care we provide reflects on the whole of the NHS, so it's vital we get it right.

Because we have many aspects of quality to share with you, we have provided signposts/hyperlinks to more detailed information.

Great Care in Action

Sally Griffin - Children's Asthma Nurse, Southampton

"I make a difference by supporting children and their families in all aspects of asthma management through offering advice, support and education.

Empowering children and young people to manage their condition safely, aims to reduce hospital admissions, promote better quality of life, and produce better health outcomes.

In addition to carrying out home visits and telephone support, I use social media to communicate relevant public health advice and health tips to service users, which keeps children and young people engaged, and informed, about the safe management of their condition"

DRAFT 18-19

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

Statement from our Chief Medical Officer and Chief Nurse

Developing, delivering, and maintaining strong and effective, high quality services is the core priority for Solent NHS Trust. We are continually reviewing and improving our systems and processes to ensure that the quality of our services is at the heart of what we do every day, and how we do it.

We are committed to providing care that is safe, effective and efficient. It is important that service users, patients and their families have a positive experience of our services, and can clearly see the ways in which we strive, year on year, to improve what we offer. As such we continue to gather feedback using the Friends and Family Test (FFT) which asks patients and users of our services, as well as our people, to tell us to what extent they would recommend our services to their friends and families.

The Trust's Quality Improvement (QI) programme continues to grow in strength and impact, aiming to support all who work with us (patients and colleagues) to develop the skills and confidence to identify, deliver and sustain improvements across our services. Our QI programme has been extended this year to include a 'Foundation Level' one day training to provide an introduction to Quality Improvement methodology, as well as bespoke QI sessions within Trust leadership and development programmes.

A core part of the programme is the involvement of patients, service users and families in identifying what could be improved, and in delivery and testing of changes. This is part of the Foundation training and of the core programme.

Looking ahead we will maintain our focus on the quality of care, safety and the wellbeing of people who use our services and our staff. This remains our highest priority. The purpose of this Quality Account is to confirm this pledge and to hold our organisation to account to deliver these standards across all those services we directly provide and in those services where we work in partnership with others.

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Part Two: Priorites for Improvement and statement of assurance from the Board

2.1 Quality Themes and Priorities

Quality Themes

Our quality themes next year are inter linked to our strategic aims, and our quality themes are focused on the following:

Theme 1: Involving People

In order to deliver great care by involving service users in shaping care , always learning from their experiences, and working closely with partners to join up care we will develop a community engagement framework, which is inclusive of patients, people who live in our communities and the local organisations and stakeholders.

In 2018/19 we will:

- Develop the community framework
- Engagement with our communities
- Develop an approach to patient co-production in delivery of service change or improvement

Theme 2: Safe Care

To ensure we provide quality services, which are safe and effective we will develop and embed quality improvement in all we do

In 2018/19 we will:

- Launch the Research and improvement Academy – home of Solent Q.I.
- Develop a QI Leaders programme
- Develop a toolkit to enable patient and family participation in quality improvement activity

Theme 3: Learning Organisation

Developing a learning framework, which delivers real change that makes a difference to people as a result of positive and negative events and feedback

In 2018/19 we will

- Launch change an improvement data base
- Develop a toolkit for learning from excellence
- Evidence the improvements as a result of learning and change

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Theme 4: Spreading excellence

Treating people with respect, giving equal emphasis to physical and mental health is key to us and spreading excellence from our outstanding specialist Learning Disability (LD) service means that we can improve care for people with learning disability across our services everywhere

In 2018/19 we will

- Work towards identifying all people with LD accessing any of our services and provide appropriately adjustments to their care plans
- Replicating the outstanding success factors from the LD service across other service lines

Theme 5: Safer Lives

We will continue to help vulnerable people in our communities live safer lives

In 2018/19 we will

- Embed Mental Capacity Act(MCA) and Safeguarding training across our services
- Develop our peoples capabilities in the application of the MCA and safeguarding principles

Theme 6: Supporting our Staff

In order to make Solent a great place to work we will continue to develop and supporting our people

In 2018/19 we will promote wellbeing in the workplace

- Creating opportunities for professional and personal development
- Rewarding excellence in our people

DRAFT 18-19

2.2 Statements of assurance from the Board

Contracts

We have a total of 99 contracts that are related to healthcare and of these 52 related to where we purchase health services.

The Organisation has reviewed all the data available to us on the quality of care in these contracts. . The income generated by these contracts represents 100% of the total income generated from the provision of these relevant health services by the Organisation for 2017/18.

Participation in local and national clinical audits and national confidential enquiries

National Clinical Audits

During 2017/18, we participated in 11 out of 12 national clinical audits and national confidential enquiries, covering health services that we provide. The audits and enquiries that we were eligible to participate in during 2017 /18 are included in Appendix A, together with the number of cases submitted to each audit or enquiry.

National audit reports are distributed on publication to the relevant service line and local audit leads along with a summary of recommendations and an action tracker to measure compliance. National audit reports are also highlighted at the trust learning and improvement group to promote cross service learning for improvement.

Local Clinical Audits and Service Evaluations

109 local audit and service evaluation project reports have been completed and reviewed during the 2017/18 financial year. These projects are determined by each service, based on their priorities, and are as a result of patient and staff feedback, business plans, complaints investigations, serious and high risk incident investigations, as a means of measuring compliance with NICE guidance and as a baseline measure for Quality Improvement projects.

Audit plans and actions are reviewed at service line audit groups with key learning and improvements shared at the trust learning and improvement group. Audit and evaluation action planning for improvement is also increasingly integrated into the trust Quality Improvement programme. Specific training on audit and evaluation is also provided.

Examples of some of the improvement outcomes achieved and actions planned as a result of local audits and service evaluations are detailed in the tables below:

DRAFT 2019

Audit title	Improvement as a result of audit
Re audit of Nutrition and Hydration for in patients (Royal South Hants).	An improvement was demonstrated to achieve 100% compliance with standards in comparison to 76% in the previous quarter.
Re-audit of pelvic inflammatory disease care in sexual health services.	Improvements were shown in comparison to the 2015 audit in exclusion of pregnancy (from 45% to 72%), correct antibiotics given (from 57% to 98%) and attendance for treatment of partners (from 1% to 16%).
Re-audit of Patient Group Directive (PGD) compliance in sexual health.	Documentation of expiry date and batch numbers of medication improved from 21% errors in 2016 to 6.7% errors in 2017 re-audit.
Re-audit of recording parental consent in specialist dental.	Compliance with the standard increased from 44% in the previous audit to 65%.
Re-audit in Mental Health services of short-term risk assessment of a self-harm episode on or during admission (NICE NG16).	Compliance with the NICE criteria was 100% from previously less than 8% in the original audit conducted in 2014.
Re-audit in Child and Family of CAMHS "was not brought" (WNB) children.	This re-audit demonstrated an improvement in attendance rates for appointments at Southampton CAMHS since September 2016, from 13% WNB to 7.9%. The most marked change was in initial assessments, from 47% WNB in 2016 to 5.6% in 2017.
Re-audit in Primary Care services of retinal screening of diabetic patients registered at Solent GP.	The percentage of patients who had documentation of retinal screening had improved since the initial audit from 71% to 76%.
Re-audit of pressure ulcers comparison with NICE guidance.	June 2017 compliance with standards was 94-100% except use of at risk care plan (88%). Re-audit in August 2017 shows similar high scores and increase use of care plans to 100%.
Re-audit of triage and prioritisation of referrals into adult speech and language therapy (east).	A previous audit highlighted that receipt of referrals was slow and the use of triage and prioritization was limited as was use of the single point of access (SPA). The re-audit shows significant improvement in all areas measured with the majority now achieving 100% compliance. The average time from sending to triage of referrals had reduced from 8 to 3 days.
Re-audit of Podiatry use of PGD (Patient Group Directions) for provision of antibiotic therapy.	Comparing 2016/17 to 2015/16 audit results there have been significant improvements. Appropriate provision increased from 63% to 100%. Adherence to treatment increased by between 16% for antibiotics and 28% for Doxycycline to reach 100%. In all cases where antibiotics have been provided, signs of clinical infection have been well documented.
Re-audit of antibiotic prescribing in Solent Special Care Dental Service.	Antibiotic training in staff meetings has resulted in an improvement in record keeping and compliance. 100% compliance with standards indicated that appropriate antibiotics are being selected and dose regimes are correct. Very few antibiotics were prescribed in the audit period by the dental service which suggests that appropriate surgical management of dental infections is being carried out.
Re-audit of completion of discharge summaries for adult inpatient services (West).	Both inpatient wards demonstrated an overall improvement in compliance percentage. Fanshawe scored 94% in quarter 1 and 100% in quarter 3. Lower Brambles scored 94% in quarter 1 and 99.7% in quarter 3.

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Audit/Evaluation title	Example actions planned as a result of audits and evaluations
Evaluation of parental satisfaction with autism assessment pathway (LD services).	Parents were concerned about waiting time and uncertainty of process for feedback. A feedback clinic has been set up to address this.
Evaluation of 'ADAPT' Pain Management Programmes (PMP).	Maintain on-going review of the PMP working with the local IAPT service and pain clinic; review how the initial screening service dovetails with subsequent assessments of suitability for PMP or 1:1 self-management; look into the longevity of giving patients pre-group preparation sessions. Reduce the number of sessions for PMP to 10 from the current 12; change from 1 month and 9 month follow-ups, to just one follow-up at 6 months.
Evaluation of clinical discussions regarding Domestic Violence (DV) (Health Visiting).	Provide further training to explore the nature of DV conversations (for disclosure and public health information) and how to enable effective early intervention to improve outcomes and safe discussions around DV; change of electronic records to incorporate healthy relationships, discussion questions and DV on every template; review individual staff record keeping and provide feedback regarding conversations about DV, interventions offered and the outcome evident; review current practice guidance to update insert that is attached to each Parent Held Record.
Evaluation of paediatric saturation probes in GP Surgeries within Portsmouth COAST catchment (NICE Clinical Knowledge Summary).	The majority (76%) of GP surgeries had at least one paediatric oxygen saturation probe; 82 % did not have paediatric saturation probes available in all consultation rooms; 72% felt that this was a problem. Some surgeries have indicated that they will change practice. Audit findings were sent to GPs to encourage them to invest in sufficient paediatric probes.
Impact of the introduction of CAMHS East Crisis Role.	Introduce another clinician to increase the amount of children and young people offered duty appointments and risk reviews; develop an urgent distress tolerance group to ensure they receive fast, effective treatment to manage their emotions and mental state.
Re-audit of Infection Prevention and Control (multi-service).	Staff training provided to highlight issues around use of hand moisturiser; hand hygiene; waste knowledge.
Routine sexual history consultation of patients presenting with a new diagnosis of sexually transmitted infection at the Royal South Hants Hospital.	Create a patient information collection tool to use with the current sexual history tool, to simplify partner notification and risk assessment and for use with the geospatial mapping software to highlight locations where there is a cluster of STIs to target health promotion; create posters for staff rooms to remind clinicians to follow the BASHH guidelines; present audit findings at monthly staff meeting.
Risk assessment for self-harm (longer term management) (NICE CG 133) in adult mental health.	Raise awareness of the importance of maintaining compliance with standards by presenting the audit at Solent's 2017 Research & Improvement Conference; set up psycho-education in coping strategies for self-harm patients on Orchards ward.
Re-audit of "Was Not Brought" children to CAMHS.	Develop a reminder service (text message) as clinicians who carried out telephone reminders had low WNB rates. Educate

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Audit/Evaluation title	Example actions planned as a result of audits and evaluations
	staff on completing appointments on electronic records; introduce pro-forma text on records to assist with the process of recording outcome / reason for WNB.
Prescriptions of Tramadol or Pregabalin with antidepressant drugs in a pain service outpatient clinic (NICE-CSK Analgesia).	Develop a process to ensure concomitant use of SSRI, SNRI and TCA and Tramadol are always included in GP correspondence; create a patient information leaflet & process; recommend to GPs that they repeat the GAD score to consider appropriate treatment; create a service standard to document if patient reports euphoria/internet buying, add record alerts to warn of concomitant use of these medications as risk factors for addiction.
Audit of Pressure Ulcers (2017-18 Quarter 3) (NICE CG 179 / QS 89) Southampton.	Introduce measures to reduce pressure ulcers by: (i) Roll out of Intentional rounding to all localities once new community nursing structure is embedded, (ii) Consideration of extension of Purpose-T pilot to community teams (Purpose-T = Pressure Ulcer Risk Primary Or Secondary Evaluation Tool); Launch updated "TIMES" wound assessment tool on records.
Audit of Family Nurse's use of Ages and Stages Questionnaires (ASQ) and Family Nurse Partnership (FNP) tools with evaluation of training needs.	Meet with nurses to provide them with the FNP guidelines and a quick start guide provided to use whilst administering ASQs; order the most up to date ASQ 3rd edition resources; arrange for NHS Digital to amend FNP Information System cut-off scores, to reflect those shown on paper assessments; establish an ASQ Pathway to ensure consistent use.
Re-audit of triage and prioritisation of referrals into adult speech and language therapy (east).	Form a centralised triage team and process to ensure that referrals are triaged equitably across the three general caseload areas. Develop a tool for demand and capacity.
Completion of diabetic foot assessment tools by GP's and nurses (Podiatry).	Attend meeting between podiatry and the nursing team to discuss findings and get feedback about DFA forms from nurses; a new DFA is now available online which may increase accuracy and completeness of forms.
Re-audit of retinal screening of diabetic patients registered at Solent GP.	Set up a batch report to ensure texts are sent to all patients who have not had retinal screening, on a six monthly basis (and check the rate of screening six monthly to ensure uptake does not drop below 75%).
Re-audit of Nutrition and Hydration for in patients (Royal South Hants).	Feedback audit results to staff with discussion around critical completion times; a mitigating circumstances box was entered onto electronic records for staff to record the reason why a MUST assessment wasn't completed, inform senior staff that they need to monitor compliance; remind staff that a care plan is needed for a MUST score of 1 or more.
Response time to safeguarding team advice line, since introduction of Lync system.	Undertake customer satisfaction evaluation; share information with the Adult Safeguarding Lead Nurse that data collecting tool should include the service that had contacted the team to make the data collection more streamlined.
Re-audit of Dental Recall Interval (NICE CG 19) (2017-18).	Share results with all staff via "Newsbites", discuss in locality meetings, discuss in general anaesthetic clinic meeting; seek clarification as to whether NICE tab used for audit data collection and the new compulsory field could be combined.

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Research

The number of patients receiving relevant health services provided by the trust in 2017/ 18 that were recruited during that period to participate in research approved by a research ethics committee was 2310.

The Trust continues to be the highest recruiter of participants in research for Care Trusts in England and further information on research activity can be found at page (n) – link to Appendix and at http://www.academy.solent.nhs.uk/

Commissioning for Quality and Innovation

A proportion of income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between ourselves and our Commissioners through the Commissioning for Quality and Innovation payment framework.

		Achievement			
Service Line	Scheme	**Q1**	**Q2**	**Q3**	**Q4**
Portsmouth Care Group	#1 – Improving Staff Health and Wellbeing				G
Southampton Care Group	#1 – Improving Staff Health and Wellbeing				G
Adult Mental Health	#3 – Improving Physical Health for people with Severe Mental Illness	G	G	G	G
Adult Mental Health	#4 - Improving services for people with Mental Health needs who present to A&E	G	G	G	G
Childrens East	#5 – Transitions out of Children and Young People's Mental Health Services (CYPMH)	G	G		A*
Childrens West	#5 – Transitions out of Children and Young People's Mental Health Services (CYPMH)	G	G		G
Adults Portsmouth	#8b – Supporting proactive and safe discharges - Community		G		G
Adults Southampton	#8b – Supporting proactive and safe discharges - Community		G		A*
Portsmouth Care Group	#9 – Preventing ill health by risky behaviours – alcohol and tobacco	G			
Primary Care	#9 – Preventing ill health by risky behaviours – alcohol and tobacco	G			
Adults Portsmouth	#10 – Improving of Wounds Assessment		G		G
Adults Southampton	#10 – Improving of Wounds Assessment		G		G
Adults Portsmouth	#11 – Personalised Care and Support Planning		G	G	G
Adults Southampton	#11 – Personalised Care and Support Planning		G	G	G
Sexual Health Services	#1.1 – Activation System for Patients with Long Term Conditions (LTCs)				R**

*Will be updated for yr end- the expected to be green

**It should be noted that the Activation System for Patients with Long Term Conditions (LTCs) by Sexual Health Services was achieved but outside the contractual timeframe

Flu Vaccinations.

This year we were set a target of vaccinating 70% of front line staff against the Flu. This was a significant challenge to us as the previous year we achieved 54%. Our Occupational Health Team initiated a number of new approaches including the introduction of peer vaccinators within service lines, incentive schemes/competitions to encourage uptake and a proactive communication strategy. This has had a significant effect and by the end of the year we vaccinated 71% of our front line staff and over 2300 staff in total

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 2017/18.

The CQC registers and licences us as a provider of care services as long as we meet the fundamental standards of quality and safety. The CQC revisited a number of services in 2017/18. As we reported in last year's Quality Account there were a number of services rated 'Inadequate', and it was these services that were re-inspected:

Children and Young Peoples Service were revisited by CQC in October

The Inspectors noted substantial improvements in the service delivered through the specialist schools we inspected on this occasion, and evidenced through the pre-inspection presentation.

They re-rated the service 'Requires Improvement' from 'Inadequate' as the Service had

- Medicines management processes, although showing improvements, were not yet fully embedded for safe practice
- Records were in the main stored correctly but not consistently and some contained out of date information

They also commented on the highly personalised care, record keeping and process assurance at one of the schools, and that the services had completed the actions we required it to take following the inspection in June 2016.

Child and Adolescence Mental Health Services were revisited in May

The Inspectors rated the services 'Good' from 'Requires Improvement' as the Service had:

- completed the actions we required it to take following the inspection in June 2016
- Staff understood how to assess and manage the risk to young people
- Staff completed care plans to support the safe and effective care of young people on their caseload Care plans were completed
- Staff demonstrated empathy, kindness and caring when working with young people.
- Staff actively encouraged young people and their carer's to be engaged in making plans of care and to provide feedback on the service they received.

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Substance Misuse Service was also visited in May

- The Inspectors rated the service 'Good' from 'Requires Improvement' as the Service had addressed the issues identified following the June 2016 inspection. This included:
- Putting protocols in place for those who regularly did not attend appointments or disengaged from the service.
- There was clear and visible leadership and oversight across both services.
- Manager's ensured staff attended mandatory training and received supervision and appraisals.
- Local and senior managers worked together to ensure the staff were supported in their roles to achieve positive outcomes.

The CQC have also carried out a number of unannounced visits to our Mental Health Wards and we have taken actions to address any issues they found which have included:

- Ensuring we promote, review and oversee patient collaboration with staff regarding its reducing restrictive interventions programme
- Ensuring that patient care plans are patient specific, reviewed and updated regularly, contain patient views, and that patients are given copies,
- Ensure that there is evidence regarding the approved/responsible clinicians' assessment of the patients' capacity to consent or otherwise

We welcomed a specific visit to our new Kite ward by the CQC Registration Team to ensure that the facilities were suitable for the patient cohort we look after there. More news about the new Kite unit can be found on page (n)

We also participated in two systematic reviews by CQC Teams. The first was a review of services for looked after children and safeguarding in Portsmouth in June. This included our Sexual Health, Mental Health and Community services. In March this year, we participated with colleagues in a Local System Review in Hampshire, to enable the CQC to have a better understand the pressures and challenges across the Hampshire system and identify any areas for improvement needed in health and social care services. The review focused on services for people over 65 and whether people using local services are provided with safe, timely and high quality care.

Our ratings posters can be found at:

http://www.cqc.org.uk/provider/R1C/posters

Information Governance

Information Governance Toolkit attainment - the organisation has completed an annual Information Governance Toolkit Assessment achieving 97 percent compliance. 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 was 294. This remains consistent when compared to the number of requests received the previous year (2016/17).

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This year we have achieved 91.9 percent compliance with the 20 working day response target, which is an increase in compliance when compared to 2016/17's compliance level of 87.1%. At this time, 9 requests are not currently due and have therefore been excluded from these figures.

The Trust made significant changes to the way in which it processes FOI requests in quarter three and four of this financial year and identified a dedicated resource to process these requests; this has improved compliance, which in these quarters rose to 99.3 percent

Subject Access Requests (SARs) – the number of subject access requests received within a financial year has increased by 18 percent when compared to the number of requests received the previous year (2016/17).

This year we achieved 87 percent compliance with the mandated 40 day response target, with 67 percent of requests being responded to within the best practice timeframe of 21 days. Compliance has increased when compared to 2016/17's compliance level of 83 percent. At this time, 49 requests are not currently due and have therefore been excluded from these figures.

The Trust made significant changes to the way in which it processes SAR requests in quarter there and four of this financial year and identified a dedicated resource to process these requests; this has improved compliance, which in these quarters rose to 95.5 percent compliance with the mandated 40 day response target, with 77 percent of requests being responded to within the best practice timeframe of 21 days

Payment by Results (PbR)

The Trust was not subject to a PbR clinical coding audit during 2017/18 by the Audit Commission

Clinical Coding

Clinical coding is the translation of written medical terminology into alphanumeric codes. Each code 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. We have achieved a top level three rating for the last three years. The audit examines the quality and completeness of clinical information available for coding as well as the completeness and accuracy of the coding itself.

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Data Quality

During 2017/18, a new Data Quality Team was established to assist our services in the validation and improvement of their patient data. After the transition of our clinical record system in recent years, a high number of data quality legacy issues were created. Many of these issues have been resolved to date but work is still required in a number of areas to improve our data quality.

The first focus of the team was to validate patients who were being reported as waiting over 52 weeks for their first appointment for all services to ensure that there was clear oversight of the waiting list position across the Trust. Between October – December 2017, the team managed to reduce the number of incorrect waiters by over 3000 and have implemented monthly processes with services to help maintain a good standard of data quality in this area and to further reduce the existing data quality issues.

Data Quality Report
52 Week Waiters by Service Line

NHS Solent NHS Trust

Service Line	Week Commencing														
	02/10/2017	09/10/2017	16/10/2017	23/10/2017	30/10/2017	06/11/2017	13/11/2017	20/11/2017	27/11/2017	04/12/2017	11/12/2017	18/12/2017	25/12/2017	01/01/2018	08/01/2018
Adults Southampton	644	638	629	371	339	261	188	155	141	129	72	44	30	19	7
Primary Care	643	512	510	298	73	74	66	66	55	25	27	25	17	15	11
West Child & Family	1082	789	779	736	710	654	594	399	277	271	262	144	70	70	63
Adults Portsmouth	217	207	206	122	113	64	55	47	48	38	30	12	12	7	7
Mental Health	121	148	147	133	135	136	135	136	67	66	49	22	10	9	0
East Child & Family	806	743	741	677	653	542	542	535	334	321	98	102	48	45	34
Special Care Dental	5	5	3	3	0	TBC	TBC	0	4	0	0	0	0	0	0
Grand Total	3518	3042	3015	2340	2023	1731	1580	1338	926	850	538	349	187	165	122

The second part of the waiting list validation project for the Data Quality Team was to work with our services again to validate any patient reported to have been waiting between 18-51 weeks for their first appointment. Again, really good progress has been made by reducing the number reported by over half in Quarter 4 2017/18. Work will continue to reduce these further and validation will commence on all other waits during 2018/19.

Data Quality Report
18 - 52 Week Waiters by Service Line

NHS Solent NHS Trust

Service Line	Data correct as of											
	02/01/2018	01/02/2018	01/03/2018	02/04/2018	01/05/2018	01/06/2018	02/07/2018	01/08/2018	03/09/2018	01/10/2018	01/11/2018	03/12/2018
Adults Southampton	724	635	455	464	-	-	-	-	-	-	-	-
Primary Care	356	359	326	274	-	-	-	-	-	-	-	-
West Child & Family	493	140	110	136	-	-	-	-	-	-	-	-
Adults Portsmouth	287	270	169	126	-	-	-	-	-	-	-	-
Mental Health	170	153	146	138	-	-	-	-	-	-	-	-
East Child & Family	665	200	161	125	-	-	-	-	-	-	-	-
Sexual Health	20	10	4	7	-	-	-	-	-	-	-	-
Grand Total	2715	1767	1371	1270	-	-	-	-	-	-	-	-

Learning from Deaths

Recognising the importance of the National Quality Boards Learning from Deaths report, the Trust implemented a Mortality Policy in July of this year. This has provided regular reports to our Assurance Committee and to our Board.

We also acknowledged the importance of involving the bereaved family and our Policy describes

- How we will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death.
- It also describes how the trust supports staff that may be affected by the death of someone in the trust's care.
- It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy has been reviewed and amended following the publication of the NHS Improvement Framework which was published to help standardise and improve how Trusts identify, report, investigate and learn from deaths. This has become the Learning from Deaths Policy which can be found at

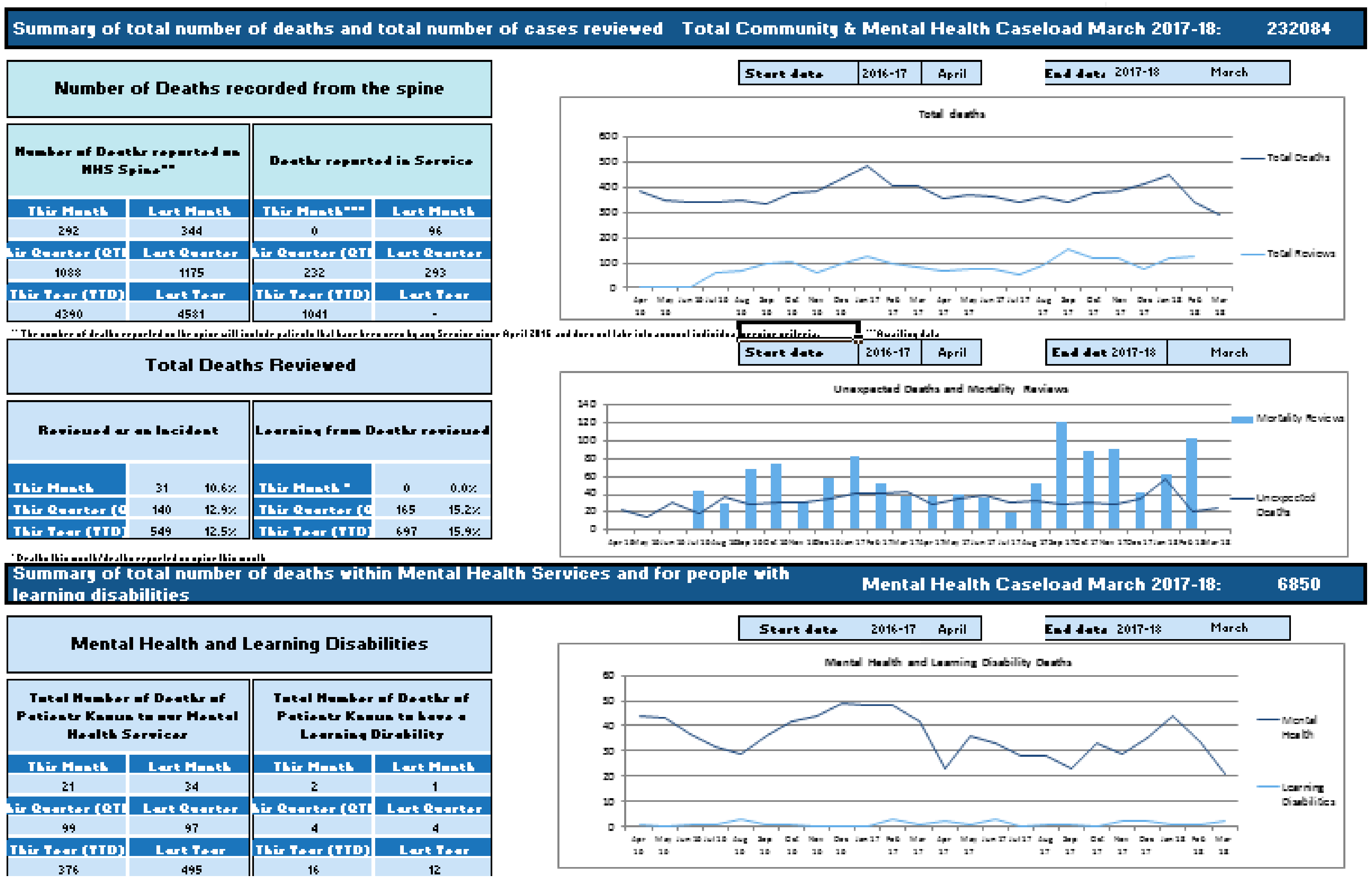
http://www.solent.nhs.uk/page.asp?fldArea=1&fldMenu=12&fldSubMenu=5&fldKey=592

Our Policy includes:

The trust's case record review process, including the method used, how the scope of deaths for potential review is determined and how deaths are selected for review.	How the trust responds to the death of someone with a learning disability or severe mental health needs, of an infant or child, or a stillbirth or maternal death.	How the trust decides which deaths – whether reviewed or not – require an investigation under the Serious Incident framework.	How the trust engages with bereaved families and carers, including how they are supported by the trust and involved in investigations where relevant.

The Trust has also recognised the importance of completing a case record review, where clinicians review individual case notes to determine whether there were any problems in the care provided to a patient or if in any way the death was due to a problem in care. If problems are identified we then use our Serious Investigation or High Risk criteria to complete an investigation. In order to ensure a systematic approach to these reviews we have adapted the Royal College of Physician's National Mortality Case Record Review methodology. This will commence and be reported on from April 2018

The Board has received regular reports and the aggregated report produced at the end of the year is detailed below:



Summary of total number of deaths and total number of cases reviewed — Total Community & Mental Health Caseload March 2017-18: 232084

Number of Deaths recorded from the spine

Number of Deaths reported on NHS Spine**		Deaths reported in Service	
This Month	Last Month	This Month***	Last Month
292	344	0	96
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1088	1175	232	293
This Year (YTD)	Last Year	This Year (YTD)	Last Year
4390	4581	1041	-

** The number of deaths reported on the spine will include patients that have been seen by any Service since April 2016 and does not take into account individual scoping criteria. ***Awaiting data

Start date 2016-17 April — End date 2017-18 March

Total Deaths Reviewed

Reviewed as an Incident			Learning from Deaths reviewed		
This Month	31	10.6%	This Month *	0	0.0%
This Quarter (QTD)	140	12.9%	This Quarter (QTD)	165	15.2%
This Year (YTD)	549	12.5%	This Year (YTD)	697	15.9%

* Deaths this month/deaths reported on spine this month

Summary of total number of deaths within Mental Health Services and for people with learning disabilities — Mental Health Caseload March 2017-18: 6850

Start date 2016-17 April — End date 2017-18 March

Mental Health and Learning Disabilities

Total Number of Deaths of Patients Known to our Mental Health Services		Total Number of Deaths of Patients Known to have a Learning Disability	
This Month	Last Month	This Month	Last Month
21	34	2	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
99	97	4	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year
376	495	16	12

NB -This image will be made clearer on the final report

The Learning from Deaths Policy demonstrates how we identify lessons and make changes following a patient's death. In this context 'learning' means taking effective, sustainable action to address key issues associated with problems in care.

These lessons have included:

Lesson Identified	Action Taken
Delegation and accountability- systems and process are not in place to guide decision making in relation to delegating care to a non-registered colleague.	We developed a Standard Operating Procedure (SOP) to support staff and to improve understanding
Need to keep the patient and family view in mind when writing reports	We changed the reporting template and way in which we present information in SI/HRI reports to ensure that it is easily understood
Positive learning: The most recent resuscitation in adult mental health services was managed well with the patients airway managed well including using non-rebreathe bag and mask	
Patient did not receive the appropriate or timely care following a fall	The service has implementing a falls 'toolbox' which will include an accessible checklist for AMH wards.
Information on what to do if the patient felt they were getting worse was not available	We are working to provide easy to understand advice to patients and record what has been provided in the patients records
There needs to be clear guidance and support to teams who provide end of life care in settings where this is not normally provided	The End of Life framework will ensure that we develop a resource package to provide information, support and supervision to teams to enhance end of life care in these environments
There is not a clear process for triggering a VTE Reassessment on AMH wards	The AMH teams will agree what point in a patient's journey will trigger review for VTE assessments. A template/proforma supported by a SOP will be assessed through an audit later in the year.
Positive Learning :Patients in community inpatient rehab wards benefit from seeing the same consultants through the pathways of care	

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The Policy ensures that Board and Non-Executive Director responsibilities are met and ensure that the Organisation

- learns from problems in healthcare identified by reviews or investigations as part of a wider process that links different sources of information to provide a comprehensive picture of their care and
- Providing visible and effective leadership to support their staff to improve what they do.

2. 3: Reporting against Core Indicators

Department of Health Mandatory Quality Indicators

We have reviewed the required core set of quality indicators which we are required to report against in our 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). These indicators are specific to our Mental Health Services

Indicator	2016-17	2017-18
Preventing People from Dying Prematurely - Seven Day Follow-Up	100%	99%
Enhancing Quality of Life for People with Long-term Conditions – Gatekeeping	100%	100%
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	77%	63%
Improving access to psychological therapies (IAPT):		
a) proportion of people completing treatment who move to recovery (from IAPT dataset)	53%	58.2%
b) waiting time to begin treatment (from IAPT minimum dataset) i. within 6 weeks of referral	99.5%	99.8%
ii. within 18 weeks of referral	100%	100%
Care programme approach (CPA) follow-up: proportion of discharges from hospital followed up within seven days	98%	99%

**the final figures will be updated for year end, currently not available*

Cardio-metabolic assessment

The Physical Healthcare Matron is the lead who ensures that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the service areas:
a) Inpatient wards
b) Early intervention in psychosis services
c) Community mental health services (people on care programme approach)

Staff are trained to assess physical healthcare and use the following tool:

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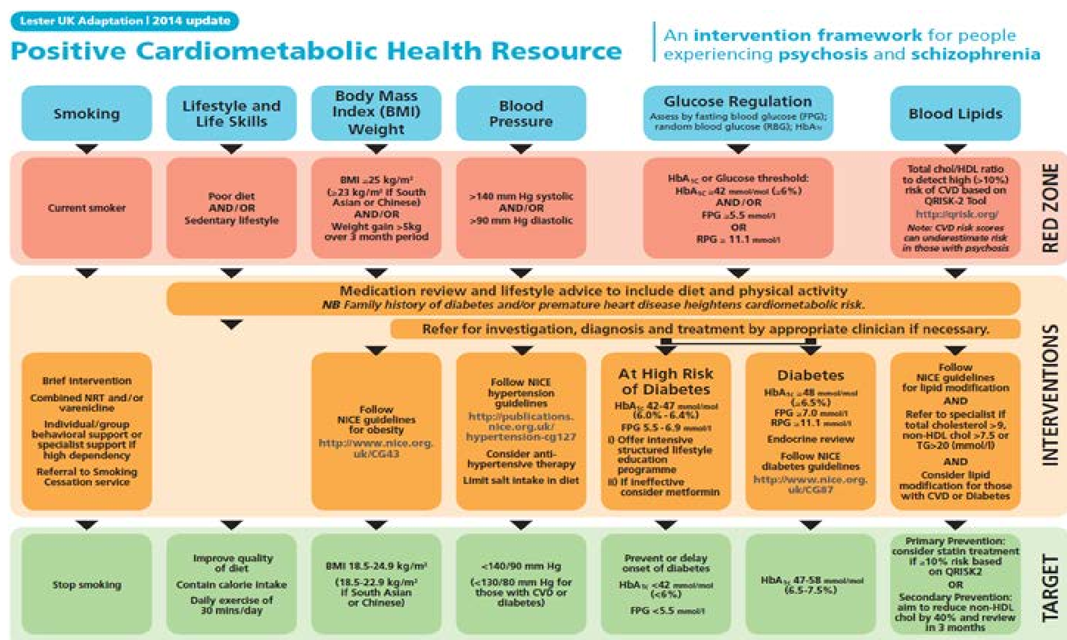

Admission of Young People into Adult Mental Health Wards

During the year we admitted 2 young people into our adult wards. Both were over 16 and were with us for less than 3 days. In each case we reported the admissions as a Serious Incident and completed an investigation. Neither young person came to any harm as a result of the admission and were well cared for by CAMHS specialists whilst an inpatient.

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.

The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period
The full survey is published at:

http://www.cqc.org.uk/provider/R1C/survey/6#undefined

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Friends and Family Test (FFT)

Patient FFT

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
17/18	**95.89%**	1.46%	**18506**	14127	3617	367	131	139	125
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

Positive feedback received from carers and service users has continued to grow and improve over the last 3 years, with an increase in the proportion of respondents who would be 'extremely likely/likely' to recommend Solent services to Friends & Family. The proportion who responded they would be 'unlikely/extremely unlikely' to recommend has also improved year on year (target is a low score on this measure).

During 2017/18 additional methods for providing feedback via the Friends and Family test have been introduced, including email in settings where this is appropriate, and monkey survey for children and young people. This has resulted in an encouraging increase in the response rate overall. The number of free text comments has also increased from 12243 (during 2015/16) to 20818 (during 2017/18). These comments provide us with the insight to know what we do well and where we need to make improvements based on patient feedback. Comments related to 'caring and professional staff' and 'feeling listened to' are recurring themes.

Services share the feedback with staff that is often personally named by service users. The most
Most frequently used words to describe Solent services have been aggregated below

These are examples of complimentary comments

'The service is very professional and friendly'

Primary Care

'Extremely thorough personal service. Thank you!'

Sexual Health

'The nurse was very friendly and helpful and explained everything to me.'

Adults Southampton

'The dentists involved and her assistant are extremely friendly / helpful and supportive. This is an excellent service.'

Specialist Dental Services

'Great understanding of my situation; great eye contact. Overall great experience here as I felt listened to and respected like my views were valid.'

Adult Mental Health

'The team help in a quiet and friendly way; I feel that I can rely on their services.'

Adults Portsmouth

'Very supportive and give great advice.'

Children and Family

Examples of 'YOU SAID - WE DID' learning and actions

You said: can never get appointments, change the way they accept calls.

We did: The surgery is working hard to release more capacity and have reviewed the impact on the growing surgery list. This is an ongoing project and will keep the patients informed via the PPG Group.

You said: The process is timely and very frustrating I feel that it's a shame that it feels like a postcode lottery for different services and care that can be provided. The staff despite these pressures have been fantastic & we cannot fault their commitment.

We did: The service is currently undergoing a transformation plan which aims to reduce the wait times for assessment and therapy. We are actively implementing wait list initiatives to reduce wait times and looking at staffing levels to help reduce wait times.

Feedback from children using Monkey Wellbeing

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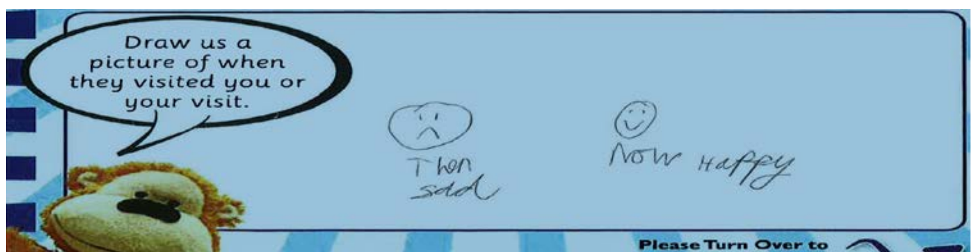

What we have learnt…

1. It is important to agree clear expectations with patients about their care.
2. 'Same day appointment' works better than 'waiting to be seen' in Sexual Health.
3. On-going need for customer care training in some settings.

Staff Survey

A total of 1876 people took part in this survey. This is a response rate of 56% which is above average for combined mental health and community trusts in England (45%), and compares with a response rate of 55% in the 2016 survey.

Compared to last year, we saw a significant improvement on 12 individual question scores and a worsening of scores on only 2 questions. Out of 22 NHS key findings across comparable trusts, we scored better than average on 15 and none worse than average. Our results show that we have maintained the positive levels of engagement achieved in 2016/ 17 through the continuation of our Great Place to Work Programme and focus on improving the 'Top 3': Learning & Development, Effective Leadership and Genuine Involvement.

The opportunity in the year ahead will be to firmly embed our purpose at the heart of our strategy through our narrative, 'The Solent Story'. Engaging people from the bottom up in sharing their stories of how they make a difference in keeping more people independent, safe and well in the community.

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2017 NHS Staff Survey headlines

NHS Solent NHS Trust

55.8% of people took part | **3.86*** Engagement score | (increase from 3.83* in 2016 and above the average of other comparable trusts: 3.79*) | Out of 22 NHS key findings we had:

better than average

worse than average

The majority of the questions show an improvement on last year

Here are some areas where the improvement is significant

The care of patients/ service users is my organisation's top priority
79%
Increase of 4%

I would recommend my organisation as a place to work
59%
Increase of 3%

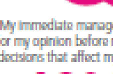
The team I work in have a shared set of objectives
77%
Increase of 3%

My organisation takes action around errors, near misses or incidents
79%
Increase of 3%

I am satisfied with the support I get from my immediate manager
76%
Increase of 4%

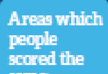
My immediate manager can be counted on to help me with difficult tasks
78%
Increase of 3%

I have had training, learning or development in the last 12 months
77%
Increase of 5%



My immediate manager asks for my opinion before making decisions that affect my work
63%
Increase of 3%

My immediate manager is supportive in a personal crisis
80%
Increase of 3%



Areas which people scored the same:

- The way we work together in our teams
- The quality of our non-mandatory training
- The opportunities we give for career progression, regardless of background
- The difference you feel you make to patients
- The action we take to help you manage your health and wellbeing

Areas which people scored lower:

I am satisfied with my level of pay
32%
Decrease of 6%

I am working additional unpaid hours
66%
Decrease of 3%

I had the opportunity to talk about the Trust values and my development needs during my appraisal
63%
Decrease of 2%

Next steps

Look out for your team reports. Your manager will talk with you about next steps and the actions you can take as a team.

Over the coming weeks we will be communicating the Trust results with you in more detail. You can find the Trust survey report on SolNet within Staff Zone.

Part Three: Other information

Achievements in 2017/18

The Organisation identified a number of priorities which are detailed below, however Services were involved in many other quality initiatives.

Priority 1: We will implement the Trust's professional frameworks so that our nurses and allied health professionals (AHPs) continue to deliver great care.
We will do this by: publishing a career framework and strategies by December 2017

We met this priority by delivering a number of actions for both nurses and AHPs:

- Our Nursing Conference in May launched the nursing strategy and we established Professional Advisory Groups
- Task and Finish Groups met and took action to progress each of the strategic commitments
- Launched a Career framework

This priority was met and we will develop it further as part of our business as usual and are now considering the development of a multi-disciplinary clinical strategy

Priority 2: We will deliver the Quality Improvement Programme to enhance patient experience and make a difference to people's health and wellbeing.
We will do this by: having 2 groups of staff completing the programme and publishing newsletters and programme outcomes every quarter

Quality Improvement Programme (QIP) has become embedded within the Organisation and we are now on Cohort 5. We have recruited both clinical and corporate teams to make a difference in a number of areas including:

This has been met and the Solent Quality Improvement (QI) Programme has been established to equip our staff with the confidence and skills to deliver improvements in their areas, and to be able to demonstrate how these have made a difference.

Those on the programme are encouraged to work with patients to identify and deliver improvement.
The programme has the following elements:
• A graduated programme of skills development (see below)
• A series of add-on masterclasses
• Bespoke facilitation and support to deliver Quality Improvement projects
• Support in placing the patient voice at the heart of improvement

Further information is available at:

http://www.academy.solent.nhs.uk/improvement/

Priority 3: We will continue to improve our services by using the learning from incidents, complaints and feedback.
We will do this by: launching an Organisational Learning Framework by September 2017

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The delivery of this priority has been reframed to ensure that lessons are identified and learning is disseminated throughout the organisation. Clear actions and learning points are identified at the end of

- The Serious Incident Panel.
- The Learning from Death Panel (which was launched in July 2017) and the
- Complaints Scrutiny Panel

We also record what changes we would expected to see in Services and by when.

The Organisation has invested in an electronic recording system which will capture these details, which will be in place from April 18

The Organisation is exploring all avenues of communication to share the learning; this includes newsletters, presentations, Solet and the normal Service Line governance processes.

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Priority 4: We will implement the Trust's competency assessment framework to support our staff to consistently deliver safe and effective care.
We will do this by: developing a Trust library of competencies for Nursing and AHP workforce by July 2017

This priority was met by delivering the following

- We established a core framework of job descriptions across all bandings
- We developed a Trust library of competencies for Nursing and AHP workforce

With the implementation of SolNet, these competencies can be published on this intranet to make them more accessible to all staff.

Priority 5: We will have a consistent approach to involving people in the development of our services.
We will do this by: launching our volunteer strategy and web site for volunteers by December 2017

This priority has been met by delivering the following:

- We launched our volunteer strategy and actively recruited volunteers.
- We developed and issued protocols to our services for the recruitment and deployment of volunteers

We launched the Volunteers website: http://www.solent.nhs.uk/page_sa.asp?fldKey=815

We will continue with this priority as business as usual next year by developing a community engagement strategy which we will launch in Q1 2018/19

Patient Experience Indicators

Complaints

The approach to complaints handling in the Trust is based on the principles published by the Parliamentary and Health Service Ombudsman (PHSO). Their principles outline the approach the PHSO believe public bodies should adopt when delivering good administration and customer service, and how to respond when things go wrong. They underpin their assessment of performance, vision of good complaint handling and our approach to putting things right.

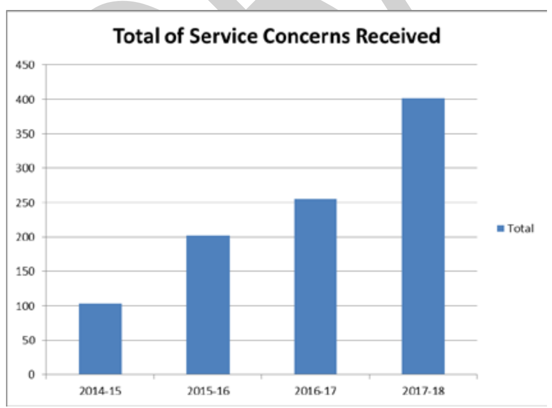
These are:

- 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.

The Trust encourages the staff closest to the people receiving our services to, wherever possible and with the service user's consent, to deal with concerns and problems at the local level. This means that if they arise issues can hopefully be resolved quickly and in a way that is responsive to the service user's needs and circumstances.

Timely intervention can prevent an escalation of the issues raised and achieve a more satisfactory outcome for all concerned. Although if the complaint is initially dealt with as a service concern, it does not prevent the complaint being escalated formally should the patient remain dissatisfied with the initial outcome.



By placing an emphasis on resolving complaints at the local level, which has involved close 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 gradual reduction in the number of formal complaints received

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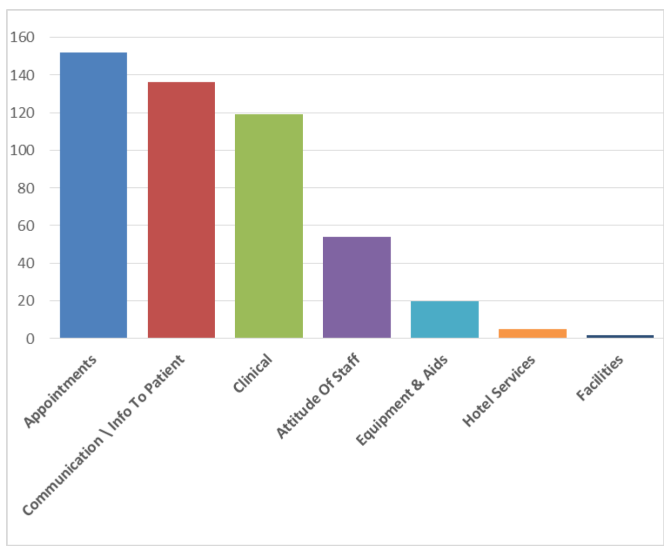

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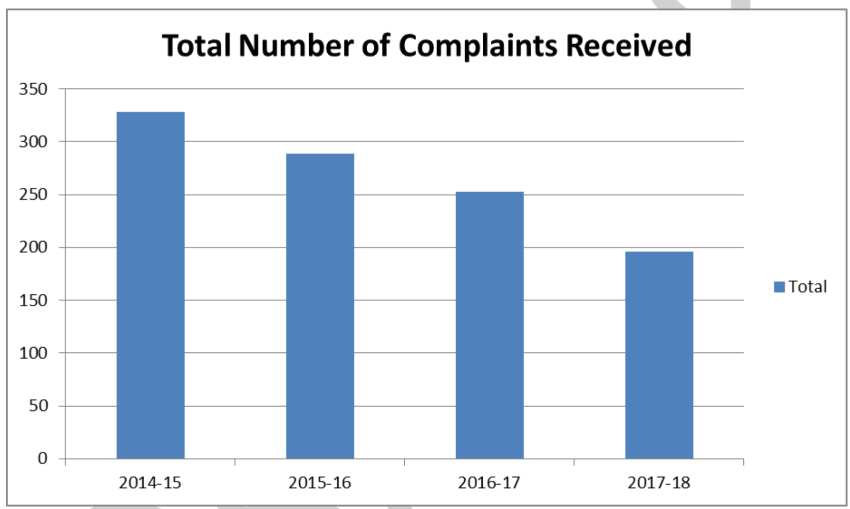
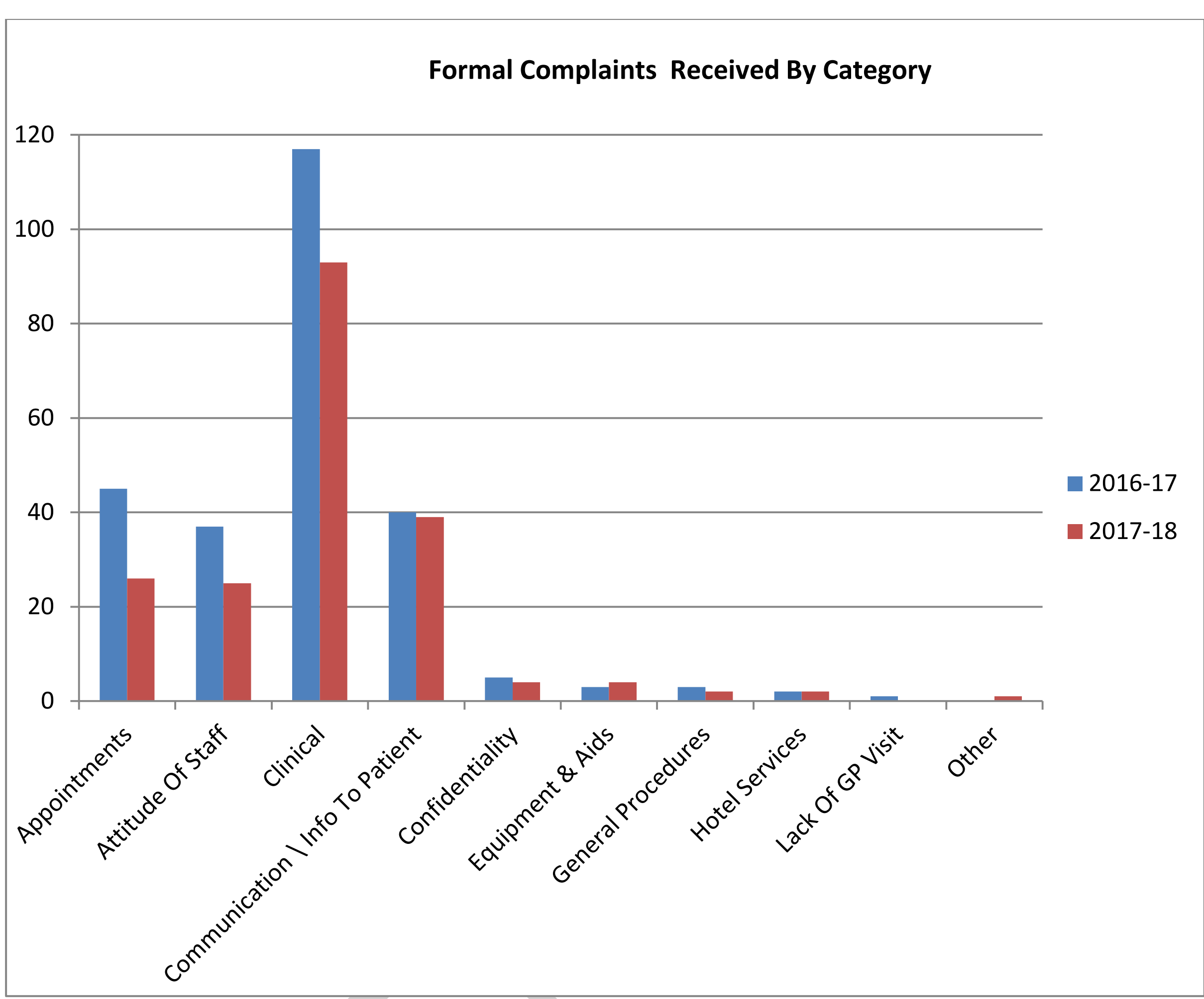


During 2017/18 there was a reduction in the number of people making contact with our Patient Advice and Liaison Service (PALS) for advice, signposting and general queries. We received 590 contacts compared to 682 in 2016/17

Our Trust Board receives regular monthly reports and updates on the number, themes and learning from complaints and a member of the Executive team personally reviews each 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.



As an organisation we strive to embed and sustain the changes made as a result of complaints and concerns to enable long term improvement. Changes and outcomes are monitored within the services concerned and, to ensure learning across service lines, are shared at our quarterly complaints scrutiny panel. This 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:

- Ensuring that patients' are provided with adequate amounts of medication, upon discharge from wards to home, to hopefully minimise the effects of what can already be a stressful situation
- When a formal complaint has been de-escalated to a Service Concern the Executive team should still be made of the outcome so that they are kept fully aware of the complaints resolution process.

Patient Led Assessment of the Care Environment (PLACE)

The Organisation had the highest scores for the South of England in the category registered for all of the assessment areas and improved on the scores achieved in 2016. However this does not mean we can still do even better.

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National Overview

	Solent Score	National Score
Cleanliness	99%	98%
Food Score	98%	90%
Organisation Food Score	98%	88%
Ward Food	98%	90%
Privacy, Dignity and Wellbeing	91%	84%
Condition, Appearance and maintenance of buildings	97%	94%
Dementia	92%	77%
Disability	93%	83%

In Summary for our Organisation

- All our wards improved in one area or another from last year
- We want to improve in the areas of Privacy, Dignity and Wellbeing , Dementia and Disability
- All locations continue to monitor and review action plans following the visits in 2017 and progress will be monitored

Future Plans

Looking forwards, the Trust will continue to improve/maintain high standards in all assessment areas to the benefit of patients and maintain its position as one of the highest achievers in the assessment areas for the PLACE inspections.

We will be looking to:

- Identify how we can further improve dementia awareness in all locations including
    - what learning can be identified from areas that achieve higher scores;
    - Involvement of patients and service users.
    - Reflecting on the dementia awareness improvements that have been implemented since the visit which should lead to an improvement in the scores in the planned 2018 inspection.
- Improve the Privacy, Dignity and Wellbeing and Disability scores on the wards at the Royal South Hants.
- Improve the condition, appearance and maintenance of buildings-in areas where Solent are not the landlord. This is a challenge and we will continue to support services to challenge the landlord regarding the general appearance and up keep of building s that our patients are seen in.

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Same Sex Accommodation Requirements

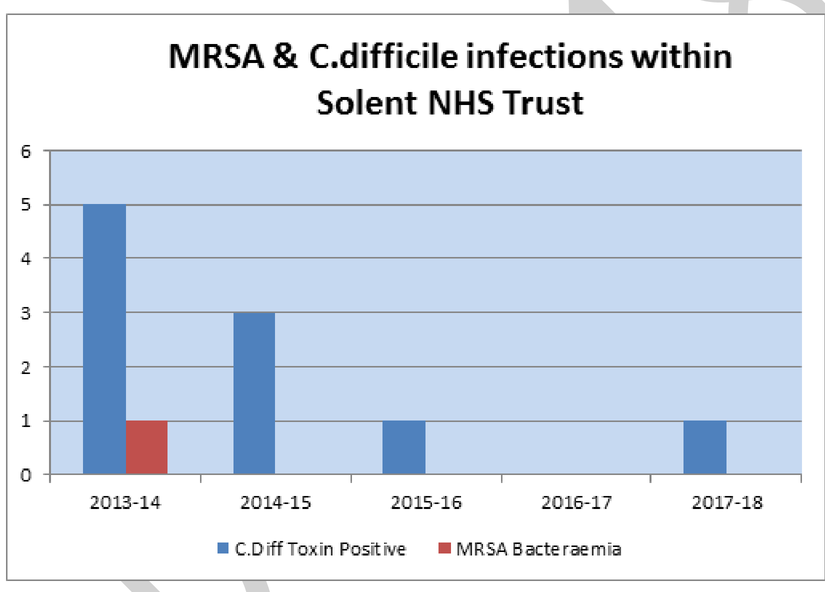
There have been no breaches during this year

Avoidable Healthcare Associated Infections (HCAI's)

The Trust continues to be committed to a zero tolerance approach to any avoidable Healthcare Associated Infections (HCAI's). Through a variety of forums and processes we are able to ensure that all aspects of infection prevention and control remain embedded in practice.

As a community organisation we are not given reduction targets for HCAI but if and when they occur each case will undergo careful scrutiny to ensure that any lapses in care are addressed and actions put in place and monitored. There was one case of a MRSA bacteraemia across multiple providers this year, that including Solent NHS Trust, which was attributed to the CCG and one case of Clostridium Difficlie (C.difficile) that was fully investigated and actions for learning shared. We have taken part in the investigation and any learning from this event will be embedded within in our Organisation

There have been no ward closures due to any outbreaks of infection during the year.



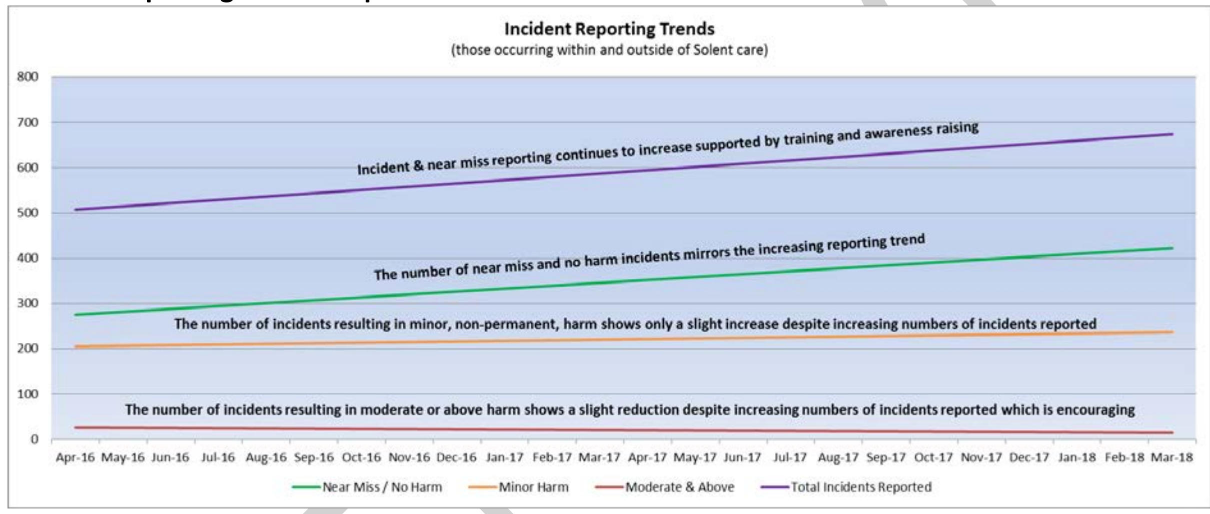
Patient Safety Indicators

Reducing Patient Harm

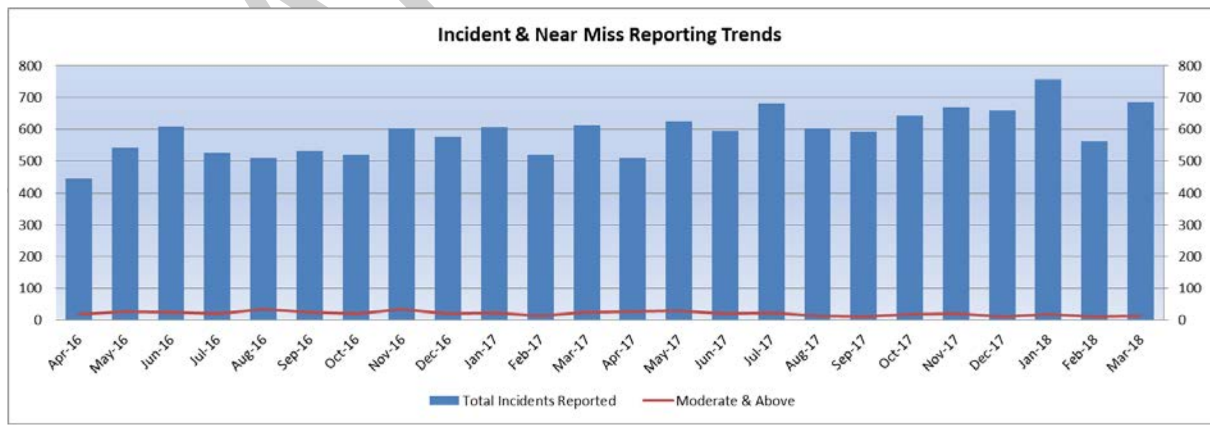
What it means in Practice

We have continued to invest in ensuring there is a culture of reporting incidents and issues within the Organisation, and we use an electronic system to capture and report incidents from all areas. We have improved our reporting culture and we have developed Serious Incident Panels to ensure that staff feel able to learn from mistakes.

Incident Reporting Trends - April 2016 to December 2017



Incident and Near Miss Impacts

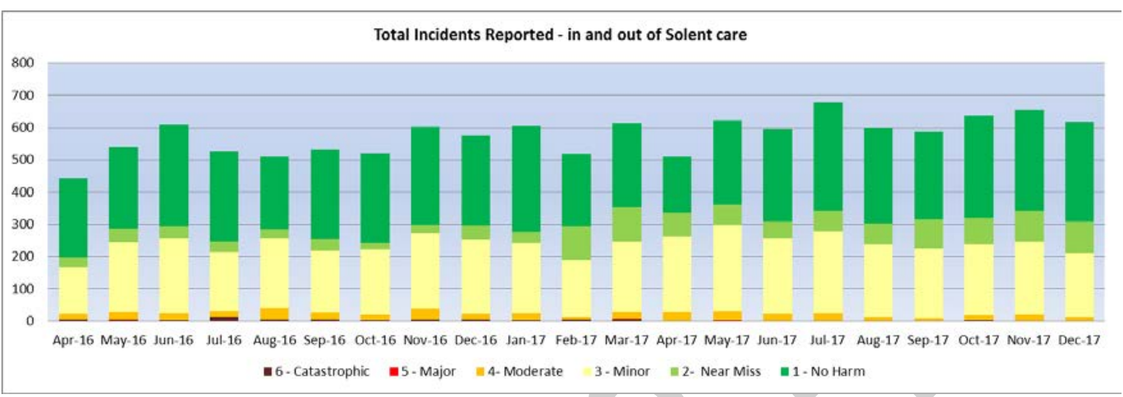


The number of incidents reported as moderate and above is comparable to the numbers reported in Q3 in 2015. This can be attributed to the consistent validation of incidents following the reintroduction of incident reporting training for staff.

Reduction in Harm

Reporting levels are showing a steady increase since April 16. The number of moderate incidents reported this quarter has decreased and the number of no harm incident has increased, this indicates a positive and open reporting culture.

Total number of Incidents reported April 2016 to December 2017



Avoidable Pressure Ulcers (PU)

Comparison of avoidable Pressure Ulcers Q1-3 16/17 and Q1-3 17/18

Service Line	Pressure Ulcer	Q1-3 16-17	Q1-3 17-18	Trend
Adults Portsmouth	**Avoidable**	**19**	**9**	↓
	Unavoidable	24	6	↓
	To Be Determined	*0*	*4*	*N/A*
Adults Southampton	**Avoidable**	**6**	**3**	↓
	Unavoidable	27	4	↓
	To Be Determined	*0*	*0*	*N/A*
Mental Health	**Avoidable**	**1**	**0**	↓
	Unavoidable	0	0	↓
	To Be Determined	*0*	*0*	*N/A*

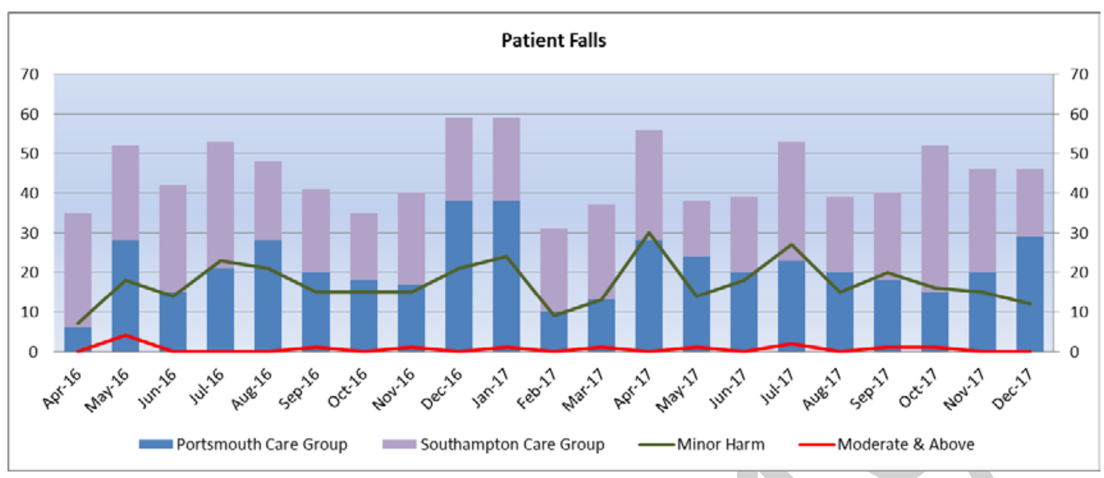
*This table will be updated with Q1-4

In Quarter 1-3 17/18 the number of Pressure ulcer incidents that have been reported as potentially avoidable has significantly reduced (by 55% in Portsmouth services against a 10% reduction target). This is due to the Pressure Ulcer review process that was introduced In April 2017.

Falls graded minor or above

Adults Portsmouth, Adult Mental Health and Adults Southampton, continue to report the greatest number of patient falls. Moderate incidents remain low and minor incidents are on the decline.

Number of patient falls, per month April 2016 to December 2017



Falls reduction

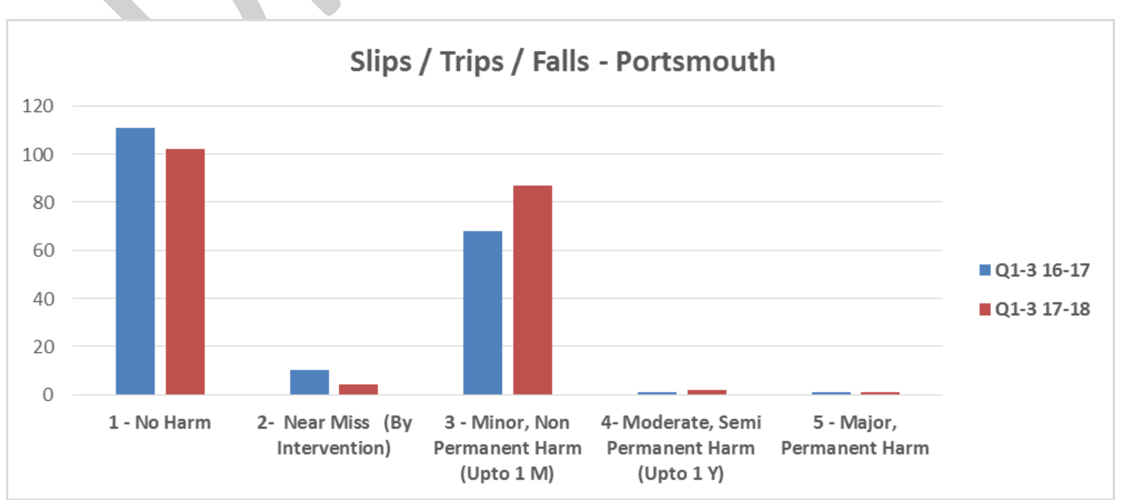
A Falls Thematic Lead is now in post and the Trust Slips, Trips & Falls policy has been updated and made available for staff. This policy includes plans for Falls Champions and an E-learning module on falls in addition to a cascade training model for staff in falls prevention and management.

A meeting with the inpatient services matrons was held in January 2018 to discuss falls risk assessments and post-falls management. The thematic lead is also providing bespoke training and a resource for staff investigating patient falls.

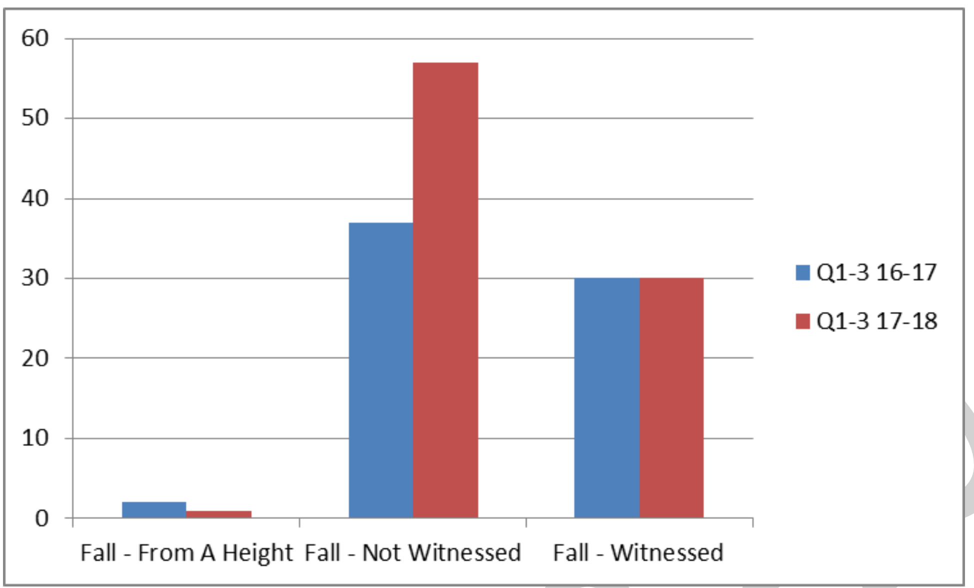
Patient falls resulting in harm – comparison of Q1-3, 16-17 and Q1-3, 17-18

	Q1-3, 16-17	Q1-3, 17-18	Change	Trend
Portsmouth	70	91	30%	↑
Southampton	85	81	-5%	↓

Further review of the Portsmouth data has shown a reduction in the number of 'No harm' or 'Near miss', however there has been a rise in the 'minor' harm category.



Further analysis shows that the increase in minor / non- permanent harm relates to an increase in the reporting of unwitnessed falls.



Falls in Mental Health Services

There has been in an increase in the number of falls during December within the Mental Health Services, the majority of these were reported as no harm or a near miss.
The Thematic Lead is working with the Older Mental Health wards on a Falls Quality Improvement Programme. A further update will be provided in the next Quality report.

Medication incidents resulting in minor or above harm

There has been a slight increase in quarter 3 of medication errors in Solent care; however the majority continue to be reported as no harm. Compared to Q1-3 2016-17 the number of moderate medication incidents has slightly decreased.

In Southampton one of the medication incidents in quarter 2 was a moderate, related to missing controlled medication on an inpatient ward. This was managed by the pharmacy team and the senior ward management. There are no themes or trends to report upon in the medication incidents in Southampton.

During Quarter 3 there has been increase in the number of missed doses incidents within Adults Portsmouth, Community Nursing Service. The service has reviewed their missed doses incidents and has attributed the majority to errors in the allocation of visits. The service has since organised additional SystmOne training for staff. During this time Portsmouth services had a moderate medication incident whereby consent was not obtained for a child's vaccination; this was reported as a High Risk Incident and is currently being investigated.

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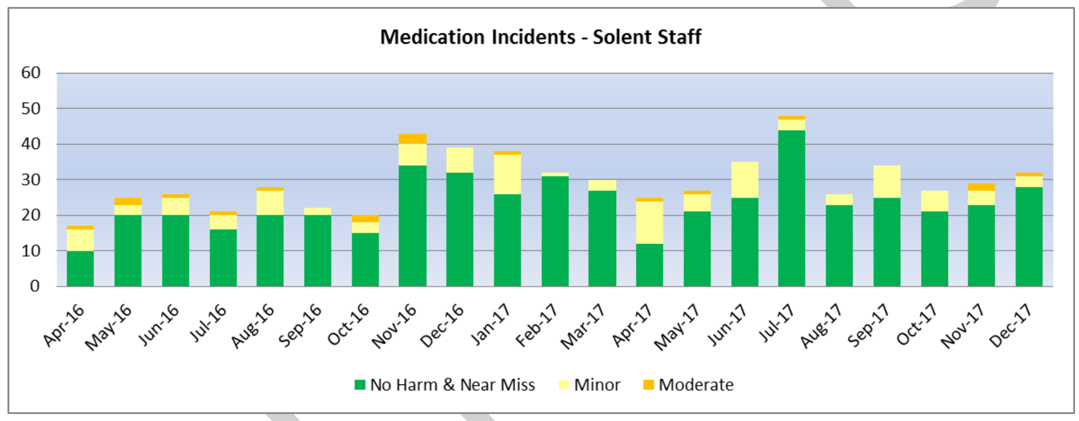
Medication errors in Solent Care, level of harm

	Q1-3, 16-17		Q1-3, 17-18		Trend
Meds Errors in Solent care	**241**		**283**		↑
No Harm	187	78%	222	78%	↔
Minor Harm	43	18%	55	19%	↑
Moderate or Above	11	5%	6	2%	↓

Medication errors in Solent Care resulting in harm

	Q1-3, 16-17	Q1-3, 17-18	Change	Trend
Portsmouth	37	37	0%	↔
Southampton	12	23	92%	↑

Medication incidents in Solent Care, by actual impact



**These figures will be updated at year end*

Serious Incidents (SI)

A total of 21 Serious Incidents, all were subject to a full investigation and were heard at the Trust SI panel which is held monthly. The lessons learnt from each SI are shared with the service line and commissioners.

The Service Line reporting the highest number of SI's is Adults Portsmouth 9 of which were Pressure Ulcers. Following Pressure Ulcer panel some of these pressure ulcers are later determined as unavoidable, which is important to recognise. The acuity of the patients is also increasing, hence the increased likelihood of the development of pressure ulcers.

Number of SI raised per month

There have been no incidents that have resulted in the death of a patient

Clinical Effectiveness Indicators

We have already reported on our clinical effective indicators which were:

- The implementation of the Trust's professional frameworks so that our nurses and allied health professionals (AHPs) continue to deliver great care.
- The delivery of the Quality Improvement Programme to enhance patient experience and make a difference to people's health and wellbeing.
- Implementation of the Trust's competency assessment framework to support our staff to consistently deliver safe and effective care.

Spot light on other Quality Improvements

Spot light on other Quality Iniaitives

Accessible Information (AI)

The impact of the compliance of the Accessible Information Standard (AIS) supports our Trust values - 'Everyone counts' and 'Respectful' of people with communication and information needs. Across the Trust the increase in the availability of AI has:

- Improved patient and carer experience illustrated in feedback and plaudits.
- Increased concordance with treatment and care plans.
- Provided person-centered care for people with communication and information needs.

We have also have improved the provision of Easy Read resources produced in line with the corporate standards, and co-produced accessible self-help resources for CAMHS and LD. It is hoped that there will be multiple impacts including improved patient satisfaction and improved productivity. Our external engagement continues to promote our national reputation

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Falls

The prevention of falls continues to be a priority for the Organisation and out thematic lead is working with many services to reduce the occurrence and impact of falls especially in our frail and elderly patient groups who are the most vulnerable. This year we have updated and re-written the Prevention and management of Patient Slips, Trips and Falls Policy and commenced Trust-wide Inpatients' staff falls meetings with matrons and champions.

Our training has also been focussed on the management of patients post fall and bespoke face to face falls training. We are also developing a Screening tool for community staff in Portsmouth which signposts staff as to correct referral processes for falls risk assessment and links to the Multifactorial Falls Risk Assessment

End of Life

An End of Life Trust Wide Audit was completed and collated data collected in relation to the decision making and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and reviewed the Trust wide audit. The audit raised awareness of the importance of decision-making documentation and observing patients' wishes in relation to DNACPR. The results from the audit have formulated an action plan around training

The development of the end of life policy and strategy will provide all professionals who work in Solent NHS Trust who have a responsibility for providing end of life care will support staff to provide the best care to patients and those important to them at the end of their lives.

Recovery & Peer Workers

Previously there has been an identified need for additional peer workers and in order to address this we have:

- Promoted the Peer Volunteer procedure within the Volunteer Policy
- Developed the Peer Volunteer Role descriptions & Peer Worker (paid) role to ensure progression pathway
- Developed the recruitment process
- Developed the framework for a Peer Volunteer training package

The thematic lead has promoted and raised awareness within and external to Trust about the nuances and value of coproduction as a means to engaging with people who use services. A replacement of Patient Reported Outcome Measure in Adult Mental Health Services has also been implemented.

Homeless Healthcare

During 2017 it was the 25th Anniversary of the commencement of the Homeless Healthcare Service within Southampton City. The team has evolved over the years however what remains at its core is the commitment to support the vulnerable service users who may experience discrimination and equality in their lives due to their current situation.

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The Homeless Healthcare Service works in partnership with local charity Two Saints as well as Southern Health Foundation Trust who support the mental health provision for the service. The team are also supported by Health Visitors. In partnership the services aim to provide healthcare, with onward referrals to secondary services, supporting with accommodation, encouragement and guidance to support service users to find employment.

In conjunction with the above teams a celebration event was held in July with previous members of staff and supporters of the service as well as past and current service users invited to attend. A major supporter of the service Laurie McMenemy (former Southampton FC Manager) was in attendance and gave a rousing speech; he also spoke to service users who were keen to have their shirts signed by Laurie. Whilst the event was a celebration it was widely acknowledged that the challenges faced by the homeless were still as current today as they were 25 years go.

Solent NHS Trust staff supported a Christmas campaign for the Homeless, with shoe boxes being filled by members of staff with items such as toiletries , gloves, socks and food not only for the service users but for those who have pets especially dogs. In excess of a 100 boxes were donated and this was much appreciated.

The Homeless Healthcare Team also participated in 2017 / 2018 the Solent NHS Trust Quality Improvement Programme in order to utilise improvement methodology to increase the conversion of referrals to secondary care for the Homeless. This is traditionally an area of challenge and the programme helped to identify areas for improvement in the pathway.

Primary Care Services

Solent NHS Trust host three GP Surgeries based throughout the Southampton City. The GP Surgeries functioned as individual surgeries each with their own ways of working and had no shared functionality although the operational and professional leadership was shared across the three. Recognising the benefits of extending the sharing of staff and processes the surgeries merged from April 2017. Whilst the official merging was completed and patients informed within April 2017 work continues to merge the processes and standardising ways of working.

The Solent GP Surgery has developed a “back office” to ensure that documentation, reports and results are actioned from secondary services as well as internal communications. There are plans for this to be extended and this will in turn support the Reception Staff to be released to concentrate on patient facing activities.

The Surgery also continues to develop its workforce and have developed a trainee Advanced Nurse Practitioner programme and will develop a similar programme for Practice Nurses.

The GPs within the Surgery are also keen to develop their ability to support “trainee” Registrar GP capacity acknowledging that GPs are challenging to recruit.

Whilst the merger has been positive there continues to be work on-going throughout the coming months to further embed the single surgery identity.

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Sexual Health Services

Staff identified there was an increasing number of men who have sex with men disclosing that they participated in chemsex (chemicals to enhance sexually intercourse). They identified that the service was not meeting the needs of this population so set up a QI project to address this.

The project aim was to:

- Decrease harm from chemsex
- Support staff within sexual health teams to ask appropriate questions about chemsex as part of the sexual history
- Provide brief interventions to reduce risk

Outcome:

- Questions added to the sexual history in the integrated service and the online testing service to identify men that use chemsex
- Training provided to staff on new assessment questions
- Pathway put in place for at risk patients to be referred to the health advisor for brief intervention to reduce risks.

Adult Services in Portsmouth

The Portsmouth Enhanced Care Home Team Pilot is a service developed collaboratively with Solent NHS Trust (Solent), Portsmouth Primary Care Alliance (PPCA), Portsmouth Clinical Commissioning Group (PCCG) and Portsmouth City Council (PCC). The pilot service is provided jointly by Solent and PPCA and Portsmouth City Council PCC Medicines Management Team.

The pilot was based upon the seven core elements for success within the NHS Framework for Enhanced Health in Care Homes:

1. Enhanced primary care support
2. Multi-disciplinary team (MDT) support including coordinated health and social care
3. Reablement and rehabilitation
4. High quality end-of-life care and dementia care
5. Joined up commissioning and collaboration between health and social care
6. Workforce development
7. Data, IT and technology

The service was designed to improve the quality of life for individuals and improve the care and support they receive whilst living in one of the Portsmouth Care Homes. The following outcomes were designed to be monitored throughout the pilot implementation:

- A reduction in urgent care resources utilised by the Care Homes receiving the Medical Model of Care

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- A reduction in urgent care resources utilised by the Care Homes receiving the Clinical Model of Care
- Releasing capacity within Primary Care
- All residents to have a Care Plan in place and an Advance Care Plan where appropriate
- A reduction in the number of patients on oral medications and a reduction in the prescribing costs
- Increased satisfaction of residents and their carer's within the services
- To provide equitable access for all residents in Care Homes to community Services and NHS Primary Care Survives.
-

The new model started to be delivered in 7 homes in Portsmouth in July 2017. Two of the seven homes are receiving a fully integrated model with increased GP support. Five homes are receiving enhanced nurse led support.

Early analysis of data showing differences in the pilot homes in the year before implementation and the first six months of implementation shows a 32% reduction in 999 calls in the pilot homes and a 26% reduction in conveyances. Homes that were not included in the pilot showed a 90% increase in 999 calls and a 60% increase in conveyances.

The project has also shown a saving of £8, 121 in medicines for the pilot homes as a result of medicines review.

A business case is being written to roll out the model to all 27 Portsmouth Homes.

Adult Services in Southampton

Kite Unit

After many months of consultation, engagement and planning we are delighted that the 10 bedded Kite Unit, previously situated on the St James' Hospital site in Portsmouth has now moved to its new home at the Western Community Hospital in Southampton. The unit provides specialist neuropsychiatric and neuro behavioral rehabilitation services for patients across the health economy.

Although care delivery in Portsmouth was excellent; the previous building was no longer fit for purpose with ligature risks, inhibited lines of sight, and a dated environment with limited space for treatment intervention and limited provision for female patients. Our new unit has been purpose build to address all of the issues mentioned above and we now have an environment that strikes the right balance between being calming and stimulating to aid patient rehabilitation.

Internally we now have a fully equipped patient kitchen and a laundry room where patients are encouraged to be as independent as possible. There are designated spaces for therapeutic interventions and a small gymnasium. Patients have good connection to outdoor spaces and the unit is light and airy with careful design features for signage and use of colour incorporated. These factors have known positive benefits in terms of reducing medication and challenging behavior.

Staff too are benefitting from co-location with colleagues, having an area where they can take much needed breaks and also, from a safety perspective, have access to newly designed door controls and alarm systems for emergency use.

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The successful relocation has already demonstrated positive benefits for patients, their families and staff and we look forward to building on these over the coming year.

Children and Families Services

Solent NHS Child and Family Team are currently working with young people in Portsmouth and Southampton to look at how services are currently delivered and how we can together shape the future of the service for children, young people and families in the delivery of care. The meetings sparked a wealth of discussion and debate between professionals and young people about preferences for NHS provision and their opinions as to what is essential to young people's lives. The young people brought a lot of questions and plenty of their own experiences and perspectives of the Solent NHS to the meetings.

Following on from the inspiring meeting with the 'Solent Young Shapers' 7 young people are helping the service review their environment that children and young people are seen in by completing the '15 Steps Challenge'. The information gained from these visits to service delivery sites will be used to redesign the environments and also link into the Always Events. This is a national programme that the Child and Family service have engaged with to develop consistent ways to meet the individual needs of patients to make sure that care is patient centred and delivered in partnership with them and their families.

Children and Family teams have also been running a digital innovation project in the 0-19 School Nursing and Health Visiting service. As part of this project, engagement with parents, young people and the public has been a central theme; listening to feedback and using this to drive improvement. We engaged with 83 Parents and 91 young people during this process; their feedback included how they wanted the service to communicate with them, digital options which they wanted available to give choice, what they did and did not like in website design and content, what they thought of virtual face to face contact and how they wanted to provide feedback to us. Based on this feedback we designed a new website, built a bespoke SMS Text service for clinical advice and queries, promoted apps which are reliable with features to help parents and young people, created new feedback mechanisms and commenced live interaction sessions through the website which are advertised on social media.

Mental Health

In Adult Mental Health in-patient wards we have developed the psychological skills and knowledge of our staff. A series of psychological skills workshops were delivered to staff by our psychology team. The topics covered in these workshops were:

- Essential counselling and validation skills
- Anxiety Management
- Dialectical Behavioural (DBT) skills
- Motivational Interviewing
- Behavioural activation and problem solving.

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Feedback from staff has been extremely positive with increased staff knowledge and confidence in using psychological tools. Staff have told us that they are using the interventions taught to better support service users in our care.

Due to the success of this we are continuing this programme of workshops into the coming year, with 90% of Adult Mental health inpatient staff (bands 2-6) either already completed a set of workshops or booked to attend one.

Special Care Dental Services

National Guidelines, Public Health and Domiciliary Dental Teams have long identified that oral care for patients in Rest/Care homes is not comparable to other settings. Staff turnover is fast and there is no existing organised training. Originally commissioned in 2013, this quality project was re-commissioned in 2017. The Oral Health Promotion team based in the Eastern Locality are leading with this pilot study that aims to be rolled out to the whole of Portsmouth

Aims of the Project:

- This project aims to `train the trainer' so that staff trained can cascade their knowledge to their colleagues.
- This meets the challenge of limited NHS resources educating many carers in various Rest/Care homes across the city.
- A pilot study in one Rest Home to be undertaken, then adaptations made before larger scale training. This includes auditing care plans and gathering other information.

Outcomes of the Project:

- An `oral assessment' tool has been developed. There is an existing `Australian' tool that is used in the community setting. This is found to be too complicated and the new tool will have more visual guidance.

- A `train the trainer' book has been written to support `face to face' training. This encompasses
    - what is expected for good oral care according to national guidance;
    - other medical conditions that poor dental health can cause;
    - causes of tooth decay;
    - good tooth brushing; denture care; problems and causes in soft tissues/tongue and
    - how alcohol and smoking affect oral health.

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Annex 1:

Statements from commissioners, local Healthwatch organisations and overwiew and scruitny committees

Annex 2:

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 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 2017/18 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 2017 to [the date of this statement]
- papers relating to quality reported to the board over the period April 2017 to [the date of this statement]
- feedback from commissioners dated XX/XX/20XX
- feedback from governors dated XX/XX/20XX
- feedback from local Healthwatch organisations dated XX/XX/20XX
- feedback from Overview and Scrutiny Committee dated XX/XX/20XX
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
- the latest national patient survey XX/XX/20XX
- the latest national staff survey XX/XX/20XX
- the Head of Internal Audit's annual opinion of the trust's control environment dated XX/XX/20XX
- CQC inspection report dated XX/XX/20XX

• The Quality Report presents a balanced picture of the 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

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• 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

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Appendix A

National Clinical Audits & Confidential Enquiries that Solent NHS Trust was eligible to participate in during 2017-18 are as follows:	Solent participated?	Number of cases submitted to each audit or enquiry as a percentage of the number required (or just number if percentage not applicable)
National Audits		
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation **ORGANISATIONAL** Audit	Yes	Adults Portsmouth & Adults Southampton submitted as required
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation **CLINICAL** Audit	Yes	Adults Portsmouth (21 cases) Adults Southampton (52 cases)
Prescribing Observatory for Mental Health Quality Improvement Programme: 17a - Use of depot / Long-acting antipsychotic injections for relapse prevention	Yes	Mental Health (10 cases)
Prescribing Observatory for Mental Health Quality Improvement Programme: 15b - Prescribing valproate for bipolar disorder	Yes	Mental Health (15 cases)
National Clinical Audit of Psychosis (NCAP) (NICE CG 178)	Yes	92 / 100 (92%)
Physiotherapy Hip Fracture Sprint Audit (PHFSA)	Yes	Clinical audit: 5 cases Home rehab 2 cases Next Step Facilities audit: East - Spinnaker Ward West - Royal South Hants
NHS Bench-marking network: "National audit of Intermediate Care" (NAIC)	Yes	Adults Portsmouth – two teams submitted as required
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Stroke ESD Team - 149 cases Stroke 6 month Reviews - 129 cases (Most recent official figures available for August 2016 – July 2017)
National Diabetes Audit - Adults: National Footcare Audit	No	Data collection using electronic records was not possible during the audit period. This has now been set up for 2018/19.
National Confidential Enquiries		
NCISH: The assessment of risk and safety in mental health services	Yes	Survey completed
Child Health: Chronic Neurodisability Clinical Review	Yes	1 / 1 clinical case note questionnaire completed
Child Health: Young People's Mental Health Clinical Review	Yes	2 / 3 clinical case note questionnaires completed

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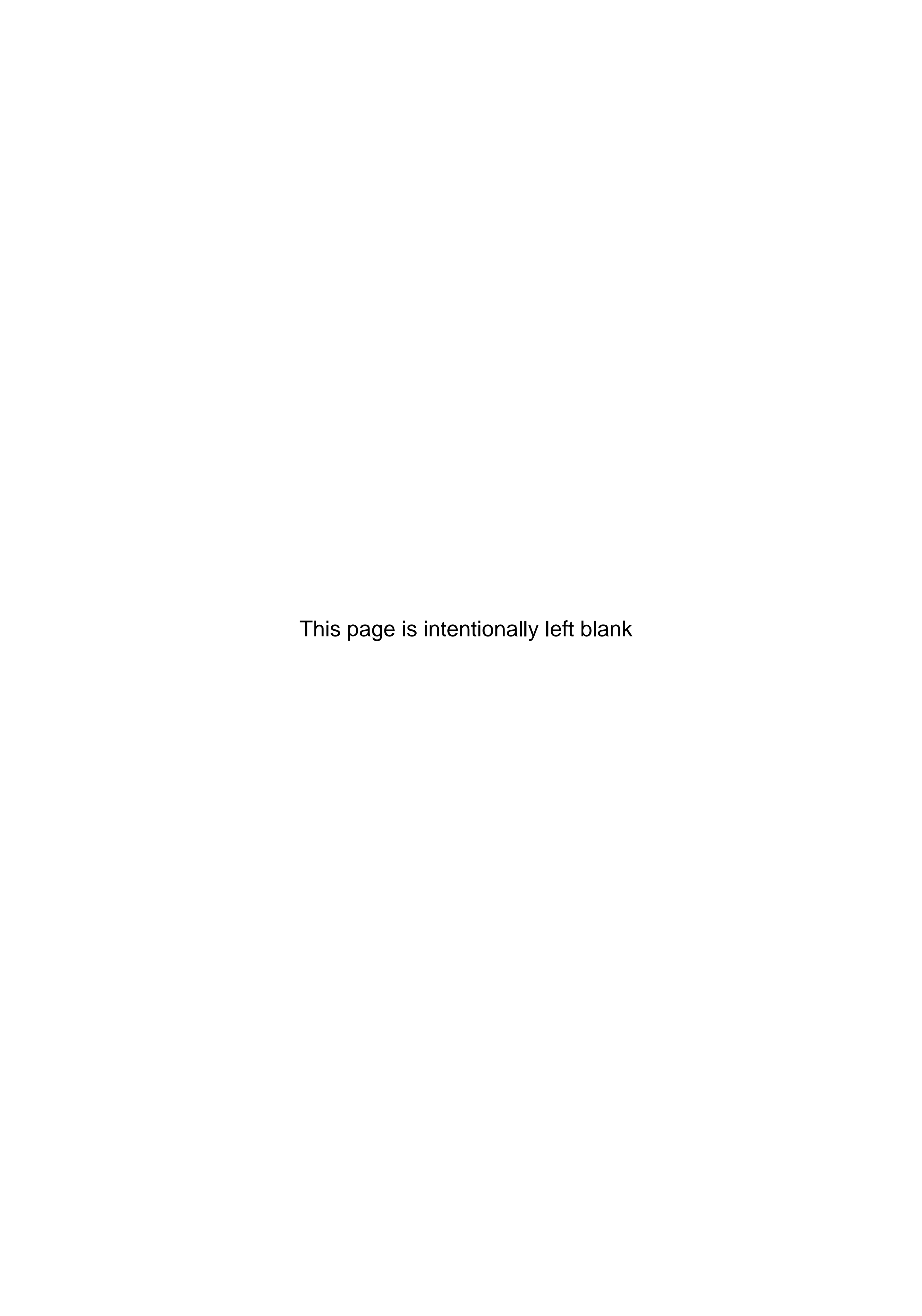
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QUALITY REPORT & QUALITY ACCOUNT 2017/18

Draft V16 Quality Report 17 & 18 - 13apr18 Ready for **Health Overview and Scrutiny Committee**

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Part 1: Statement on quality from Dr Nick Broughton, Chief Executive Officer of Southern Health NHS Foundation Trust

Improving the quality and safety of our services is undoubtedly the highest priority for me and the Southern Health Board. I believe that 2017/18 saw the Foundation Trust continue to make good progress in this regard. Since I joined Southern Health in November 2017 I have met hundreds of staff and visited many of our services across Hampshire. I have been impressed by the energy, commitment and dedication of our workforce and have no doubt that the Trust has the potential to be an outstanding organisation in the future.

Whilst clear progress has been made and I have confidence in the approach we are now taking, I am also acutely mindful of past failings and recognise the ongoing need for improvement at Southern Health.

As in 2016/17 much of our work this year has focused on meeting the recommendations from the Mazars report published in December 2015, and the Care Quality Commission (CQC) warning notice (following a focused inspection in January 2016). We have continued to work closely with NHS Improvement, NHS England and our Clinical Commissioning Group (CCG) on the quality undertakings applied in early 2016.

The Serious Incident and Mortality improvements put in place to meet the recommendations of the Mazars report have been reviewed by external consultants Niche and Grant Thornton who found that we had made significant improvements in the areas of;

- Identification, reporting and monitoring of patient deaths
- The quality, completeness and timeliness of the investigation process
- The process in relation to thematic review and the impact that each one has
- The culture in relation to transparency and learning lessons from deaths
- The practice of the Trust in relation to promoting physical health
- The practice of the Trust in relation to family involvement.

Our Family Liaison Officer, who joined us in late 2016 as part of our improvement plan, has made a real difference and has been well received by families and their loved ones as a dedicated support through the incident investigation process which can be a harrowing and distressing experience. Feedback has been overwhelmingly positive and her caring and compassionate approach has ensured that the voices of families are heard during the investigation phase and that we make improvements as a result of their experiences.

Providing clinical services of the highest quality is only possible if you have an excellent, engaged workforce. Our staff are our greatest asset and one which we must value accordingly. In keeping with this in December 2017 we celebrated our

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annual Star Awards. The Star Awards are all about rewarding and recognising colleagues for the hard work and commitment they provide every day to the people we support. Awards have been designed to recognise teams and individuals, both clinical and non-clinical, who truly go above and beyond their call of duty and are passionate about finding new ways of working, and providing the best possible service to people we care for, the local population and their colleagues. In early 2018 we expanded our reward and recognition programme and now also celebrate employees and teams of the month as well as long service. Staff recruitment, retention and engagement is a key quality priority for the coming year as is supporting and developing our workforce at a time when this is a challenge to all healthcare providers.

I am clear that further transformation is required for Southern Health to become an outstanding organisation, and that we must learn from other parts of the NHS which are already delivering the highest standards of quality. In 2017/18 I launched the Transformation Programme which will oversee major change across all the Trust enabled in part by our newly established Quality Improvement approach. This has been developed in partnership with colleagues from Northumberland, Tyne and Wear NHS Foundation Trust (NTW). This organisation is rated as outstanding by the CQC, and have themselves overcome quality challenges not dissimilar to ours. I am grateful to our experts by experience, the carers, families and other external stakeholders who are working alongside us in the development and delivery of this exciting programme.

We must not forget that there are examples of outstanding practice already across Southern Health.

Within our Community Services we are proud of our staff delivering the Health and Wellbeing project, which supports frail patients returning home from hospital, that were finalists at the 2017 Health Service Journal (HSJ) Awards. The project, which is a partnership with Age Concern Hampshire, hosts daily activities in our Petersfield and Gosport War Memorial Hospital rehabilitation wards to speed up patients' recovery and reduce the likelihood of readmission to hospital. Colleagues in our mental health services have launched the innovative Crisis Lounge, based at Antelope House, Southampton, which offers a safe haven to people at times of urgent need. This enables them to avoid having to call an emergency GP or visit a busy A&E department. It is a quiet, safe environment with staff who are experienced in caring for people with mental health conditions. I was also delighted to hear recently that our diabetes service have been shortlisted for the 2018 HSJ Awards for the work they are doing to support service users with mental health problems or learning disabilities – a fantastic example of how being a combined mental and physical health Trust can bring real benefits to the people in our care.

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Whilst significant improvements are being made, the impact of past failings continue to be felt and serve as stark reminders of where we have come from and why we must continuously strive to improve.

In September 2017 the Trust was fined £125,000 by the Care Quality Commission in relation to failures to ensure a safe environment at one of our hospitals which led to the injury of a patient. In March 2018 the Trust was fined £2m in relation to the deaths of two patients, Teresa Colvin in 2012 and Connor Sparrowhawk in 2013, following a prosecution by the Health and Safety Executive.

We fully accept that we failed to provide safe care and I apologise unreservedly both personally and on behalf of the Trust for this. Over the past two years our Health and Safety expertise and capacity has been strengthened significantly and this has happened alongside a coordinated, comprehensive program of environmental risk assessments. We are working diligently to make sure that Health and Safety rightfully becomes everyone's responsibility, and that the environments we work in are as safe as possible, both for our patients and our colleagues.

There is huge potential in the year ahead to significantly build on the progress of the last 12 months, and this is something myself and the Board are very excited about. We are looking forward to a comprehensive inspection by the Care Quality Commission in the coming weeks, and are confident that the quality improvements we have made will be recognised, alongside our efforts to better involve service users, carers, families and staff as we continue in our journey of improvement.

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

Date:

Signature:

Dr Nick Broughton

Chief Executive Officer

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

Section 2a. What is a Quality Report?

All NHS Foundation Trust healthcare providers are required to produce an annual Quality Report, to provide information on the quality of services they deliver. We have taken this opportunity to outline how well we have performed over the course of 2017/18, taking into account the views of service users, carers, staff and the public, and comparing ourselves with other Mental Health, Learning Disability and Community physical health Trusts. This Quality Report outlines the good work that has been undertaken; the progress made in improving the quality of our services and identifies areas for improvement.
Every Quality Report must contain priorities for improvement, to be achieved in the following year; we have used 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.

Section 2b. Priorities for improvement in 2018 and 2019

How we decided our quality priorities for the next 12 months
In determining the areas the Trust should focus on for our quality priorities in 2018/19, we sought the views of our patients, carers, staff, governors and stakeholders in a number of ways over a five month consultation period.
Suggested quality priorities were put forward based upon our progress against the 2017/18 quality priorities, our knowledge of incident reporting and complaints, national and local initiatives, and feedback from staff and patients.
Our consultation included a presentation about Quality Improvement and Quality Priorities. Postcards asking for suggestions for inclusion were circulated at numerous events including;

- Annual Quality Conference attended by staff, stakeholders and patient representatives
- Annual Nursing Conferences
- Quality and Safety Meeting through all the Trust’s Divisions
- Council of Governance meetings
- The ‘Families First’ Group
- Through our Head of Patient and Public Engagement at all the meetings they attended
- Via our Weekly Bulletin sent electronically to all of our staff and members

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- Through a poster presentation and suggestion box in the Cedar Café at the Trust's Head Office

After careful consideration of the main themes emerging from this feedback, our Governors, the Quality and Safety Committee, the Executive Team and Trust Board reviewed the suggestions and agreed the priorities for 2018/19.

We decided to continue the practice of linking our quality priorities to the three recognised domains of;

- Improving patient safety
- Improving patient experience
- Improving patient outcome.

Priority 1: Domain Improving Patient Safety
Priority 1.1 Risk Assessment and Crisis Contingency Planning
We have rolled this priority forwards from 2017/18 as we want to continue to monitor our improvement work in this area. It is extremely important that our patients feel safe, are involved in their risk assessments and the development of their safety (Crisis and Safety) plans.

In 2017/18 we measured whether all patients in our Adult Mental Health, Learning Disabilities and Older Person's Mental Health services had a risk assessment and crisis plan. In 2018/19 we wish to extend this good work and review the quality of these plans through an audit process undertaken by the senior nursing team. By March 2019 it is expected that a minimum 95% of plans audited will demonstrate excellent quality and the offer of involvement of the patient and their loved ones.

Priority 1.2 Reducing Restrictive Practice
Following recent Care Quality Commission inspections and the proactive work of our internal SAFER forum, reducing restrictive practice remains a key priority for the Trust. A new training programme has been developed and will be implemented during the year.

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This year focus we will concentrate on three areas for improvement;

1. Staff training – roll out of Supporting Safer Services "sSs".
2. Accurate reporting
3. Care planning for prone restraint to eliminate this as a regular practice.

The SAFER forum will measure performance against these areas and it is anticipated by March 2019 that 80% of the relevant Safe groups will have received the new training.

Priority 1.3 Collaborating with local communities to reduce suicide
The Five Year Forward View for Mental Health called for the Department of Health, Public Health England and NHS England to support all local areas to have multi-agency suicide prevention plans in place as part of major drive to reduce suicides in England. Following on from the work at Mersey Care we agree with their principle that suicide should not be viewed as "inevitable or unavoidable for anyone within our care". We aim to improve by learning from each tragic death in a multi-service manner.

In order to meet the requirement of the Five Year Forward View we aim to reduce the rate of suicide of our service users by 10% by 2021. On this basis we will be looking to achieve a reduction of 4% based on the April 2015 to March 2016 data in 2018/19.

Priority 2: Domain Improving Patient Experience
Priority 2.1 Consistent Staffing
Building relationships between staff, patients and service users is a key factor in promoting wellness. Establishing trust and understanding of long term patient and service user need is essential to a good therapeutic experience.

Research has shown that without exception patients' experiences are influenced by how care is delivered and their relationship with the key people who deliver it. Experience is adversely affected by constant changes within teams which can lead to the patient or service user distrusting the clinical information and disengaging from the treatment recommended.

Safe staffing is a priority for every NHS Trust and the recruitment and retention of quality staff is a key factor. The national picture for the recruitment of doctors and nurses is challenging. Over the past couple of years it has been recognised that the Trust could improve its efforts to retain its staff, some of whom are choosing to leave within their first 12 months of employment.

The outcomes from all the projects associated with this work stream are planned to reduce vacancy levels from 9% to 7% by March 2019.

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Priority 2.2 Triangle of Care
The Trust wishes to revisit and further develop the work achieved in the roll out of the Triangle of Care in the Mental Health Division. This will build on principles for involving families in the care of the patient, and work on information sharing with common sense confidentiality'.

The Triangle of Care emphasises the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental illness. It promotes a therapeutic alliance between service user, carer and clinicians to ensure that a positive, honest and open relationship is created from the first point of contact.

The six key standards state that:

1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2) Staff are 'carer aware' and trained in carer engagement strategies.
3) Policy and practice protocols re: confidentiality and sharing information are in place.
4) Defined posts responsible for carers are in place.
5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6) A range of carer support services is available.

By March 2019 it is expected that all carers of Mental Health service users will have access to carers' support and carers groups.

Priority 2.3 Reducing Incidents of Violence and Aggression
The Trust aims to reduce two aspects of violence and aggression in the coming year.

1. Incidents of violence and aggression from patients to patients.
2. Incidents of violence and aggression towards staff by patients.

Any incident of violence and aggression is extremely damaging and distressing to all individuals involved, both the perpetrator and the injured. It demonstrates a breakdown in relationships where frustrations have escalated to the point where there is loss of control.

For a service user the experience can result in a strong negative impact on the overall experience of care. For staff the experience can result in a belief that they are not protected in their working environment.

The Trust has liaised with other trusts who have successfully implemented violence reduction initiatives and found that setting targets for reduction does not work and promotes under reporting of incidents. These initiatives, if not supported by a quality improvement methodology, will not be sustained in the long term as they do not embed and support cultural change. Taking this into consideration, the measure is

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going be based on the implementation of the SafeCare model across our wider Mental Health Division.

Priority 3: Domain Improving Patient Outcomes

Priority 3.1 Improving the Recognition of Sepsis in the Community (education of patients and their families)
Sepsis is a common and potentially life-threatening condition triggered by an infection. It can arise as a consequence of a variety of infections, though the most common sources are infections of the lung, the urinary tract and the abdominal organs. Though it can affect people of any age, it is most common in the elderly and the very young.

When people suffer from sepsis, the body's immune system goes into overdrive, setting off a series of reactions including widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can reduce the blood supply to vital organs, starving them of oxygen. If not treated quickly, sepsis can lead to multiple organ failure and death. But in many cases, sepsis is avoidable, and it is treatable. Source: NHS England 2015

This is a priority for our physical health community teams who recognise that patients, their families and carers require guidance and education about what sepsis is and how to seek urgent advice. By March 2019 it is anticipated that 90% of relevant community staff will have received training to ensure that they are competent in delivering the key messages about sepsis as part of their clinical assessment.

Priority 3.2 Improving the Management of Deep Tissue Injuries, Pressure Ulcers and Wound Care
The cost to the NHS of caring for patients with a chronic wound is conservatively estimated at £2.3bn–3.1bn per year (at 2005–2006 costs); around 3% of the total estimated out-turn expenditure on health (£89.4bn) for the same period (Posnett and Franks, 2007). With proper diagnosis and treatment, much of this burden should be avoidable.

The impact on a patient of having a wound which requires regular dressing changes is dramatic and impacts on general living for both them and their families. It is important that they are partners in the treatment plan and in the prevention of further wounds developing from pressure injuries.

The activities within this Quality Account priority will feature as part of the three year Tissue Viability and Wound Care Strategy. This is once again a priority for the community physical health teams and the key year one activities will focus on training. By March 2019, 350 registered staff will have attended the Wound Care course taught by the Tissue Viability Nurses and all clinical staff will have completed the Pressure Ulcer E-learning training.

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Priority 3.3 Improving Access to Psychological Therapies
Psychological therapies are an important part of the treatment pathway for some patients.

It has been recognised within the Mental Health and Older Person's Mental Health services that there is a disparity in the access to psychological therapies which has been associated with long waiting times in some services. During the year we will be agreeing the model for psychological therapies across Mental Health and Older Person's Mental Health that provides the best patient outcome / recovery.

Waiting times are to be improved by 25% over the coming year in those services where the waiting time exceeds the national standard.

All of these priorities will be included in our Trust Quality Strategy document alongside our contractual quality requirements and the national CQUIN programme. Progress will be monitored quarterly by our Quality Governance Business Partners and reported through the Quality Improvement Programme Delivery Group which meets every week.

Section 2c. Progress made in meeting our priorities for improvement in 2017/18
Details of the progress made to meet our priorities for improvement in 2017/18 are given below.

Priority 1: Improving Patient Safety

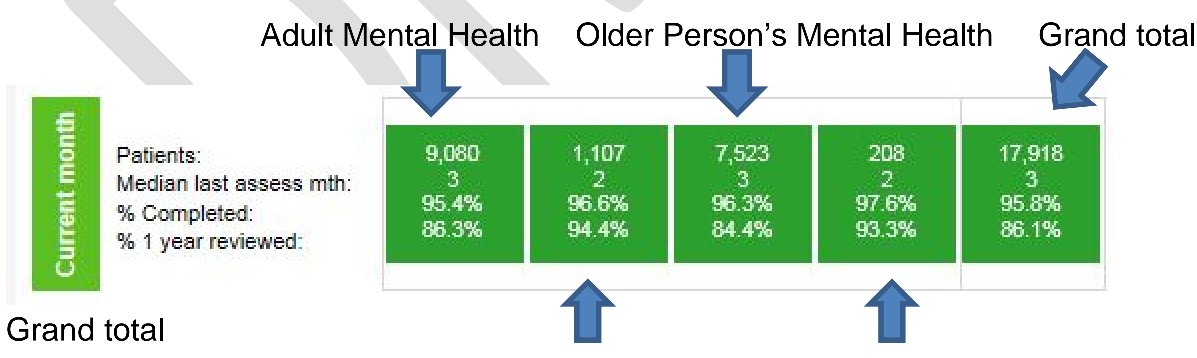
Indicator 1.1
95% of patients should have a risk assessment

Achieved	Partially Achieved	Not Achieved
✓		

Aim: A risk assessment is an assessment of someone's risk, to themselves and others. It is a document that should be written collaboratively with a service user and their family or carer. A risk factor is a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur. A good therapeutic relationship must include both sympathetic support and objective assessment of risk. Risk Assessments are a core component in planning care within Mental Health, and Learning Disabilities. We believe that a Risk Assessment should be focussed on positive risk taking, be structured and evidence based. All of our patients should have a Risk Assessment and these important documents should be completed collaboratively with the patient. A patient should have their individual level of risk assessed at each stage of their journey, or if their clinical condition changes.

Achievements: This indicator applies to services within the Mental Health and Learning Disabilities Divisions. An improving trajectory has been seen, with the divisions meeting this indicator during 2017-2018. Below shows a chart of patients who have had a Risk Assessment completed and the percentage that have been reviewed within the year, the target required is 95%, the graph below shows an improving trajectory, with the divisions meeting this indicator during 2017-2018.

Division's final % in relation to those patients with a Risk Assessment



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Data as of 2 April 2018

Future plans: We have seen improvement throughout the year and believe that this is such as important priority that we need to continue our focus on this. We will be continuing to monitor this priority in the coming year, 2018/19, but will be also reflecting the quality of our Risk Assessment not just whether there is one in place.

Indicator 1.2
Risk Assessments should be created using a holistic approach with input from all clinical specialities and input from the patient/carers with a copy sent to the GP. The Risk Assessments of those most unwell patients should be discussed at multidisciplinary meetings.

Achieved	Partially Achieved	Not Achieved
	✓	

Aim: The aim of risk management is to assess likelihood of risk events; this should be completed in conjunction with the patient, carer and family members. The assessment should be an activity of 'no decision in isolation', and as such should be formulated from a multi-disciplinary approach, ensuring that all factors are considered, whether this be social, physical or personal risks. Within Mental Health division a Crisis Plan is a document written collaboratively with the patient to identify signs of crisis and how they would like to be supported during that time. For our Integrated Service Division (ISD) looking at the physical health of patients specific Risk Assessments, such as falls, skin integrity and malnutrition screening tool (MUST) are completed if indicated on the initial patient screening.

Achievements: We completed an audit to measure the collaborative element of the formulation of the Risk Assessment and the quality of that Risk Assessment and Crisis Contingency plans. In the Mental Health division a small improvement has been seen in this year, with the involvement of patients, carers and family. Although an improvement has been seen, it has established that this is an area that needs further work. Risk Assessments were reviewed as part of the weekly Multi-

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disciplinary Meetings (MDT) held within Mental Health services, to ensure it is a dynamic assessment with input from all specialities involved in the patients care.

Prior to August of 2017/2018 a Crisis Contingency Plan was in place for patients, to create a plan of what they require as support when in crisis and their behaviours when in crisis; there were also separate plans in place for safety and how they would like to keep themselves safe. This was changed to a combined “My safety/My crisis” plan so that the patient had one single plan that they could work with clinicians to create in order to support them through times of crisis. The quality of the “My crisis/My safety” plan is subjective as it is a document that is owned by the patient. However, as a Trust we measured the quality of both the Risk Assessment and the “My crisis/My safety” plan, by a selection of them being reviewed by the team leaders or managers of wards, to ensure that the information contained within them was of the expected quality in their professional position as a clinician.

Quarter	**Patients with a risk assessment that is holistic and of high quality**	**Patients with a "My crisis/My safety" plan that was of high quality***
Q2	95%	80%
Q3	96%	60%
*Q4***	*98%*	*70%*
* Patients requiring a "my crisis/my safety" plan is only for those who are identified of medium risk and above.		
*** Q4 is not confirmed yet, the number in those columns relate to interim figures.*		

Our Integrated Service Division (ISD) performs an initial holistic assessment of each patient on admission and if indicated a specific Risk Assessment. From these assessments, a Care Plan is developed collaboratively with the patient and/or family/carer. The Quality Assessment Tool (QAT) is a monthly assessment tool that includes a review of patient care plans. Each team is targeted to review three patients a month under the tool, with 491 completed in 2017/18. The results show over 98% of patients felt involved in their Care Plan and that staff were responsive to their needs.

Future Plans: Although an encouraging picture has been seen. The Divisions have created an action plan to address the shortcomings identified; therefore this will continue to be an indicator in 2018/19.

Indicator 1.3
There is a reduction in Risk Assessments and Crisis Plans being a contributory factor in serious incident investigation reports

Achieved	Partially Achieved	Not Achieved
✓		

Aim: An 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 was carried out by Mazars (Mazars, 2015) and published in December 2015.Subsequent CQC inspections identified that “the Foundation Trust did not have robust governance arrangements to investigate incidents, and therefore had missed opportunities to learn from these incidents and to take action to reduce the likelihood of similar events happening in the future”. On the basis of this a thematic review was completed in order to review all serious incidents reported to identify if Risk Assessments or Crisis Contingency Plans were a contributory factor in serious incident investigation reports.

Achievements: The thematic review identified that there was a reduction in Crisis Contingency Plans and Risk Assessments being a contributory factor, with the breakdown below.

Quarter and Year	Total number of Serious Incidents*	%
Q4 16/17	16	50%
Q1 17/18	20	40%
Q2 17/18	18	22%
Q3 17/18	15	20%

During this year a launch of the combined ‘My Safety/My Crisis Plan’ has been completed, this combined plan is proving to be a more satisfactory way to record the patients’ wishes in one plan, thus it becomes a less onerous task for both patient and clinician to complete collaboratively.

An external audit was completed by Niche Consulting and the auditors Grant Thornton to establish whether the Trust had implemented the recommendations made within the Mazars report. They confirmed that the Trust had made significant improvements in relation to the themes they had audited.

Themes were:

- Identification, reporting and monitoring of patient deaths
- The quality, completeness and timeliness of the investigation process
- The process in relation to thematic review and the impact that each one has
- The culture in relation to transparency and learning lessons from deaths
- The practice of the Trust in relation to promoting physical health
- The practice of the Trust in relation to family involvement

The grading’s of assurance applied by Niche Grant Thornton were:

- A Evidence of completeness and embeddedness and impact
- B Evidence of completeness and embeddedness

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- C Evidence of completeness
- D Partially complete
- E Not enough evidence to say complete
- U Yet

The audit indicated the following:

Identification, reporting and monitoring of patient deaths	A
The quality, completeness and timeliness of the investigation process	B
The process in relation to thematic review and the impact that each one has	B
The culture in relation to transparency and learning lessons from deaths	A
The practice of the Trust in relation to promoting physical health	B
The practice of the Trust in relation to family involvement	A

Future Plans

The audit gave the Trust assurance that the learning had been implemented, the grading of B indicates that the auditors found evidence that these actions had been implemented, however it was too soon to evidence that this has been embedded in usual practice, therefore this will be re-audited in quarters two and three of 2018.

The thematic review highlighted that there has been a change in Risk Assessments and Crisis Plans being a contributory factor in serious incidents, however, we will continue to monitor this in the Adult Mental Health quarterly Mortality and Serious Incident meetings.

Priority 2: Improving Patient Experience

Indicator 2.1
There is evidence of patient/ service user family/carer involvement with risk assessments and crisis contingency plans

Achieved	Partially Achieved	Not Achieved
	✓	

Aim: It is part of a holistic risk assessment that it is created collaboratively with patients, carers and family members. NICE guidance CG136 - service user experience in adult mental health: Improving the experience of care for people using adult NHS mental health services (NICE, 2011) identifies that a conversation should occur with the patient to identify how they would like their family/carers to be involved in their care; this should be at different points within their patient journey. Consent should be given by the patient in order to include the family. However, if consent is

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denied, it does not mean that family members and carers cannot be involved, it merely means that consideration should be given in relation to the information shared and that the patients request for confidentiality is not breached.

Achievements: An audit was completed during the reporting period to ascertain the involvement of patients, family and carers in relation to Risk Assessments and crisis Contingency Plans. Initial outcomes were disappointing; however, an improving trajectory was seen in quarter three and quarter four,

RESULTS to be inserted. This will be available mid April, once the audit has been completed for Q4

Future Plans: Although an encouraging picture has been seen. The Divisions have created an action plan to address the shortcomings identified; therefore this will continue to be an indicator in 2018/19.

Indicator 2.2
There is evidence of the involvement of patients in Divisional patient participation meetings

Achieved	Partially Achieved	Not Achieved
✓		

Aim: We believe that patients attending Divisional meetings is important and that patient representation will provide opportunity for challenge in relation to our business processes.

Achievements: A Strategy for Experience, Involvement and Partnership has been developed and formally published in June 2017. This strategy sets out a commitment to working in partnership with patients, service users, families, carers, the public and its representatives to ensure that services are delivered in a comfortable, caring, compassionate and safe environment. The strategy will do this by setting minimum standards for involving people in decisions about their care and treatment, and ensuring people who use services are given opportunities to participate meaningfully in the design, development and delivery of services

The Trust's Divisional and Business Unit structures for involving patients/ service users have developed during the year, and vary to reflect the diversity of services. Involvement mechanisms include patient/service user forums, focus groups, task and finish groups including experts by experience and opportunistic discussions. Patient participation at Divisional meetings has been challenging to achieve; this is due to factors in relation to the recruitment of patient representatives and difficulties in generating enough applications in relation to this role.

The Learning Disabilities Division, have a network of locally based participation groups who are involved in many aspects of service development. This is also true of

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the Specialised Services Division, who currently has a service user involved in improvement work to review restraint practice within the service.

The Families First Group was put in place in January 2017 and has a significant role in the Trust. One of the group's duties is to review the Trust's policies and procedures to ensure they are fit for purpose, and provide an expert by experience view point for inclusion, into these documents.

In the Health Visiting service they have reviewed the first contact with patients in relation to the musculoskeletal services. Patients were involved in the rewriting of the first appointment letter; a Complaints working group including experts by experience redesigning information on how to make a complaint; and a client with additional communication needs designed an information board about the Health Visiting service.

Future plans: Work continues in all areas of the Trust to ensure that patients, carers and families are consulted on our work and documentation. Carers groups are in place in Learning Disabilities and in the North and West Areas for Adult Mental Health, further groups for Southampton and the East Area of Hampshire are ongoing. These groups are consulted in relation to any proposed changes to the service, and on documentation that will be used. The Older Person's Mental Health Division are currently in the process of developing a support group for patients six weeks post discharge, it is envisaged that this will act as peer support and will be designed to help people stay well.

Indicator 2.3
All new Trust literature will be have undergone coproduction and have been reviewed by patients, they will also be version controlled.

Achieved	Partially Achieved	Not Achieved
✓		

Aim: That patients and users of our literature should have input into the creation of our literature and that it should be in a format that can be easily understood.

Achievements: A standard operating procedure has been created alongside a revised policy for Production of Patient Information, this is to ensure that all patient information requests have a design brief, and can evidence consultation with/ involvement of patients in the development of the information. The process includes a log of all requests, and the completion of each stage. The policy includes a minimum requirement to consult with the target audience on the content and presentation of the information. The group have had involvement in the following information:

A leaflet for the Forensic Community Learning Disability Team, an Emotional Wellbeing leaflet and poster, First Time Parent Group poster and leaflet.

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In addition, several publications were completed: A Common Sense Guide to Confidentiality (Adult Mental Health), Trust wide Information sharing leaflet was produced, based on discussion with families and service users at a workshop, and subsequent involvement of the Families First Involvement Group, and consulting with a wider group of families. Two posters were also co-produced with families and service users – ‘' what to expect from us during a person's care and treatment" – one for families carer and friends and one for patients/service users. Examples of these can be seen below:

If you have any concerns, or require further information, please speak to your healthcare professional in the first instance.

Alternatively, please contact:

Complaints and Patient Experience Team

023 8087 4065 or

hp-tr.customerexperience@nhs.net

This information is available in other formats and languages including large print, braille and audio.

Please contact:
Communications and Engagement Team
023 8087 4666

@Southern_NHSFT

Southern Health

Become a member of our Trust.
Email: membership@southernhealth.nhs.uk
or call 023 8087 4253

www.southernhealth.nhs.uk

Quality care, when and where you need it

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Confidentiality and information sharing

Information for patients

The Trust takes confidentiality and privacy very seriously. We need to ask you for personal information that is relevant to your care that will allow us to carry out your treatment effectively and efficiently. This information is kept securely on your clinical record.

Everyone working in the Trust, and within our partner agencies, e.g. GPs and Social Care, has a legal duty to keep information about you confidential. You can be assured that only relevant staff have access to information that is necessary for them to carry out their duties.

In order for us to work together with other health and social care professionals, there are times when we need to share this information. This may be for instance, when your healthcare professional needs to discuss your case in order to plan your care. We do this in order to provide the most appropriate treatment and support for you and your carers, or when the welfare of other people is involved. We will only share information in this way if we have your permission and it is considered necessary.

Overriding Circumstances

However, there may be other circumstances when we must share information with other agencies. In these rare circumstances we are not required to seek your consent. Examples of this are:

- If there is a concern that you are putting yourself at risk of serious harm
- If there is concern that you are putting another person at risk of serious harm
- If there is concern that you are putting a child at risk of harm
- If we have been instructed to do so by a Court
- If the information is essential for the investigation of a serious crime
- If you are subject to the Mental Health Act (1983), there are circumstances in which your 'nearest relative' must receive information even if you object
- If your information falls within a category that needs to be notified for public health or other legal reasons, e.g. certain infectious diseases.

Sharing information with Family, Friends and Carers

We also need to be able to work with the most relevant people in your life, and to do this, may need to share information about you. We would do this with your agreement, and this may include general information about your diagnosis, and medication, i.e. benefits and possible side effects.

This is in order that your carers are helped to understand:

- Your present situation
- Your treatment plan and its aims
- Any written Care Plan, Crisis Plan or Recovery Programme
- The role of each professional involved in your care
- That denied requests for information will be explained to the carer.

You also need to be aware that carers may give information to staff. This is also confidential, and can only be shared with you if the carer agrees.

Future Plans: The Triangle of Care (Carers Trust, 2013) was published to set out best practice to include and recognise carers as partners in care. We remain committed to continuing to implement The Triangle of Care, as it offers key standards and resources to support services to support mental health service providers to ensure carers are fully included and supported with the person they care for in the centre. This will be a focus for our quality priorities in 2018/9.

Priority 3: Improving Patient Safety, Improving Patient Experience

Indicator 3.1
Family Liaison Officer - monitor patient/carer/family involvement, through production of quarterly report

Achieved	Partially Achieved	Not Achieved
✓		

Aim: The involvement of families and carers in the investigation of Serious Incidents is essential to the Trust. The Family Liaison Officer (FLO) is available to provide support to families and carers through this process. The FLO completes a report to identify the involvement they have had with families and this is presented to the Patient Experience, Engagement and Caring Group for the Trust, where it is discussed in detail.

Achievements: The FLO has provided support to 91 families this year; this has involved contact with different family members. Support can be varied, and can include the facilitation of meetings between both internal and external teams and families, supporting families through the Serious Incident investigation and providing information in relation to other organisations, such as the Red Lipstick Foundation or Simon Says, who offer more specialist bereavement services.

The Patient Experience and Caring Group reviews what support the FLO offers and how families have felt about this. Two family members who have had support from the FLO made videos regarding their experiences which were shown at the Trust's Annual Quality Conference in October 2017. This provided invaluable insight into their own experience of the Trust and identified to Trust staff, commissioners, governors and members of the Families Involvement Group how important it is for family members to be engaged in the care provided. The FLO took the opportunity to reiterate that the majority of families/carers want to be involved, whether in the care provided to their relative or in analysing care and that working together can only have benefit for all involved.

The FLO has also been involved in providing support to families who have attended Coroners inquests. This support includes talking them through the process of what an inquest entails, how the inquest is conducted and what they may expect to hear. This enables them to be prepared for what often can be a distressing occasion.

Sharing messages and findings of investigations with families is difficult and the FLO has provided specialist training. The 'Sharing Reports' training was developed with this in mind and has been presented in conjunction with Canon Nick Fennemore, to Investigation officers and senior staff involved in difficult conversations.

The FLO is an active member of the Hampshire Suicide Prevention Forum and the Southampton Citywide Suicide Prevention Strategic Group. A short presentation was made at the World Suicide Prevention Day Event at the Mayor's Parlour in Southampton in September; the focus of the event was 'Take a Minute, Save a Life'. The presentation focused on providing and accessing support for families and partnership working to improve and develop the support that is currently available across Hampshire.

Future Plans: The FLO is working with a number of local support agencies and the Trust Chaplain to try to bring more support into various locations across Hampshire, to support the bereaved, carers and service users.

The FLO is also focused on the development of Carer's Packs, predominantly within the Mental Health units within the Trust, but with consideration to all areas. This area of work has previously been raised through the Families First Group and more recently through the Caring Group. Work is ongoing with the Trust Learning Disabilities unit to develop information to assist those with a learning disability, and their carers, in understanding and coping with a death.

Indicator 3.2
Monitoring and escalation of Duty of Candour compliance

Achieved	Partially Achieved	Not Achieved
✓		

Aim: The Trust believe that promoting a culture of openness is a prerequisite to improving patient / service user safety and as such it ensures communication is open, honest and occurs as soon as possible following an incident between healthcare organisations, healthcare teams and patients/service users and/or their carers. Duty of Candour was introduced for NHS bodies in England (Trusts, Foundation Trusts and special Health Authorities) from November 2014. It applies to incidents that are graded as moderate or above in harm, and is always applied when a patient death occurs be that either expected or unexpected. It consists of three processes:

- 1a That the patient and/or family should be contacted by the care giver as soon as possible to notify them that a safety incident has occurred and the care giver should, provide an account of all the facts known at the time and provide an apology to the service user.
- 1b That the care giver should follow up on 1a with written notification which will include an apology for the incident occurring and inform of any investigation that may occur.

2 The completion of any investigation to share the findings with the patient and/or family or carers to apologise for any omission in care and provide opportunity for discussion.

At any stage the patient/family/carer can refuse to be part of this process, however we have a legal duty to record their refusal.

Achievements: The Duty of Candour process has been reviewed by the Caring group on a quarterly basis. Work continues in relation to compliance with this requirement, with daily enquiry in relation to steps taken to meet Duty of Candour. As part of this the Trust implemented a daily panel to review all incidents of moderate grading or above, during the panel, Duty of Candour is discussed and a lead identified to ensure that the patient/family or carer is involved.

To provide assurance that the Duty of Candour process is being followed, an internal audit was conducted by RSM Tenon – Risk Assurance Limited.

Future Plans: Duty of Candour is now embedded within our Divisions and continues to be reviewed on a daily basis.

Priority 4: Improving Clinical Outcomes

Indicator 4.1
Locality team development programme to establish a clear purpose for cross-organisation and multi-disciplinary teams.

Achieved	Partially Achieved	Not Achieved
✓		

Aim: To develop a framework for the delivery local care to ensure resources are targeted to patients who have the highest needs. This includes services such as Extended Primary Care Team (EPCT), Same Day Access Service (SDAS) and Acute Visiting Services (AVS)

Achievements: The local acute hospital in the region of the trial has seen reduction in non-elective and care home admissions. This can be related back to the work of the Extended Primary Care Team.

The Vanguard pilots have drawn to a close; this has provided a good grounding to develop the EPCT model further; including the development of neighbourhood teams for the Trust. CCGs are commissioning an Acute Visiting Service across Hampshire - which is a testament to the success of the model.

There is an Acute Visits Team, a Care Homes Team and a Same Day Access Service (SDAS) operational in Gosport. For Fareham, the Care Homes activity has been extended to two care homes. The Willow Group have implemented an initial

phase of Long Term Conditions (LTC) hubs for respiratory and diabetes which involve primary and community nurses working together.

Future Plans: The Better Local Care project teams have identified the next high impact areas to be addressed to improve patient care; Delayed Transfer of Care (DTOC) and Falls related admissions.

The plan is to establish the blue print for the Neighbourhood Team development (as part of EPCT) and to implement that plan in the Willow Group. CCGs are facilitating the development of a system wide governance structure which will reduce silo based working and support system wide decisions making rather than as separate organisations. The Trust is represented on this board.

Indicator 4.2
The experience of patients will be ascertained in relation to the delivery of their care

Achieved	Partially Achieved	Not Achieved
✓		

Aim: As part of the Hampshire Vanguard project (Better Local Care initiative) the Trust has collaborated in a range of projects. An example is a project in Fareham and Gosport to deliver an extended primary care, breaking down the traditional boundaries between primary and secondary care. The patient feedback on these projects is collated in a number of reports from external companies.

Achievements: Better Local Care Hampshire "Multi - Community Partnership Vanguard" report highlights:

- E-Consult Patient Data – Over 80% of patients were satisfied with the service and would recommend it to others. This is now part of STP Digital Programme.
- Same Day Access Service (SDAS) - High level of patient satisfaction with mode of contacting healthcare services.
- Paramedic Home Visiting Service – Over 85% of patient were satisfied with the service and would recommend it to others.

RSM-PACEC "The power of being understood" report is based on a monthly patient telephone survey. (RSM Tenon is an external audit firm, (Risk Assurance Limited, Public and Corporate Economic Consultants))

- 85% claimed that considerable effort was made to listen to the things that matter most to them about their health issues.
- However, only one in four people cited that family and friends were involved as much as they wanted them to be in decisions about their care.
- Common theme for improvement was having access to one GP that knew the patient's history.

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Future Plans: External suppliers will continue to conduct patient interviews and provide evaluation of results on new trialled services.

Indicator 4.3
To ensure shared care records and team working across organisations are in place

Achieved	Partially Achieved	Not Achieved
✓		

Aim: Hampshire Vanguard project (Better Local Care initiative) has looked at how healthcare organisation can have shared views on patient records to improve the efficiency of care delivery.

Achievements: Medical Interoperability Gateway (MIG) projects facilitate the sharing of data between different systems and software providers. Phase one allows Trust Community staff to have access to GP patient records held on EMIS and TPP SystmOne systems.

- Trust staff have one-click access to GP Primary Care records (electronic patient records systems). Approximately 1,000 views each week.
- Records are shared in real time.
- RSM-PACEC Deep Dive Evaluation Report for Phase 1 estimates significant staff time savings where GP records were viewed for new referrals.

Pilots created in Petersfield using EMIS and New Milton using TPP SytmOne.
- Adult Nursing and Therapies team have moved to using EMIS and TPP SystmOne (electronic patient record system).
- Full record sharing and electronic referrals enabled.

Future Plans: MiG Implementation:
- Phase 2- Adult Community, Mental Health and Children's records from RiO, down to progress note level, will be available to GP practices
  - One-click access from EMIS to RiO records – Q1 18/19
  - One-click access from TPP to RiO records to be developed – Q1 18/19.
- 2018/19 funding has been secured to October 2018. (STP Digital work stream and New Care Models work stream.)
- Work has started to transition the functionality to CHIE (Care and Health Information Exchange computer system used in primary care)

EMIS Petersfield and TPP SystmOne New Milton Pilots - Exploring funding options, including the costs of exiting pilots if interest is insufficient.

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Section 2d. 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.

1.Review of services

During 2017/18 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 them on the quality of care in 49 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 90% of the total income generated from the provision of relevant health services by the Southern Health NHS Foundation Trust for 2017/18.

2.Clinical audits and national confidential enquiries

During 2017/18 ten national clinical audits and one national confidential enquiry covered relevant health services that Southern Health NHS Foundation Trust provide.

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

The national clinical audits and national confidential enquires that Southern Health NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

National Clinical Audit	Eligible	Participated in
POMH-UK Use of depot/LA antipsychotic injections for relapse prevention (POMH – Prescribing Observatory for Mental Health)	✓	✓
POMH-UK Prescribing valproate for bipolar disorder	✓	✓
POMH-UK rapid tranquilisation	✓	✓
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	✓	✓

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Sentinel Stroke National Audit programme (SSNAP)	✓	✓
Society for Acute Medicine's Benchmarking Audit (SAMBA)	✓	✓
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care	✓	✓
Intermediate care	✓	✓
National Clinical audit of Psychosis(NCAP)	✓	✓
National Falls Audit 2017	✓	✓
National Confidential Inquiry into Suicide and Homicide by people with mental illness.	✓	✓

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The participation level was reduced in two of the audits. This is thought to be related to the patient population and those who do not receive either Depot/LAI antipsychotic or Valproate treatments. In year 2018/19 the reasons for non-participation will be more clearly recorded.

National Clinical audit	**% of required cases submitted**
POMH-UK Use of depot/LA antipsychotic injections for relapse prevention	83 cases submitted 32% of sites
POMH-UK Prescribing valproate for bipolar disorder	139 cases submitted 38% of sites
POMH-UK rapid tranquilisation	Data currently being submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	100%
Sentinel Stroke National Audit programme (SSNAP)	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA) - annual since 2012	100%
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care and neurology)	100%

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Intermediate care	100%
National Clinical audit of Psychosis(NCAP)	100%
National Falls Audit 2017	100%

The report of five national clinical audits were reviewed by the provider in 2017/18 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

POMH UK The use of depot (long-acting injectable (LAI)) medication for relapse prevention.

- Good compliance with the standards. Future work will focus on moving towards consistency across the Trust and targeting 100% compliance.
- Care Plan standards is an area that was considered generally poor and needs further attention.
- Inpatient and Community teams are formulating local action plans to reflect the key areas for improvement.
- Senior level support is required to prioritise the POMH audits and ensure all clinical teams participate.
- The next audit is expected in October 2019 (provisional date) and will require all relevant clinical teams to participate.

POMH-UK rapid tranquilisation

- Ward staff are encouraged to document the debrief from an episode of rapid tranquilisation within 72 hours as per the NICE guideline.
- Similarly the audit highlighted that Trust and NICE guidelines call for patient physical health monitoring following episodes of rapid tranquilisation.
- Progress monitored with a repeat audit for all areas of the mental health division in early 2018.

Society for Acute Medicine's Benchmarking Audit (SAMBA)

- The Trust mainly run Community Hospitals, providing limited acute services that fall under the SAMBA remit. Hence we have relatively small patient numbers in the audit. Our patient acuity is higher than average, a reflection of age, comorbidities and frailty scores for our region. The data submitted demonstrates the Trust is engaged with Quality Improvement in relation to urgent or emergency care.

National audit of intermediate care

- This was a benchmarking audit for the Integrated Service Division.

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Falls audit

- The Royal College of Physicians' Blood Pressure tool for patients in lying and standing positions has been shared across Trust. Practical drop-in sessions have been held to support staff understanding and use of the tool.
- Similarly the Royal College of Physicians' Vision tool has been introduced to Community Hospitals via our Falls Champions, to quickly assess a patient's eyesight in order to prevent them falling or tripping while in hospital.

The reports of 45 local clinical audits were reviewed by the provider in 2017/18 and Southern Health NHS Foundation Trust intends to take actions following these to improve the quality of healthcare provided.

Audit title	Actions
Minor Injuries Unit (MIU) Records	• Update to documentation for patients under 18 to make checks clearer.
Meticillin-resistant Staphylococcus aureus (MRSA)	• Where service users are not MRSA screened on admission, the reason is recorded on their clinical record. • Details of the service user areas MRSA screened are recorded on their clinical record.
GP Communication	• Improve information on the services that Health Visitors, School Nurses and Children in Care specialist nurses offer : o Create "You said we did " letter for GP's following the audit. o Relaunch Health Visiting and School Nursing request for support forms o Redistribute Healthy Child Programme 0-5 and 5-19 leaflets and share with GPs at GP liaison o Promote Health Visitor advice line o Promote "ChatHealth" and resend promotional material
Physical health assessment OPMH	• Updated policy. Ensure induction Nursing staff review individual patient assessments and all patients have physical health care plans to meet their needs. (OPMH medical staff) • Introduce 'new' OPMH Matrons Quality Assessment tool to ensure thorough completion of patient records (Modern matrons and Ward managers)

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Audit title	Actions
Wound Audit	• Further education on treatment and prevent of wound infections. 354 wounds showed signs of infection. • Training to report all pressure ulcers and deep tissue injuries and understand the “levels of harm”. • Also training on recognising a deteriorating wound, how to treat and when to refer to a specialist. • 2 day leg ulcer training and follow up to achieve competency within staff. • 2 link nurses within ISD teams available to staff
Physical health assessment – community Learning Disability	• Blood pressure monitoring will be recommended as appropriate and communicated back to the GP/ Primary Care within responses to GP/ Primary care. • Learning Disability Psychiatrists to check the results of investigations to ensure that they have been undertaken and any abnormalities followed up appropriately. • A task and finish group will be coordinated by the Associate Director of Nursing, AHP & Quality (Learning Disabilities) to plan how the Learning Disability Division will manage physical health monitoring.

3.Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Southern Health NHS Foundation Trust in 2017/18 and staff that were recruited during that period to participate in research approved by a research ethics committee was 1,600.

4.Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Southern Health NHS Foundation Trust income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Southern Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standardcontract/cquin/cquin.

In 2017/18 income totalling £ 5,713,616 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals. In 2016/17

income totalling £5,774,814 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals, of which payment of £5,112,445 was received.

Our CQUIN schemes for 2017-2019 follow the national guidance also available at the link on previous page.

Within Mental Health Service contracts there is a single local scheme in the Hampshire wide Mental Health Service contract and in the Southampton City 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 scheme for the Child Health Information Services (CHIS) and Immunisations team for increasing the participation and reducing inequalities in Immunisation uptake (HPV, Td/IPV and MenACWY) for Children aged between 12 years and 15 years.

5.Care Quality Commission Registration and Actions

Southern Health NHS Foundation Trust is required to register with the Care Quality Commission (CQC) its current registration status is 22 locations registered with CQC under the Health and Social Care Act (2008). Southern Health NHS Foundation Trust has the following conditions on registration: no conditions.

The Care Quality Commission has not taken enforcement action against Southern Health NHS Foundation Trust during 2017/18.

Southern Health NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

On June 2017 the Trust pleaded guilty to charges brought by the Care Quality Commission relating to a health and safety incident which took place in December 2015 at Melbury Lodge in Winchester. The Trust was sentenced in October 2017 and was fined £125,000 for “failing to provide safe care and treatment and putting people at risk of avoidable harm”.

In March 2018 the Trust was fined £2m in relation to the deaths of two patients following a prosecution by the Health and Safety Executive.

6.The Care Quality Commission Inspections

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.

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The Care Quality Commission has carried out four inspections during 2017/18. Each of these was a follow-up inspection to review progress against the actions from the 2015/16 – 2016/17 inspections. One inspection was within the Trust's social care services and this service received an individual rating of 'Good'. Another was within the Foundation Trust's primary care service, The Willow Group. This service received an individual rating of 'Good'.

A further Care Quality Commission inspection at the Trust took place in March 2017 and was reported in July 2017. The inspection was carried out to follow up on areas that CQC had previously identified as requiring improvement or, particularly in mental health, where they had questions and concerns that they had identified from their ongoing monitoring of the Trust. The Care Quality Commission concluded that the Trust had turned a corner. The interim chair and chief executive had a clear vision and understanding of what was required to bring about improvements and were committed to ensuring that improvement was made in a timely manner. They also reported that there had been a notable improvement in the timeliness and quality of investigation reports following serious incidents, including deaths. The Care Quality Commission did not re-rate the Trust following this inspection.

A further focused Care Quality Commission inspection took place between April and June 2017 in two of the Trust's acute mental health units. CQC had received concerns about low staffing levels, high use of bank and agency staff, not enough suitably trained staff on the psychiatric intensive care unit (PICU) and use of seclusion. CQC reported that the Trust had taken significant steps to address the serious concerns raised at the last inspection to address the issues within the seclusion room. They also reported that the senior management team had committed resources to analysing the issues of concern on the ward and there was clear planning with regard to driving improvements across the hospital, this included increasing the numbers of restraint trained staff on the wards, increasing staffing levels and skill mix across the wards too. Because this was a focused inspection CQC did not re-rate the service.

The Trust has been informed by the Care Quality Commission that they plan to carry out a full comprehensive inspection in 2018. The Trust received the request to complete the CQC's Provider Information Request (PIR) on 6 March 2018 and this was submitted on 27 March 2018. Although still to be confirmed by the Care Quality Commission, the Trust is expecting all core services to be inspected during May/June 2018 and for there to be a Well-led review in July/August 2018, after which the Trust will be re-rated.

7.Quality of Data

Southern Health NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are

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included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:
  98.6% for admitted patient care
  100% for outpatient care and
  97.2% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was:
  99.3% for admitted patient care;
  99.9% for outpatient care; and
  98.4% for accident and emergency care.

Southern Health NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 90% and was graded green 'satisfactory'.

Southern Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by NHS Improvement.

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

- Investing significant resource in supporting improvements in corporate and clinical data quality, including:
  - Patient level validation lists, available daily, for extended clinical measures such as risk assessments, outcome measures and clinical assessment forms
  - Daily availability of governance related data quality validation lists, including mortality reviews, Duty of Candour and action plans resulting from incidents
  - The availability of staff level workforce and financial validation to ensure an employee's Electronic Staff Record accurately reflects the allocation within the Trust's financial ledger
- The above functionality is being extensively used by clinicians and has resulted in sustained improvements to data quality across a range of Trust performance measures.
- During 2018/19 the Trust will be committing to further improvements in data quality through the following initiatives:
  - Clinical validation of one Board level clinical Key Performance Indicator per month to ensure reported performance is supported by robust and reliable clinical documentation
  - Data Quality kite-marks to be incorporated into the Trust Integrated Performance Report on a monthly basis to assess levels of data quality for each Board Key Performance Indicator
  - The development of personalised, employee level performance dashboards within Tableau (The Trust's Business Intelligence Tool)

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that will be shared directly with each staff member once a month and which will form part of an employee's formal supervision

8. Learning from Deaths

As a Trust, we must ensure that we regularly review our processes so as to learn when things don't go well and apply that learning to improve the services we provide to the people we serve, their families and carers.

While many deaths do not require detailed investigation, we have a duty to our patients and their families to make sure that any decision not to investigate a death is properly considered and recorded.

It is vitally important that we record deaths accurately and maintain good records.

This approach also means:

- Relevant deaths are recorded using a simple electronic form on our incident recording system; making the process of reporting and investigating deaths more streamlined
- Every case is initially reviewed within 48 hours so we can ensure that the case either proceeds to full investigation or with deaths that do not require an investigation, we will be able to demonstrate to the family why that decision was made.
- It makes it easier for staff to pick up on themes and trends that might otherwise go unnoticed.
- The information that we hold about our patients and the circumstances of their death can help inform regional and national initiatives such as Suicide Prevention Strategies.

The processes for reporting and investigating deaths enable us to ensure we take every opportunity to learn from patient deaths. This learning is shared across the Trust through learning events and publications such as 'Hotspots' and 'Learning Matters'.

Our Criteria for the Reporting of Deaths

Due to the variation of services which the Trust provides, criteria has been written to support which deaths are reported onto the Ulysses Risk management System. These are;

For All Services

- All deaths of patients where any concern is raised about the care provided by the Trust to staff prior to a patient's death, by family or others. This must always be reported regardless of how long the patient may have been discharged.

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- Patients / service users who die detained under a Section of the Mental Health Act.

Adult Mental Health & Specialised Services

- All deaths of patients with an open/active referral including palliative care patients
- All suicides or suspected suicides that occur within 12 months of last contact (regardless of whether on open referral or discharged) Patients who die following transfer to an acute/general hospital from a Trust inpatient unit (including those who are under a Section of the Mental Health Act)
- Patients who die following transfer to an acute/general hospital from a Trust inpatient unit (including those who are under a Section of the Mental Health Act.)

Learning Disabilities

- All deaths of patients within 12 months of last contact (regardless of whether an open referral or discharged) and including palliative care patients

Older Person's Mental Health, Physical Health, and Children's (Inpatient)

- All deaths of in-patients, including;
- Palliative care patients
- Patients who die following transfer to an acute/general hospital from a Trust inpatient unit (including those who are under a Section of the Mental Health Act)
- Child deaths may also be subject to a Rapid Response Process through Safeguarding.

Older Person's Mental Health, Physical Health, and Children's (Community)

- The patient had been discharged home from a Southern Health inpatient unit in the preceding 30 days
- The patient was known to have an open referral to adult or children's safeguarding
- Where the death has been reported to the Coroner, or concerns have been raised by any individual or organisation as to the circumstances surrounding the death
- If any acts, omissions or concerns in care provided by Southern Health services have been identified
- All suicides or suspected suicides that occur within 12 months of last contact (regardless of whether on open referral or discharged)

Older Person's Mental Health Liaison Service Services

- OPMH – All deaths by suicide/related to self-harm should be reported.
- Patients who die following transfer to an acute/general hospital from the Trust service under an active Mental Health Act Section.

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Psychological Medicine – Liaison Services

- The patient was known to have an open referral to adult or children's safeguarding
- Where the death has been reported to the Coroner, or concerns have been raised by any individual or organisation as to the circumstances surrounding the death
- If any acts, omissions or concerns in care provided by Trust services have been identified
- All suicides or suspected suicides that occur within 12 months of last contact (regardless of whether on open referral or discharged)

Hampshire and Isle of Wight Multi-Agency Pathways (MAPS) - Pathway and Pathfinder Pathway

- The service users within this service are managed by the National Probation Service, some of whom may be registered with a General Practitioner. The primary focus of this service is to support the professional (Offender Manager's) in working with the service user group (personality disordered offenders posing a high risk of harm to others and a high risk of reoffending) and therefore Southern Health care is only time limited joint work sessions with the Offender Manager and service user. All outcomes are reported on the National Probation Service electronic recording system 'Delius'.
- **Pathfinder** – As above although RiO records are kept and a caseload exists the care coordination (for health referrals) or risk management (for criminal justice referrals) remains the responsibility of another party.
  Only report if:
  - If any acts, omissions or concerns in care provided by Trust services have been identified.
  - Concerns have been raised by any family member
  - The service user was under Trust care coordination / mental health services within the previous 12 months.
  - The service will be involved in any investigation undertaken by the National Probation Service, the general practitioner or mental health service provider (Solent or IOW) as requested.

General Practice (operated by the Trust)

Established processes for reporting and reviewing deaths to NHS England and commissioners are in place. This process includes establishing whether there are any concerns that may need further investigation, where this is the case, this procedure would be instigated.

In addition Trust procedure will be instigated where;

- Any death requiring reporting to the Coroner (includes suicides, industrial deaths, Road Traffic Accidents and other unexplained deaths).
- Any complaints or concerns raised to the GP in relation to a death.

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For 'The Practice' based at Lymington New Forest Hospital:

- The death of any patients seen by The Practice at Lymington New Forest Hospital within the previous 30 days.

Investigators

We have a team of investigating officers trained in Root Cause Analysis methodology who investigate our most significant incidents and those deaths reported as serious incidents. Their role is to conduct a quality investigation to enable the Trust to learn and improve. Families and loved ones are encouraged to participate in the investigation process, assisting in defining the Terms of Reference for the investigation and individualised support is offered by our Family Liaison Officer.

How do we share our findings?

The process is documented in our Policy and Procedure for Reporting and Investigating Deaths which is publically available on our website. Our Learning from Deaths report which includes our data is produced for the Trust Board on a quarterly basis and is also publically available on our website.

Information collection

Following the publication of the Mazars report in December 2015 and as part of the improvement action plan we have invested in the development of our Safeguard Ulysses Risk Management System to become our operational database for mortality reviews and incident investigations. Prior to this date files were kept electronically, however, not within an operational database which made reviewing data and themes and trends for learning challenging.

During 2017/18 742 of Southern Health NHS Foundation Trust patients died and were reported using the criteria within the policy. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Quarter	Number of Deaths	Number of Case reviews or Investigations
Before 2017/18 (reporting started Dec 2015)	1057*	1057 initial Case Reviews which resulted in; • 107 'Red Rated' or Serious Incident Investigations**
Total 2016/17	730	730 initial Case Reviews which resulted in; • 44 'Red Rated' Internal Investigations • 72 Serious Incident Investigations
Q1 2017/18	165	165 initial Case Reviews which resulted in; • 7 'Red Rated' Internal Investigations

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		• 14 Serious Incident Investigations
Q2 2017/18	146	146 initial Case Reviews which resulted in; • 9 'Red Rated' Internal Investigations • 16 Serious Incident Investigations
Q3 2017/18	219	219 initial Case Reviews which resulted in; • 6 'Red Rated' Internal Investigations • 13 Serious Incident Investigations
Q4 2017/18	212	203 initial Case Reviews which resulted in; • 4 'Red Rated' Internal Investigations • 11 Serious Incident Investigations • 9 reviews outstanding as of 31.03.18
Total 2017/18	742	733 initial Case Reviews which resulted in; • 26 'Red Rated' Internal Investigations • 52 Serious Incident Investigations • 9 reviews outstanding as of 31.03.18

*Electronically recorded on the Safeguard Ulysses Risk Management System database since December 2015
**Electronically recorded on the Safeguard Ulysses Risk Management System database since January 2016
Definitions - Red Incidents are those which require a full root cause analysis investigation as per a Serious Incident although do not meet the criteria for external reporting to CCG Commissioners as a Serious Incident under the NHS England 2015: Serious Incident Framework.

By 31st March 2018, 733 case record reviews and 78 investigations have been carried out in relation to 742 of the deaths included above

In 78 cases a death was reviewed by a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Quarter	Number of Case Reviews Completed	Number of Investigations Commissioned
Q1 2017/18	165	21
Q2 2017/18	146	25
Q3 2017/18	219	19
Q4 2017/18	212	15 with 9 case reviews outstanding

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Fifteen, representing 2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient, as shown in the findings of the investigation.

In relation to each quarter, this consisted of:

Quarter	Deaths related to problems in care provided	Percentage of Deaths in the quarter
Before 2017/18	36*	3.4%**
2016/17	20	2.7%
Q1 2017/18	2	1.2%
Q2 2017/18	5	3.0%
Q3 2017/18	7	3.1%
Q4 2017/18	1***	0.47%
Total 2017/18	15***	2.0%

*Electronically recorded on the Safeguard Ulysses Risk Management System database since December 2015
**Electronically recorded on the Safeguard Ulysses Risk Management System database since January 2016
***Ten investigations remain in progress therefore final impact grading not yet applied

These numbers have been estimated using the Structured Judgement Tool or Initial Management Assessment followed by a comprehensive Root Cause Analysis investigation and application of the Actual Impact Grading tool. For the case review of deaths of those service users with a known Learning Disability the LeDeR methodology has been used as part of the Hampshire project.

For the purpose of this report, deaths attributed to problems in the care provided are those with a final impact grading as Catastrophic Harm.

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Actual Impact Grading	
Actual Impact	**Definition**
No Harm	▪ No care or service delivery problems identified. Trust could not have prevented the death. ▪ No root cause (material factors) or contributory factors relating to SHFT care were established.
Low Harm	▪ Some care or service delivery problems identified, but only impact on quality of service, not on patient outcome. Trust could not have prevented the death. ▪ No root cause (material factors), some minor contributory factors relating to SHFT care were established.
Moderate Harm	▪ Contributory factors identified may have had a minor impact on the actual outcome for the person. Trust could not have prevented the death. ▪ No root cause relating to SHFT care was established.
Major Harm	▪ Contributory factors identified that may have an impact on the outcome for the patient. Not clear, although possible we could have prevented the death. ▪ Potential for a contributory factor to be possible root cause relating to SHFT care provided.
Catastrophic Harm	▪ Material care or service delivery gaps established. ▪ Preventable death. ▪ Root cause directly linked to SHFT care provided.

Learning from the case record reviews has highlighted several areas for improvement;

- Communication between providers incorporating collaborative working to ensure patient safety need to be improved. This work must include the sharing of known risk information in the absence of a shared electronic patient system.
- Documentation of the assessment of risk with an emphasis on timely updates being made when the level of risk changes.
- Adherence to policy and the documentation of decision making by the multi-disciplinary team when a policy is not followed. This is apparent in respect of dual diagnosis services users and although improvements have been made, for example, joint clinics held between Trust and Inclusion substance misuse services, more improvement work is required to support this group of service users who may have chaotic lifestyles.
- Involvement of carers and families in the creation of care and 'My safety' plans and ensuring that their views and concerns are heard.

Although not directly related to the deaths the Trust may have prevented, there is a theme for learning emerging from the Q3 and Q4 reports which is a system-wide issue related to the uncontrolled online purchase of medications including strong pain killers which is occurring in the community. The Trust continues to work with Hampshire Constabulary in order to put steps in place to reduce the likelihood of these occurrences. A Learning Network is due to commence in May 2018 which will

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involve rich discussion with the police and other interested parties in order to address the issue of online purchases of medication.

Further work with the Police is also in place. The Trust has a singular contact within Hampshire Constabulary in order to work collaboratively in aiming to keep people who are at risk of completing suicide safe. This work, is ongoing.

The improvement work being undertaken into all of these areas continues with;

- The launch of the redesign of the risk assessment module in the patient electronic record to make the creation and updating of assessment easier for staff.
- Business intelligence monitoring through the Tableau informatics system of compliance to updating risk assessments.
- Establishment of quality review audits of randomly selected completed risk assessments to provide assurance that they meet service users' needs.
- Ongoing work with drug and alcohol service to improve communication and create working together approach. A thematic review of these issues has been commissioned by the Serious Incident and Mortality Forum.
- Improvement in communication, for patient safety, with other providers especially those providing out of area beds.

Relaunch of the Triangle of Care as a Quality Priority for 2018/19 to improve the involvement of carers and families in the safety plan of their loved ones to ensure that their views and feelings are heard.

An assessment of the impact of the actions described in above, which were taken by the Provider during the reporting period is standardly reported to the Serious Incident and Mortality Forum. The assessment of impact is made by monitoring the contributory factors and care and service delivery problems which are highlighted in the investigations. As the improvement work begins to have impact the amount of times these factors reoccur is reduced.

Seven case record reviews and 15 investigations completed after 2016/17 which related to deaths which took place before the start of the reporting period.

Twenty, representing 2.7% of the deaths which were investigated in 2016/17, before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the impact grade of catastrophic applied to the investigation at the panel held at the conclusion of the investigation.

Fifteen, representing 2.0% of the deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient. This

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number has been estimated using the impact grade of catastrophic applied to the investigation at the panel held at the conclusion of the investigation.

Section 2e. 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 Foundation Trust by NHS Digital.

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

PricewaterhouseCooper (PwC) have considered two mandated indicators Ⓐ against NHS Improvement's requirement. Their opinion is detailed in Annex 3 and complete definitions of these indicators are included within Annex 4.

- Early Intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral. Ⓐ
- Inappropriate out-of-area placements for Adult Mental Health services Ⓐ

2.1 Early Invention in Psychosis (EIP) Ⓐ

People experiencing a suspected first episode of psychosis treated with a NICE approved care package within two weeks of referral

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 reported indicator for people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral is calculated on all patients who are referred as per the guidance given by NHS Improvement and accepted onto the caseload. The indicator looks at patients accessing or waiting for treatment at the two weeks from referral point. The completeness of the data is reliant on the responsible team entering the data, which is then routinely checked and audited by the performance information managers within the Trust. Therefore to the best of our knowledge the data is complete.

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 (internally and externally with Commissioners)

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Indicator	Early Intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral. Ⓐ				
	Apr 2016 - Mar 17	Q1 2017-18	Q2 2017-18	Q3 2017 - 18	Apr 2017 - Mar 18
Southern Health	85.4%	85.3%	92.7%	86.0%	To be updated
Average Scoring Trust	74.5%	76.2%	75.6%	74.3%	not available
Highest Scoring Trust	not available	100.0%	100.0%	100.0%	not available
Lowest Scoring Trust	not available	28.6%	0.0%	0.0%	not available

2.2 Inappropriate out-of-area placements for adult mental health services Ⓐ

Inappropriate out-of-area placements for adult mental health services is a new indicator for 2017/18.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from Trust records with verification by our external auditors.

The reported indicator for inappropriate out-of-area placements for Adult Mental Health services is calculated as per the NHS England definition of out of area. All out of area admissions are considered to be inappropriate - if the Trust had capacity to admit to a bed within its footprint it would have done so. Any specialist needs that are not provided by the Trust are managed through a separate process and are not counted in this figure (and would in the main be considered an appropriate placement). Occasionally, when there has been a ward closure for planned refurbishment work or for safety concerns, the out of area placements will be considered as appropriate (as are direct re-provision for commissioned capacity) and will be excluded from this total. The Trust currently carries all the financial risk associated with out of area placements and is working with commissioners to review this.

The completeness of the data is excellent as there is a dedicated acute care support team who are responsible for bed finding as well as ensuring payments for the placements are accurate. The data is monitored daily.

The Southern Health NHS Foundation Trust has taken the following actions to reduce the number of patients placed out of area by:

- Daily review of the “Out of area MH acute bed” flash report
- Daily patient flow meetings in all inpatient units

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- Escalation process to ensure discharge goals are built into care planning, and capacity is maximised

Indicator	Inappropriate out-of-area placements for adult mental health services Ⓐ				
	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	Apr 2017 - Mar 18
Monthly occupied bed days out of area	802 / 932 / 722	620/ 493 / 671	662 / 693 / 1010	994 / 669 / 893	-
Quarterly (Average number per month)	819	595	788	852	763

2.3 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 reported indicator for Care Programme Approach 7 day follow up is calculated on all patients who are discharged from an inpatient unit as per the guidance given by NHS Improvement. There are three potential outcomes (exempt, compliant or breach) which are calculated automatically based on the data entry processes being followed. The Trust records patients discharged to non-NHS PICU settings as exemptions. The data is entered by the respective inpatient unit (for those external to the Trust this would be by the respective Community Mental Health Team). This data is then routinely checked and audited by the performance information managers within the Trust. Therefore to the best of our knowledge the data is complete.

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'. Supporting Clinicians to navigate the correct Standard Operating Procedures to ensure the recording is done accurately.
- Monitoring the target at monthly performance meetings, both internally and externally with Commissioners and Regulators

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- The Trust exceeds the 95% target for this metric and is in-line with other Trusts.

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.				
	Apr 2016 - Mar 17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Apr 2017 - Mar 18
Southern Health	97.3%	97.5%	96.0%	96.7%	97.2%
Average Scoring Trust	96.6%	97.2%	96.7%	96.7%	not available
Highest Scoring Trust	99.4%	100%	100%	100%	not available
Lowest Scoring Trust	59.5%	92%	91.6%	73.3%	not available

2.4 Crisis resolution teams acting as gatekeeper to admission

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 reported indicator for Gatekeeping is calculated looking at all patients who are admitted into an inpatient unit as per the guidance given by NHS Improvement. There are three potential outcomes (exempt, compliant or breach) which are calculated automatically based on the data entry processes being followed. The completeness of the data is reliant on the responsible team entering the data, which is then routinely checked and audited by the performance information managers within the Trust. Therefore to the best of our knowledge the data is complete.

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’. Supporting clinicians to navigate the correct Standard Operating Procedures to ensure the recording is done accurately.

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- Monitoring the target at monthly performance meetings, both internally and externally with commissioners and regulators
- The Trust exceeds the 95% target for this metric and is in-line with other Trusts.

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				
	Apr 2016 - Mar 17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Apr 2017 - Mar 18
Southern Health	99.7%	99.6%	99.2%	99.1%	99.5%
Average Scoring Trust	98.5%	99.6%	99.2%	99.3%	not available
Highest Scoring Trust	100.0%	100%	100%	100%	not available
Lowest Scoring Trust	64.7%	88.9%	94.0%	89.8%	not available

2.5 Admissions to adult facilities of patients under 16 years old

This is a new indicator for 2017/18. The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons;

- All potential admission of patients less than 16 years old are escalated to the Duty Manager. This is supported by a formal reporting process.
- Those detained under the Mental Health Act section 136 are not in scope of the indicator as they are in a place of safety and not detained on an inpatient ward.

The completeness of the data is reliant on the responsible team entering the data, which is then routinely checked and audited by the performance information managers within the Trust. Therefore to the best of our knowledge the data is complete.

The Trust has an escalation process to Duty Managers and Commissioners within 24 hours should a young person be admitted to an Adult Mental Health facility. There have been no occurrences in the last year

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Indicator	Admissions to adult facilities of patients under 16 years old. No benchmarking data available				
	Apr 2016 - Mar 17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Apr 2017 - Mar 18
Southern Health	0%	0%	0%	0%	0%

2.6 Our readmission rate for children and adults

This indicator looks at the percentage of patients aged –
(i) 0 to 15; and
(ii) 16 or over
Re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from internal datasets within the Trust.

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 Trust Board.
- Review of learning at monthly management meeting on medically failed discharges (ISD)
- Involvement of Community teams to support the service users pre and post discharge, enabling a successful transition into the community for Adult Forensic patients.

Indicator	The percentage of patients aged 0 -15 years readmitted to a hospital which forms part of the Foundation Trust with 28 days of being discharged from a hospital which forms part of the Foundation Trust during the reporting period. No benchmarking data is available.		
	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017	Apr 2017 - Mar 2018
Southern Health*	0%	1.9%	0%

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Indicator	The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Foundation Trust with 28 days of being discharged from a hospital which forms part of the Foundation Trust during the reporting period. No benchmarking data is available.		
	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017	Apr 2017 - Mar 2018
Southern Health*	12%	17.5%	9.6%

* Annual comparison not applicable due to change in Services in 2017/18. Lymington New Forest Hospital elective surgery data is now reported via University Hospital Southampton (UHS).

2.7 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 Foundation 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 percentage, and so the quality of its services, by:

- Develop a single My Crisis & Safety Plan, and clear guidance to staff on its use, involving service users and families in it
- Involving service users and families, from individual care to service design
- Redesign crisis care in partnership with service users and families
- Medication information forms given to patients when a new medicine is prescribed (Older Person's Mental Health services)

Indicator	Patient experience of contact with a health or social worker*			
	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018
Southern Health	6.8	6.7	7.1	7.2
Average Trust score	Not available			
Highest Scoring Trust	7.5	7.4	7.5	7.5
Lowest Scoring Trust	6.5	6.2	6.1	5.9

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*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’

2.8 Our rate of patient safety incident reporting

This reporting requirement is the number and, where available, rate of patient safety incidents reported within the Foundation Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Indicator	Number of patient safety incidents reported to the National Reporting and Learning Service (NRLS)*			
	16/17 Total – 11850*		17/18 total – 8665*	
	Apr 16 – Sept 16	Oct 16 – Mar 17	Apr 17 – Sept 17	Oct 17 – Mar 18
Southern Health*	5901	5949	5283	3382
Average Trust Score**	2963	2910	3160	Not available
Highest Scoring Trust**	6349	6447	7384	Not available
Lowest Scoring Trust**	40	68	12	Not available

*results from internal incident reporting system
**results taken from NRLS

Indicator	i) Number and ii) percentage of such patient safety incidents that resulted in severe harm or death			
	16/17 Total – 140 (1.1%)		17/18 Total – 81 (0.9%)	
	Apr 2016 – Sept 2016	Oct 2016 – Mar 2017	Apr 2017 – Sept 2017	Oct 2017 – Mar 2018
Southern Health*	i) 39 ii) 0.7%	i) 42 ii) 0.7%	i) 34 ii) 0.6%	i) 47 ii) 1.4%
Average Trust Score**	33 / 1.5%	33 / 1.3%	33 / 1.2%	N/A
Highest Scoring Trust**	101 / 3.2%	107 / 2.2%	172 / 3.1%	N/A
Lowest Scoring Trust**	10/1.4$	2 / 0.1%	1 / 0.0%	N/A

*results from internal incident reporting system
**results taken from NRLS

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 and our internal incident reporting system.

The 2017/18 totals are also based on data extracted from the Trust's incident reporting system; Ulysses. These include all Patient Safety Incidents of severe harm or death submitted to NRLS (now NHS Improvement) during the specified time periods.

The numbers of patient safety incidents has shown a downward trend across the year, with the occasional spike in part due to individual patient acuity. Within Adult Mental Health Services the reduction in self-harm and injurious behaviour incidents is seen as improved patient-staff relationships with a positive change in their wellbeing. Within the Community teams there has been a reduction in treatment of care related issues in Petersfield Minor Injuries Unit. While Older Person's Mental Health has seen a reduction in the number of slips, trips, falls and accidents category.

This reduction of incident reporting in the latter half of 2017/18 and increased number of incidents that resulted in severe harm or death has resulted in the percentage for serious harm to increase to the average Trust level in 2016/17 of 1.4%. This is monitored by the Serous Incident and Mortality Forum on a monthly basis.

The Southern Health NHS Foundation Trust is continuing to take the following actions to ensure accuracy of this indicator, and so the quality of its services, by:

- Quality monitoring of the incident reports submitted by the central incident management team
- Increasing incident reporting education through the Quality Governance Business Partners.
- Increasing the ease of use of the Ulysses Incident system through continued development with liaison and feedback of users throughout the Trust. This encourages the timely and accurate reporting of incidents.

2.9 The percentage of staff who would recommend the Foundation 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.

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Indicator	The percentage of staff employed by, or under contract to, the Foundation Trust during the reporting period who would recommend the Foundation Trust as a provider of care to their family of friends		
	April 2015 - March 2016	April 2016 - March 2017	April 2017 - March 2018
Southern Health	66%	67%	67%(Q1-4)
Average Trust Score	78%	79%	71%(Q1-3)
Highest Scoring Trust	100%	98%	100%(Q1-3)
Lowest Scoring Trust	45%	44%	49% (Q1-2)

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from the NHS staff survey.

The Southern Health NHS Foundation Trust is continuing to take the following actions to improve this indicator, and so the quality of it's services, by:

- Making staff aware of the survey to increase the return rate
- Developing a culture of "collective responsibility" to ensure services achieve great outcomes for patients
- Trust staff will support the integration of services within the wider health and social care economy in order to improve the quality, efficiency and effectiveness of our services, therefore resulting in better outcomes for our patients.
- Improving the quality, efficiency and effectiveness of our services through Quality Improvement methodologies.
- Utilising the opportunities afforded through digital technologies.

2.10 The percentage of patients who would recommend the Foundation 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.

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Indicator	The percentage of patients during the reporting period who would recommend the Foundation Trust as a provider of care to their family of friends		
	April 2015 - March 2016	April 2016 - March 2017	April 2017 - March 2018
Southern Health	94.3%	93.9%	97.2%
Average Trust Score	94.5%	93.3%	93.1% (Q1-Q3)
Highest Scoring Trust	98.8%	98.3%	97.8% (Q1-Q3)
Lowest Scoring Trust	86.6%	67.5%	73.4% (Q1-Q3)

The figures for the percentage of patients who would recommend the Foundation Trust as a provider of care are calculated by combining the published results for the Foundation Trust's community and mental health services. Comparison figures include other Trusts where they have both community and mental health services.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons: this is taken published data on the NHS England website.

The Southern Health NHS Foundation Trust is continuing to take the following actions to ensure accuracy of this indicator, and so the quality of its services, by

- Reviewed the wording of non-mandated questions to ensure survey appropriate to the service, and offering the survey to all patients and services users.
- Establishing a Patient Experience, Engagement and Caring Group to review all aspects of patient experience and engagement, and provide assurance to the Trust Board
- Increasing the ways in which patients/ service users and families have a voice in service delivery and improvement
- New Head of Patient and Public Engagement appointed in March 2018.

2.11 Cardio-metabolic assessment and treatment for people with psychosis

This is a new indicator for 2017/18 and linked to the CQUIN on assessment and recording of service user Cardio-metabolic parameters. The indicator on Cardio-metabolic assessment and treatment for people with psychosis is broken down into three sections:

a) Inpatient wards
b) Early intervention in psychosis services (EIP)
c) Community mental health services (people on care programme approach)

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The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from our external and internal audits completed as part of the CQUIN programme in 2017/18. The cardio-metabolic parameters based on the Lester Tool are: smoking status, lifestyle, body mass index, blood pressure, glucose regulation and blood lipids. Intervention is required if service users fall in the red zone of the Lester Tool. Part b) the EIP audit is based on initial results from the Royal College of Psychiatrists (RCP) and this requires confirmation of the final results.

The completeness of the data is reliant on the responsible team entering the data into the correct forms on RiO (electronic patient record system). Local areas use the newly built Tableau report to monitor their performance, which are reviewed within the AMH performance meetings. Therefore to the best of our knowledge the data is complete.

The Southern Health NHS Foundation Trust is continuing to take the following actions to ensure accuracy of this indicator, and so the improve 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
- Review of all physical health forms on RiO to streamline patient record keeping.

This will facilitate continued developments in physical health monitoring and interventions for the holistic well-being of service users with psychosis.

Indicator	Cardio-metabolic assessment and treatment for people with psychosis - a) Inpatient wards
	Q3 2017/18 audit
Southern Health	94%

Indicator	Cardio-metabolic assessment and treatment for people with psychosis - b) Early intervention in psychosis services
	Q3 2017/18 audit
Southern Health	78%*

*Initial results – waiting confirmation from RCP.

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Indicator	Cardio-metabolic assessment and treatment for people with psychosis - c) Community mental health services (people on care programme approach)
	Q3 2017/18 audit
Southern Health	92%

2.12 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.

Indicator	Proportion of people completing treatment who move to recovery (from IAPT dataset)				
	Apr 16 - Mar17	Q1 17-18	Q2 17-18	Q3 17-18	Apr 17 - Mar 18
Southern Health	51.5%	51.0%	51.8%	53.9%	52.4%
Average Scoring Trust	49.9%	51.4%	51.2%	50.8%	not available
Highest Scoring Trust	86.0%	89.0%	100.0%	100.0%	not available
Lowest Scoring Trust	15.0%	23.0%	24.0%	7.0%	not available

The Southern Health NHS Foundation Trust is continuing to take the following actions to ensure accuracy of this indicator, 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

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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				
	Apr 16 - Mar17	Q1 17-18	Q2 17-18	Q3 17-18	Apr 17 - Mar 18
Southern Health	87.2%	88.9%	92.1%	92.8%	91.9%
Average Scoring Trust	86.3%	88.2%	87.9%	87.7%	not available
Highest Scoring Trust	100.0%	100.0%	100.0%	100.0%	not available
Lowest Scoring Trust	15.0%	19.0%	19.0%	4.0%	not available

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				
	Apr 16 - Mar17	Q1 17-18	Q2 17-18	Q3 17-18	Apr 17 - Mar 18
Southern Health	99.9%	99.9%	99.9%	99.6%	99.8%
Average Scoring Trust	97.9%	98.8%	98.2%	98.2%	not available
Highest Scoring Trust	100.0%	100.0%	100.0%	100.0%	not available
Lowest Scoring Trust	33.0%	55.0%	41.0%	23.0%	not available

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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 Foundation Trust.

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 service 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.

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

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and ensuring the quality priorities are met. Underpinning this Committee are three clinically led groups covering three of CQC's key lines of enquiry – Patient Safety Group (SAFE), Clinical Effectiveness Group (EFFECTIVE), Patient Experience, Engagement and Caring Group (CARING).

To help keep us on track and to drive quality improvements on the front line we have begun to appoint Quality Ambassadors in every team. These are 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.

The Trust is committed to further developing QI methodology across the organisation and has been working with partners from Northumberland, Tyne and Wear NHS Foundation Trust to establish this programme of work. The Trust will therefore be refreshing the Quality Improvement Strategy for 2018/19 to reflect this.

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, the Trust 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.

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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 has been a key focus for the Trust over the last year and the Patient Engagement, Involvement and Partnership Strategy has been 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.

In October 2017 the Trust successfully held its annual Quality Conference. The aim of the conference was to raise the profile of patient safety by sharing experiences and learning. The day focussed on three themes: Patient Safety Culture & Learning, Being Open (with patients and families), and Safety in the System.

A number of external organisations took part and gave interesting presentations on subjects as diverse as; Implementing a Safety Culture, What makes an 'Outstanding' service, Human Factors in investigations, Involving families and carers in investigations and Multi-agency investigations. They included National Air Traffic Services, the CQC, Healthcare Safety Investigation Branch, NHS England and Niche Health and Social Care Consulting. Delegates were also shown poignant videos made by two family members of service users, of their experiences with the Trust.

The conference also included a number of breakout sessions with internal speakers which delegates could choose from, to make learning specific to their experience. The subjects presented included Early Intervention in Psychosis, Sepsis care, Improving the service user Journey, Risk Management in Mental Health, Safety in Forensic Services, Psychiatric Liaison into Acute Trusts, Improvements in Epilepsy Care, Learning from a Serious Case Review and Older People with Frailty.

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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. The Trust has been informed by the Care Quality Commission that they plan to carry out a full comprehensive inspection in 2018. The Trust received the request to complete the CQC's Provider Information Request (PIR) on 6 March 2018 and this was submitted on 27 March 2018. Although still to be confirmed by the Care Quality Commission, the Trust is expecting all core services to be inspected during May/June 2018 and for there to be a Well-led review in July/August 2018, after which the Trust will be re-rated.

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.

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.

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- This includes an e-learning training package for staff on the requirements of Being Open and Duty of Candour;
- 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 3 times throughout 2017-18 and trained a further 71 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 role of the Family Liaison Officer is now established within the Trust and therefore a recent review has taken place to assess the impact of the role and the development opportunities for the future.

From commencement of the post on 5 December 2016 to 31 March 2018 there have been 152 referrals and of these:

- 52 families benefitted from additional support which has now ended (though families may choose to make contact in the future if they want assistance to access support from other agencies).
- 20 families are currently receiving support on a regular basis
- 19 families were contacted by the FLO to provide information, options for external support and contact details on a one-off basis
- 10 referrals are currently under review pending contact from family
- 51 families have not requested FLO support.

The FLO co-presents the 'Sharing Information' training and presents the 'Duty of Candour' training as part of the Investigating Officers training schedule. She is also

a member of the Trust's 'Patient Experience, Engagement and Caring Group', the 'Family Experience and Engagement Group', and the 'Families First Group'.

In supporting families through a Serious Incident Investigation or Complaint process, the FLO has been able to encourage a number of family members to provide their input and insight into various aspects of the Trust improvement work. This work has included: reviewing and commenting on 'Sharing information' literature; participating in videos to provide the family perspective for clinicians; reviewing 'Carer's Information' and attendance at meetings to focus on specific clinical issues affecting service users.

The FLO endeavours to raise any additional issues which families may mention during conversations, such as; the lack of signage at Royal Hampshire County Hospital for Melbury Lodge for people using public transport (which has subsequently been addressed); access to information leaflets in reception areas for families and feedback on what would be helpful (this is being taken forward through the Families First Group in considering Carer's Pack information).

She also continues to be an active member of the Hampshire Suicide Prevention Group and the Southampton Suicide Prevention Group and is utilising this network to encourage voluntary support agencies to work together to address the need for more access to support in various parts of Hampshire.

Sign up to Safety Campaign

Southern Health continues to participate in the national Sign up to Safety campaign, which is drawing to the end the initial 3 year phase. We are pleased to report the successful end to this year of the programme. The philosophy of the campaign is **locally led, self-directed safety improvement.** Whilst at present we await a final steer from the National Campaign as to their proposals for continuation of this programme, the intention will be to develop new priorities moving forward.

We have achieved:

- Duty of Candour e-learning training has been developed and rolled out across the Trust.
- All patients and families are now offered the opportunity to participate in developing terms of reference for Serious Incidents.
- External audit of the Serious Incident and Mortality action plan found improvements completed and embedded with the impact being seen within the Trust in relation to processes to identify, investigate and learn from Serious Incidents.
- 'You said, we did' posters are now displayed in inpatient sites and on our website, and also feature within the Annual Complaints report.

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- Information on all risks/Serious Incidents and complaints are now showing on Tableau (business reporting system) so that staff can drill down information to team level, and interrogate the data as required.

Staff Survey

The NHS staff survey is one way that the Foundation Trust can hear directly from staff about their experience at work. We activity encourage all staff to participate.

The most recent indicators for KF26 and KF21 are:

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%↔

These results remain broadly the same as in 2016/17. To address the issues raised by staff, we have:

- Organised a Health and Well-being event entitled "Tackling bullying and harassment from any source".
- Developed a network Health and Well-being champions.
- Promoted the role of the Freedom to Speak Up Guardian and the Speak Up Service.

Based on the most recent results, we will be developing local action plans where there are issues of particular concern, for example, where people report they are subject to bullying and harassment as a result of their ethnicity or gender.

Freedom to Speak Up

A dedicated Freedom to Speak Up Guardian was appointed in 2016/17 following the recommendation of Sir Robert Francis, following his review and subsequent report into the failings in Mid-Staffordshire NHS Foundation Trust.

The Guardian has been in post over a year, during this time she has had 74 contacts from every directorate and all staff groups covering a vast array of subjects throughout the year. She continues to travel about the Trust speaking with staff and teams to provide independent and confidential support to staff who want to raise concerns. As a result of concerns raised this year there have been:

- Changes made to policies,
- Workshops conducted on Speaking Up, Bullying and Harassment programs
- Input provided into the newly designed Managers' Induction programme.

Freedom to Speak Up Champions have been recruited from a diversity of staff and directorates to assist in spreading confidence to raise concerns. The Guardian remains the primary contact to collate and respond on concerns raised.

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Annex 1: Statements from commissioners, local Healthwatch organisations and Oversight 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
- Clinical Commissioning Group - Fareham & Gosport
- Clinical Commissioning Group - Southampton City
- Healthwatch organisations – Hampshire, Southampton, Portsmouth.
- Governors
- Overview and Scrutiny Committees – Hampshire, Southampton, Portsmouth,

Feedback that has been received is included in this annex.

The feedback from all stakeholders has been taken into consideration and changes have been made from the earlier version of this document which was supplied for review. We now hope that the reader will be able to clearly understand which of the priorities for 2017/18 have been achieved and the level of that achievement.

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West Hampshire Clinical Commissioning Group statement

Representing West Hampshire, South Eastern Hampshire, North Hampshire, Fareham and Gosport Clinical Commissioning Groups

LETTER TO ADD (Previously dated 19 May17 – Heather Hauschild)

Southampton City Clinical Commissioning Group

LETTER TO ADD – previously dated 2nd May from John Richards

Southern Health NHS Foundation Trust – Governors

Letter from Council of Governors,→ the Patient Experience & Engagement Group (PEEG) considered the draft Quality Report and Account 17/18.

Healthwatch

LETTER TO ADD

Health Overview and Scrutiny Committee

LETTER TO ADD

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 2017/18 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 2017 to March 2018

    Papers relating to Quality reported to the Board over the period April 2017 to March 2018

    feedback from commissioners dated 2 May 2017 (Southampton City) and 19 May 2017 (**West Hampshire Clinical Commissioning Group** Representing West Hampshire, South Eastern Hampshire, North Hampshire, Fareham and Gosport Clinical Commissioning Groups)

    feedback from the governors dated 16 May 2017

    feedback from local Healthwatch organisations dated 15 May 2017

    feedback from Overview and Scrutiny Committee dated 19 May 2017

    the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2017

    The latest national patient survey 2017

    The latest national staff survey 2017 – NHS England Friends and Families Test

    The Head of Internal Audit's Annual Opinion over the Trust's control environment dated May 2017. Lorna Raynes in RSM Tenon –

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assurance on the wider internal audit program
lorna.raynes@rsmuk.com

CQC inspection reports received between April 2017 and March 2018

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

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Annex 3: External auditor's limited assurance report

Independent Auditors' Limited Assurance Report to the Council of Governors of Southern Health NHS Foundation Trust on the Annual Quality Report

Annex 4: Data definitions

PwC tested the following indicators

Early Intervention in Psychosis (EIP)
People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral

Detailed descriptor:

The reported indicator for People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral is calculated on all patients who are referred as per the guidance given by NHS Improvement and accepted onto the caseload.

Data definition

Numerator

xx.

Denominator

xx.

Details of the indicator

xx

Exemptions x

Accountability

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.

Inappropriate out-of-area placements for Adult Mental Health services
Detailed descriptor

xx.

Data definition

Numerator

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xx.

Denominator

xx.

Details of the indicator

xx

Exemptions x

Accountability

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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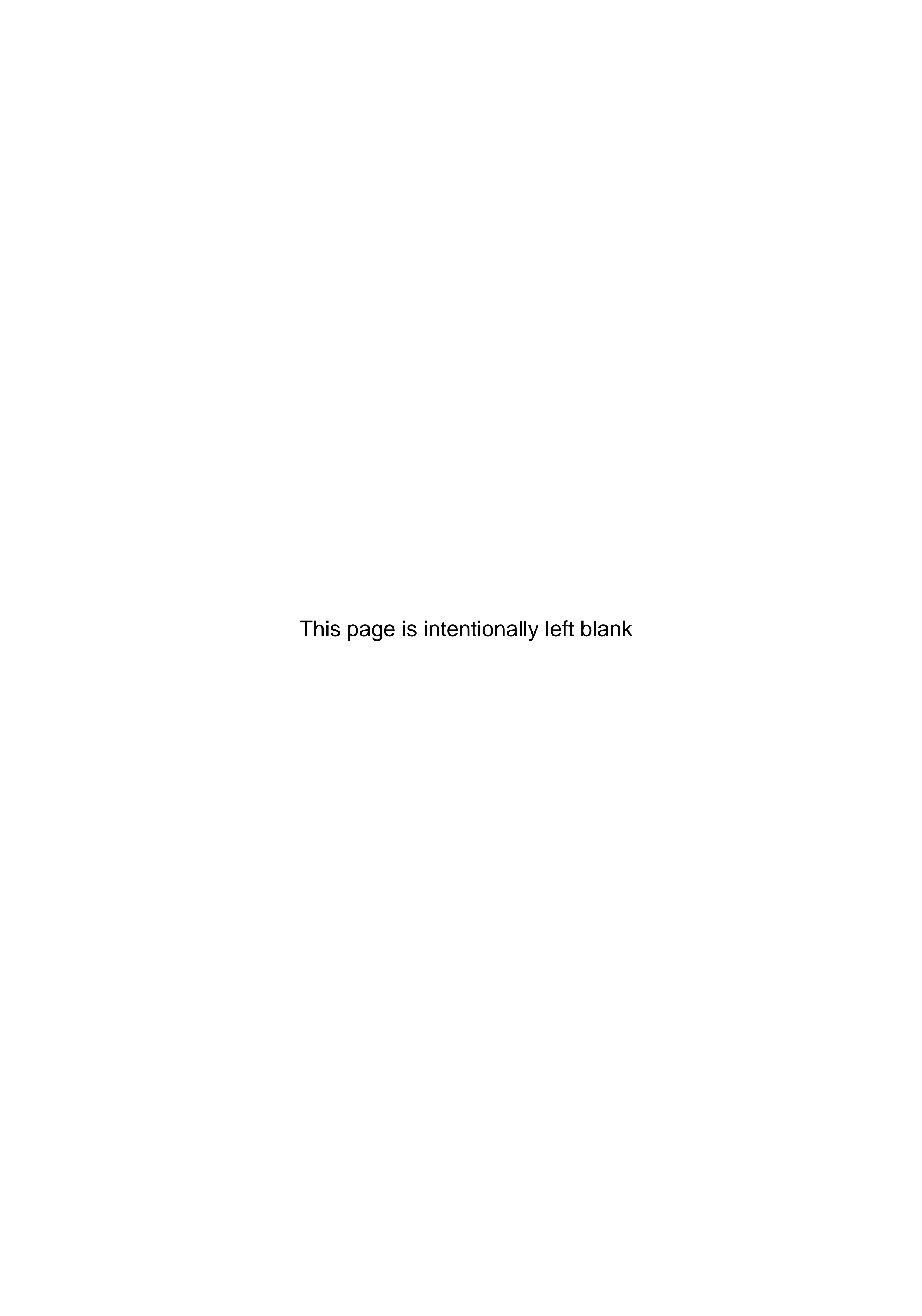
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Chief executive's welcome- pending

David French, Acting chief executive

Our approach to quality assurance

Our approach to quality

Always improving is a key value 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 the Trust Board. Derek Sandeman (medical director) and Gail Byrne (director of nursing and organisational development) are the lead executive directors for quality, while Jane Hayward (director of transformation) is responsible for quality improvement.

Quality improvement is just one element of a coordinated and Trust-wide approach to quality. In previous years these priorities have been outlined in our patient improvement framework (PIF) with priorities set against outcomes, safety and experience. This year we have changed our approach to focus on fewer key priorities, but structure these under the Care Quality Commission (CQC) domains of safe, effective, responsive, caring and well-led. This quality improvement framework (QIF) focuses our staff's minds on improving quality, rather than solely quality assurance. The QIF can be found in appendix one.

Our quality improvement framework is underpinned by strategies on safety, experience and engagement, clinical effectiveness and our staff strategy. These set out our longer term vision and 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 and departments are required to demonstrate adherence to standards of care to become accredited. The wards gain this accreditation by submitting information on key quality performance indicators and patient feedback, complaints and compliments to a senior clinical panel. Patient representatives also undertake unannounced visits to the ward or department.

Successes are celebrated and shared across the organisation, and areas for improvement are agreed where necessary.

Clinical quality reviews (CQRs) of nominated services are conducted in each division based on the Care Quality Commission (CQC) inspections and their identified key lines of enquiry. The CQR provides an internal assurance process which is proportionate, risk based, professionally informed and linked to what matters to patients and staff. This information includes 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. The metrics are used throughout the Trust from ward to board.

Our commitment to safety

In a large organisation, such as the NHS, things will sometimes go wrong and this will have an impact on all those involved. We recognise 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 processes 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.

We fully align our safety strategy to NHS England's 'Sign up to Safety' campaign to demonstrate our commitment to put patient safety first, continually learn, be honest and transparent, collaborate and support people to understand why things go wrong and how to put them right.

Duty of candour

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).

We are committed to being open and transparent to patients and their families and 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' outlines the steps that staff should take and our intranet 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 patients and families and keep them updated. Every patient (or their family) are contacted by letter following a moderate or high harm incident and are invited to ask any questions they would like answered as part of the investigation. We will also meet 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.

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. We have a Freedom to Speak Up policy and a Freedom to Speak up Guardian. Our staff survey shows that our staff consider UHS as above average in:

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		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Fairness and effectiveness of procedures for reporting errors, near misses or incidents			
	% agreeing / strongly agreeing with the following statements:			
Q12a	"My organisation treats staff who are involved in an error, near miss or incident fairly"	65	55	65
Q12b	"My organisation encourages us to report errors, near misses or incidents"	91	88	90
Q12c	"When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again"	75	69	75
Q12d	"We are given feedback about changes made in response to reported errors, near misses and incidents"	66	56	64
	Raising concerns about unsafe clinical practice			
Q13a	% saying if they were concerned about unsafe clinical practice they would know how to report it	96	95	96
	% agreeing / strongly agreeing with the following statements:			
Q13b	"I would feel secure raising concerns about unsafe clinical practice"	77	69	76
Q13c	"I am confident that the organisation would address my concern"	68	57	66

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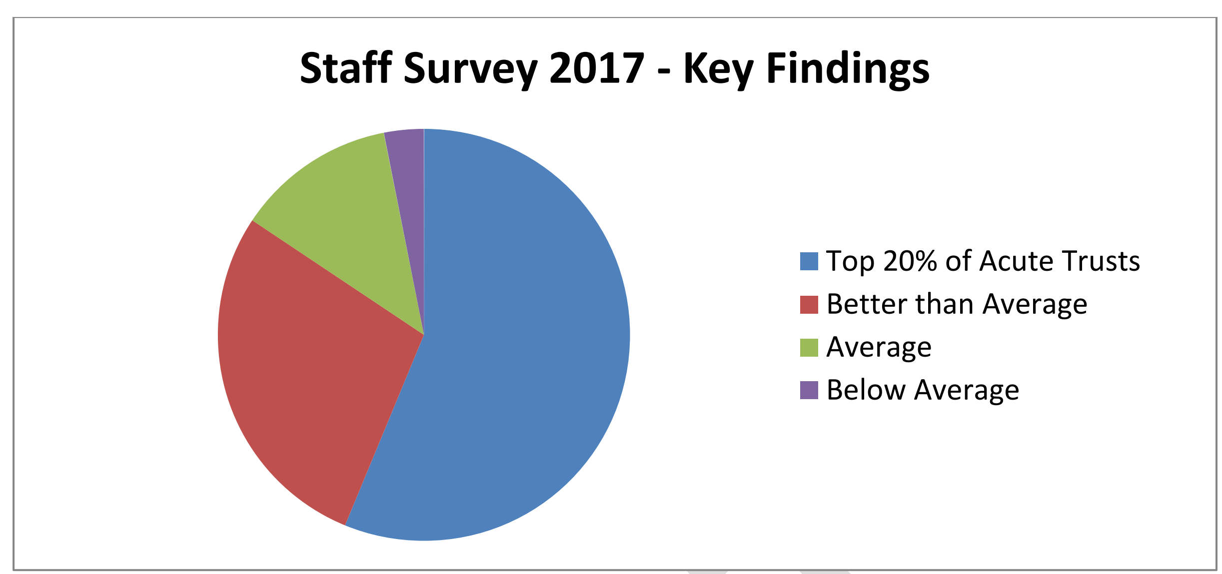
Our commitment to staff

UHS has a growing reputation as a top teaching hospital in the UK and overseas. It attracts candidates locally, nationally and internationally and is also one of the largest employers in Southampton. With over 10,500 staff working in a diverse range of healthcare related fields, we believe the Trust offers an exciting and rewarding place to work. The Trust has also been awarded 'outstanding' by the CQC in the 'well-led' domain, attributed to a strong positive working culture that is well developed throughout the organisation.

To understand how staff feel about working for the Trust, and to continue to make improvements to our services, we use the results of the annual 'NHS Staff Attitude Survey' and 'Friends and Family Test' to consider how we perform against the pledges set out in the NHS constitution and against other similar acute trusts.

Out of the 32 key findings in the 2017 survey, the Trust was in the top 20% of acute trusts for 18 findings, nine were above average, four were average, and one was below average.



Our top five results were:

1. KF31: Staff confidence and security in reporting unsafe clinical practice - 3.83 against a national average for acute trusts of 3.65.

2. KF30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents – 3.87 against a national average for acute trusts of 3.73.

3. KF15: Percentage of staff satisfied with the opportunities for flexible working patterns – 59% against a national average for acute trusts of 51%.

4. KF6: Percentage of staff reporting good communication between senior management and staff – 44% against a national average for acute trusts of 33%.

5. KF1: Staff recommendation of the organisation as a place to work or receive treatment – 4.05 against a national average for acute trusts of 3.75.

The Friends and Family Test asks on a quarterly basis (except for Q3 when the annual survey is conducted) whether a member of staff would recommend the Trust as a place for care or treatment and whether a member of staff would recommend the Trust as a place to work. In the latest results from Q2 of 17/18, the Trust achieved a 93% result for question 1 (against an acute average of 81%), and a 76% result for question 2 (against an acute average of 64%). The Trust continues to improve in both areas as can be seen below:

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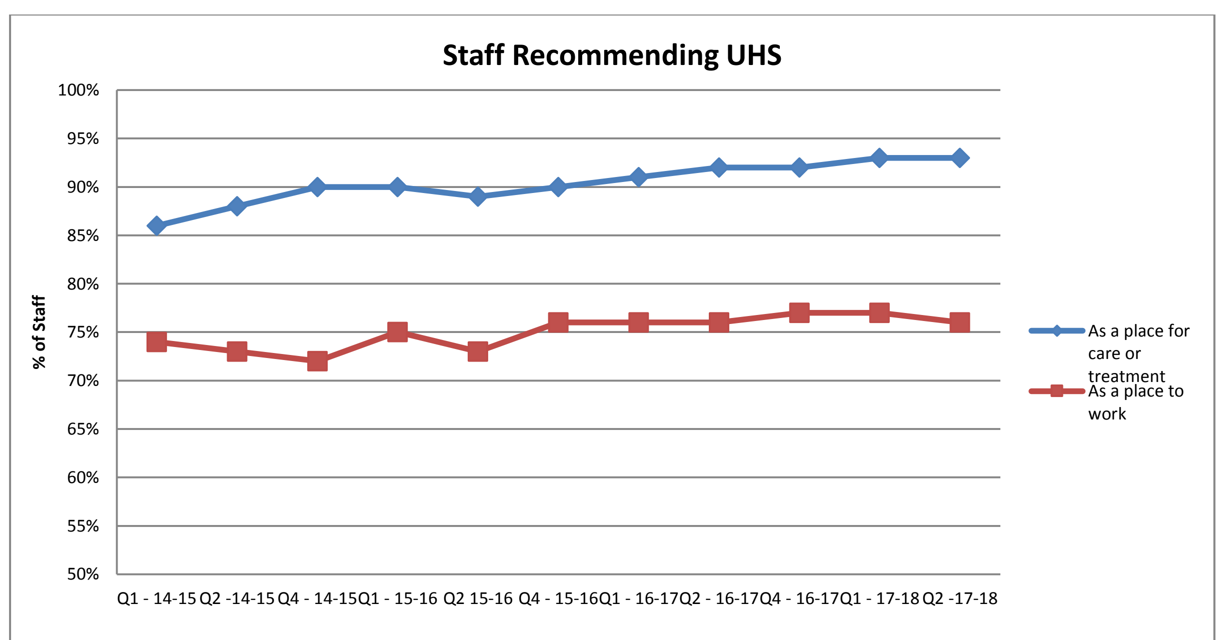

To further improve supporting our staff in 2018/19, we are rolling out a behavioural framework called 'living our values' based on our three core values which are: patients first, working together, and always improving. The framework will also be used in our recruitment, 360 degree appraisal, performance management, and talent management initiatives and link with our leadership and management programmes and succession planning

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 for every care group. We will use the feedback from the survey to support staff to improve the services we deliver and share our findings so that we can learn from our mistakes. This includes working with our Trade Union colleagues and networks to ensure views from all staffing groups are taken into account.

Some positive staff responses from the 2017 survey:

"I retired 5 years ago only for 3 weeks. Absolutely love working here with a great team of people and patients that are admitted"

"Proud and happy being part of this very prestigious organisation especially here in cardiovascular and thoracic. I always feel and treat my colleagues as second family members. Love this department especially the staff which are really working hard to make a difference to our patients' lives"

"I love my job and the team I work with, I am always supported and feel I can report any issues I am concerned about and it will be acted on accordingly"

"I love my job & I love working in ED!"

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Our commitment to education and training

All of the developments outlined in the 2016/17 Quality Account concerning training, development and workforce have continued to be developed and embedded. Three examples of this are:

1. 'Learner reviews' (where learners in UHS meet with education leads to discuss their experience of learning during placements) are now fully embedded and being used to make changes in practice.

2. A number of 'trainer development master-classes' have been held and they are well attended and evaluated by participants.

3. Our in-house 'history taking and physical assessment' programme aimed at advancing practice in non-medical professions has been embedded.

Over the course of 2017/18 improvements have been made in the quality and focus of the e-learning modules available for statutory and mandatory subjects, including offering a greater variety e-learning modules for role specific subjects, which continues to increase the accessibility and ease of completion for staff.

We have successfully delivered our Inclusive Leadership programme; 48 participants (75% BAME) have explored their leadership potential and will now make a significant contribution to increasing the cultural competency and ultimately greater representation of diversity at senior management levels.

UHS continues to provide high quality learning environments and experiences for a range of learners. Following many changes across the education sector in health, UHS is working on a number of projects to support the continuation of quality placements. This includes reviewing models of support and revisiting education programmes delivered to nursing staff and procure nurse degree apprenticeship training with a plan to support up to fifty staff to start the programme in September 2018.

In occupational therapy we are now placing students from the University of Bournemouth, as well as working with Health Education England South to develop the pharmacy pre-registration training provision. Healthcare science has supported the introduction of new training programmes in gastrointestinal physiology and bioinformatics and work continues to scope apprenticeships for level 6 in healthcare science across all specialities. UHS continues to offer high quality placements to doctors in training. Improvements are evidenced in feedback from the national General Medical Council (GMC) survey. A visit by the GMC to the Trust, as part of their quality assurance visit to Health Education Wessex, commended the Trust on "an organisational culture that identified and valued the importance of education and training to the wider organisation".

These activities run alongside the UHS commitment to work with existing and new higher education partners. UHS have designed and delivered a team fellowship programme, both internally and on behalf of Health Education England (HEE) Wessex, which integrates quality improvement and leadership development in enabling participating teams to effect positive change in their service.

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Our commitment to technology to support quality

UHS is committed to using modern technology to help improve the quality of care, safety and patient experience and is recognised as an exemplar site for IT global digital exemplar (GDE)

We are working in partnership with commissioning colleagues to plan and deliver a transformational programme of work using new technology to redesign outpatient services. The programme is overseen by our operational productivity transformation board (system level) and internal working group.

We have already introduced telephone follow-up, nurse led follow-up and patient triggered follow-up in six high volume specialties through the outpatient Commissioning for Quality and Innovation (Op CQUIN) in 2015/17. Two key workstreams are also planned which will incorporate OPdigital (UHS are a national pilot site) and medical pathway review.

OPdigital includes developments in My medical record, a patient online service developed and operated by UHS. The service is been designed to support patients whilst they are away from the hospital and as such is seen as an ideal tool in the management and support of long term condition patients. The patient can access their record and information anywhere, anytime, but the real power of the service is its ability to support the transformation of how clinical services can be provided.

A case study of prostate cancer patients has seen 90% of patients now being managed in this way, with significant time savings for nurses, who can see 20 patients in the same time it takes to see six face-to-face.

In the three years the service has been running over 2500 patients have been registered across five hospital sites and around 15,000 traditional outpatient follow-up appointments have been prevented. Further efficiencies lie in the speed with which cancer nurse specialists can review patients online versus traditional outpatients, freeing up time for more complex cases.

Wider rollout of My medical record for other pathways already include paediatric nephrology , paediatric cardiology , cystic fibrosis, multiple sclerosis , sleep teams (adult and paediatric) and rheumatology.

In 2017/18 we have successfully started the transfer from traditional paper record keeping to an electronic programme known as Electronic Patient Record (ESR).This is a rolling programme with areas going live in a planned manner.

We have also introduced a patient acuity monitoring system which is currently live in 40 ward areas across the Trust. The electronic patient acuity monitoring system (ePAMS) enables nursing and medical staff to record patient observations and some assessments without the need for paper charts. In addition to providing nurses and doctors with accurate and real-time information to review a patient's progress, the system automatically calculates early warning scores to alert staff to patients who may require urgent intervention to prevent their conditions worsening.

Its introduction reduces the need for nursing staff to transcribe patient data onto paper charts and, as a result, lowers the risk of errors occurring. It helps to change the previous practice from one where staff react to a change in a patient's condition, to one where they can identify changes much sooner and therefore pro-actively prevent problems from developing.

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GDE projects which have continued to be successfully developed include the introduction of e-whiteboards. Touch screen technology displays information taken directly from a patient's electronic record, including clinical alerts, such as existing medical conditions, length of admission and estimated date of discharge. It also acts as a tracking system to identify what is preventing discharge when patients are medically fit to leave hospital.

Previously this information was handwritten on boards when patients were admitted or moved. This required staff to take time out to interpret and re-write a patient's notes, and increased the risk of inaccuracies during translation.

Adrian Byrne, the Trust's director of informatics and chair of the Health CIO Network, said:

"This is another important step forward in our drive to enhance the use of digital technology across clinical services. Replacing handwritten notes on whiteboards may not seem revolutionary, but saving the time taken to write up notes repeatedly when patients move and minimising the risk of inaccuracies is a significant development."

It is hoped the electronic whiteboards will be rolled out across all wards by the end of this year.

Further examples of technology led projects to improve how we deliver services are:

- Telephone and patient screening perioperative anaemia clinic
- Alternative minimally invasive surgery (open/laparoscopic to endoscopic) for oesophageal cancer reducing follow-up appointments.
- 24hr nurse led advice and guidance for patients post laparoscopic surgery
- Acute surgical consultant hotline
- Virtual outpatient reviews in ophthalmology
- Remote monitoring for NIV patients avoiding outpatient appointments and home visits

Our commitment to the Care Quality Commission (CQC)

The CQC carried out a follow-up inspection of the Southampton General Hospital site between 25 - 27h January, 2017 with an unannounced inspection on 7th February, 2017. This inspection was to follow up the comprehensive inspection in 2015 which had identified some services that required improvement.

They inspected all key questions in four of the eight core services of surgery, critical care, end of life care and outpatient and diagnostic imaging and noted the Trust had a stable leadership team in place since their last inspection.

The previous inspection in 2015 had found safety of medicine and maternity services, along with responsiveness of urgent and emergency care and children's services 'required improvement'. At the 2017 inspection the following observation was made:

'At this inspection we saw significant improvement across the areas we inspected. There were improvements in surgery, critical care, end of life care and outpatients. Critical care is rated overall

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as 'Outstanding', with surgery, end of life care, and outpatients and diagnostic imaging as 'Good' overall. These services had been rated requires improvement in 2015. The improvements were in line with the trust's improvement plan and had been assisted by the trust board and executive leadership team'

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall rating for this Trust	**Good** ●
Are services at this trust safe?	Requires improvement ●
Are services at this trust effective?	Good ●
Are services at this trust caring?	Outstanding ☆
Are services at this trust responsive?	Requires improvement ●
Are services at this trust well-led?	Outstanding ☆

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The CQC saw areas of outstanding practice including:

- The integrated medical examiners group (IMEG) reviewed all deaths twice each day and approved the death certificate before it was signed, including contact with the coroner if needed. This had proven benefit to an improved accuracy of mortality data, opportunity to reflect upon practice, an improved understanding of correct death certification, consistency amongst reviewing staff, and an overall improvement to patient safety after learning.
- The chief executive officer (CEO) held patient lunches, which both staff and patients consider unique and valuable. The relevant teams then received feedback on any issues raised at the lunches.
- There were focus groups within specific cancers for patient involvement, although no patients have taken part in the governance groups as yet. The Trust used representatives from the local Healthwatch when planning major redevelopments.
- There is a culture of innovation and research, and staff are encouraged to participate. There are examples of research that were nationally and internationally recognised. Staff were supported to lead innovation projects in their work environment.
- The Trust had implemented a new tool called the favorable event reporting form (FERF). Anyone who sees an incident or an event which had gone particularly well was invited to document this. Everyone mentioned in a FERF received a personal letter, thanking them for their contribution, and the positive practice was cascaded throughout the Trust.
- The Trust has established engagement links with young people and children within the community, and many diverse activities took place on and off site for these groups .Recent 'Life labs' at Open Days gave local children the opportunity to try experiments and learn about personal health. Opportunities such as this encourage children of every socio-economic

background to view healthcare as a potential career option.

- Hospital teams, supported by hospital volunteers and emergency services, ran 'family road safety days' in central Southampton. Local children and their parents learned about road signs and had opportunities to practice resuscitation techniques.

The recommendations and findings from the CQC report have been developed into an implementation action plan. These included the areas where the CQC rated us as requiring improvement (where the service is not currently performing as well as it could). Progress against these actions is monitored on a quarterly basis by the head of clinical quality assurance with oversight from the director for nursing and organisational development, and shared with quality committees and commissioning groups.

Review of quality performance

All NHS trusts are required to report their performance against statutory quality indicators in a set format as part of their quality reports to enable the public to compare performance across organisations.

The tables in appendix two provide information against a number of national priorities and measures that, in conjunction with our stakeholders, 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.

Clinical coding did not have a payment by results (PbR) audit during 2017/18.

The last PbR audit was in 2013/14 and no further audits were recommended for the Trust as we were found to be fully compliant.

Clinical research

Research lies at the heart of our mission to deliver quality care and health and, as a major national site for clinical research, we are proud to provide our patients with some of the best access to new treatments in the UK.

In 2017/18 we further expanded our research activities across our clinical services, including the development of a nasal drop to help prevent meningitis, pioneering therapies for cancer patients, further results from the Southampton Women's Survey, and the development of a new, more effective and longer-lasting treatment for knee arthritis.

In outright performance measures we have also delivered strongly. Over 2017/18 we were again in the top 10 of NHS Foundation Trusts in England for trial recruitment, with around 20,000 patients gaining access to clinical trials, and we secured over £20 million of external funding to further support our research.

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With particular strengths in nutrition, respiratory and cancer research, the past year saw advances across all of these areas.

In 2017 our nutrition experts provided evidence showing access to a wider variety of food outlets is linked to healthier diets in children, strengthening the argument for local authorities to better support healthier childhood nutrition by supporting the establishment of more of healthy food outlets in their areas. Alongside that work, a £2.2 million award is looking at encouraging better health, diet and life choices amongst teenagers.

In respiratory medicine Southampton researchers received £2.3 million as part of a European-wide study to develop a new whooping cough vaccine, whilst a study looking at how tuberculosis (TB) bacteria interacts with the body's immune system has shown great potential in developing a life saving TB vaccine.

Beyond the hospital walls, the already successful 'pre-habilitation' programme (pre-surgery exercise sessions for cancer patients) has been awarded £2.3 million to pilot exercise sessions, as well as psychological wellbeing support, at gyms and cancer support centers across the region – widening access to this service, the first of its kind in the UK.

Southampton patients have been part of a pioneering urine test that is set to revolutionise the diagnosis of bladder cancer, whilst women across the region took part in the highest recruiting cancer study in England last year, incorporating alcohol awareness into breast cancer and screening appointments.

Innovative cancer research like this received a boost through Cancer Research UK's recent £3.5 million investment into the Southampton Clinical Trials Unit. This support, combined with the UK's first dedicated centre for cancer immunology research, based at University Hospital Southampton secures our role as a leading cancer research site.

These successes underscore the commitment and quality of our research teams and clinical researchers in driving better quality health and care to date. The '2017 – 2022 UHS Research Strategy' is our blue-print for securing and expanding this progress from here. The result of extensive consultation, 'Research for all' aims to ensure UHS remains a leading research site, working towards access to trials for all.

Review of services

During 2017/18 UHS provided and/or sub-contracted 107 relevant health services (from Total Trust activity by specialty cumulative 2016/17 contractual report). UHS has reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by University Hospital Southampton NHS Foundation Trust for 2017/18.

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CQUINS payment framework

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 2017/18 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.

The conditional income in 2017/18 upon achieving quality improvements and innovation goals was

£13,821,000. This compares to the 2016/17 figure of £13,366,000.

We have used the CQUIN framework to actively engage in and agree quality improvements with our commissioners, to improve patient experiences across our local and wider health economy.

Our CQUIN priorities for 2017/18 can be found in appendix three.

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.

UHS submitted records between April 2017 - March 2018 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As at December 2017 (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 care
- 99.7 % for outpatient care
- 99.9 % for accident and emergency care

UHS 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 organisation. UHS Information Governance Assessment Report overall score for V14 (2016/17) was 73%and was graded Satisfactory meaning 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 three accreditation against the NHS Litigation Authority risk management standards for acute trusts which contains two standards specific to records management and record keeping.

Participation in national clinical audits and confidential enquiries

During 2017/18 57 national clinical audits and three national confidential enquiries covered NHS services that UHS provides.

During 2017/18 UHS participated in 96% (55) of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

The NCEPOD studies that UHS participated in during 2017/18 were:

- Cancer in children, teens and young adult study (0-25 years)
- Acute heart failure
- Peri-operatives 'Management of Surgical Patients with Diabetes' Study

The national clinical audits that UHS participated in, and for which data collection was completed during 2017/18, are listed in appendix three 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.

How we are implementing the priority clinical standards for seven day hospital services

Priority clinical standard 1: don't wait longer than 14 hours to initial consultant review:

We have achieved this by embedding high level departmental reviews of waiting times across the Trust which hold managers accountable for their services. We monitor our performance via our in-house performance tool (CHARTS) in addition to participating in the biannual national audit. Appropriate investment has been made where service need requires, for example into the clinical workforce to enhance the out of hours teams across the Trust. Good practice and lessons learned are shared between departments at seven day services meetings, a regional 7 Day-Service forum and during an in-house nationally advertised and attended conference.

Priority clinical standard 2: get access to diagnostic tests with a 24-hour turnaround time. For urgent requests, this drops to 12 hours and for critical patients, one hour.

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We are achieving this by directing significant investment in radiology clinical staff over the last decade, including consultants, nurses, radiographers and housekeepers which has allowed the department to restructure its on-call service into a full shift system and specialty advice being available on a seven day basis. Occasional gaps in specialist radiology have been bridged by working in partnership with other organisations (OUH).

Priority clinical standard 3: get access to specialist, consultant-directed interventions

In addition to our work in radiology, this is addressed via a number of initiatives: there has been an expansion of cardiology staff to deliver a seven day emergency angiography/plasty service as well as non-invasive cardiology treatments and emergency endoscopy is provided by a multidisciplinary team of gastroenterologists, hepatologists and surgeons, increasingly covering endoscopy on-call gaps in our neighbouring smaller hospitals.

Priority clinical standard 4: patients with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

UHS has moved to daily consultant ward rounds in all clinical areas receiving emergency admission patients over the last few years in order to ensure appropriate and timely patient reviews. Patients in admission and high care areas may or may not require twice daily reviews as clinically indicated. If a twice daily review is not required, this will be clearly documented. We assess our performance against the national data set, acknowledging that patients are often seen more frequently than twice a day but that this not captured in the national data set.

Learning from deaths

During 2017/18 (to date), 2147 of UHS patients have died. 1,802 of these patients have died at Southampton General, while 345 of our patients died at Countess Mountbatten House.

Quarter	SGH + PAH	Countess Mountbatten	Total
Q1	477	90	567
Q2	460	97	557
Q3	579	111	690
Q4	286	47	333
			2147

Between the 1 April, 2017 and the 11 February, 2018, 2,110 cases have been reviewed through our Internal Medical Examiners Group (IMEG). The remaining 37 cases not reviewed were from the Emergency Department during Q1 as we only started to review these deaths from Q2, on the [7] July, 2017.

Following the IMEG reviews 173 more detailed reviews were carried out:

- 72 cases went on to have a detailed case note review at the Trust Mortality Review Group (TMRG)
- 47 cases were sent for an investigation with the patient safety team
- 37 cases were reviewed at the Child Death and Deterioration group (CDAD) and
- 17 cases reviewed at the Learning Disabilities Mortality Review group (LeDeR).

Quarter	TMRG	Scoping	CDAD	LeDeR
Q1	18	13	12	0
Q2	22	5	9	7
Q3	28	20	12	7
Q4	4	9	4	3
	72	47	37	17

To date, 25 cases representing 1.2% of patient deaths during the reporting period of 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter this consisted of:

Quarter	Amount	Percentage Per Quarter
Q1	12	2.12%
Q2	8	1.44%
Q3	5	0.72%
Q4	N/A	N/A

**

Please note that there are still some review data outstanding for Q3

These numbers have been established using the structured judgement and Root Cause Analysis (RCA) methodologies. For the RCA, an initial multidisciplinary meeting will take place to examine the details of the case, give the incident a classification, set out the terms of reference, including:

- key questions that need to be looked at for further investigation
- who needs to be interviewed or provide a statement
- the appropriate support that needs to be offered to the patients, relatives and staff
- That duty of candour has been observed.

Information is then gathered from people, documentation, equipment and the site of the incident for the investigation. This is documented in chronological order, and problems identified. All issues that are identified are then analysed to see which had the most significant impact, the root causes

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are the most significant and fundamental of these issues, but there may be many significant contributory factors. From the root causes, solutions will need to be found and actions/preventative measures will need to be put in place to stop or mitigate the risk of recurrence of a similar incident.

Main areas of failing identified in RCA	
Recognition	**4**
Escalation	**13**
Action	**4**
Communication	**5**
Timeliness	**2**
System	**1**
Process	**6**
Human Factors	**11**

The learning from our RCA's clearly indicate that human factors were a key issue. This is being addressed at education half days where the patient safety team are replacing the sessions on duty of candour (which is also covered by a VLE package) with a session on human factors. This will be initiated from the new financial year. The Trust has also appointed Dr Gillian Ansell as the new Trust lead for human factors education.

We are aware that human factor issues are a recurrent theme but we now need to introduce a system where we can outline the learning, demonstrate the actions we have taken in response, embed these throughout all relevant areas and communicate these across the Trust. We are currently introducing such a system, which will enable us to more easily track actions across the divisions, thereby giving reassurance that they have been completed.

Failure to escalate concern about deteriorating patients in an effective way is also a recurring theme, often compounded by problems with recognition or communication, and is a problem being addressed by the ROAR (recognise, observe, assess, rescue) working group. It also links in with our plans for implementation of the NEWS 2 early warning score ongoing rollout of the electronic patient acuity monitoring system (to be completed in June/July 2018) and further development of our escalation trigger tools.

The broad themes for actions (from the RCA's reporting during 2017/18) are:

- Individual learning and reflection
- Human factors discussion and educational meetings
- RCA's shared at the sub-specialty morbidity and mortality (M&M) meetings
- RCA to be given/shared with the Divisional Governance team and named clinician
- Trust-wide learning

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- Development of new pathways, processes, safety checks and guidelines
- Introduction or improvement of escalation trigger tools
- Communication training
- Introduction of audits to ensure quality improvement has occurred

Trust-wide learning includes all learning points that are published in:

- Safety Matters – a tool for disseminating information provided by RCAs – this comes in the form an anonymized case study and links in with themes from complaints and litigation
- Organisational Wide Learning (OWLs) – a practical theme based article, addressing recurring safety issues, for example missed doses of insulin
- Patient safety alerts – actions that come from a serious adverse event case review or RCA which immediately need implementing across the Trust and require notification of all clinical staff or relevant non-clinical staff.

For the next reporting period we will continue as above. We also aim to improve the way we share the results from all mortality reviewing panels with all relevant clinicians and relevant M&M leads so that it can all be fed back to as many colleagues as possible with better triangulation between these processes. We have started to put a system in place for this.

Many of these actions are difficult to objectively assess in terms of their impact as they may relate to rare occurrences, which are difficult to meaningfully audit, or to improvements in individual's knowledge or the wider safety culture.

The intention is to improve individual awareness for those involved in incidents, raise awareness in teams and put additional safety checks or immediate actions in place to mitigate risk and reduce recurrence with organisational awareness of key safety themes.

The impact is assessed by audits when appropriate, with oversight from divisional governance and clinical effectiveness (COSG). Ongoing themes are considered and reviewed by the patient safety team and the Trust mortality Review Group (TMRG). Quarterly reports are submitted to Quality Governance Steering Group (QGSG) and the Trust Board about the continued effort in striving for improvement.

There were an additional 17 case record reviews completed after the date of 1 April, 2017 which relate to deaths that took place before the start of the reporting period.

However, due to the prospective review of deaths through IMEG almost all cases with safety concerns are now identified within 72 hours of death and thereby largely eliminating late investigation of deaths with concerns, although investigations can take up to 60 working days to complete. They are provisionally graded according to avoid ability within 72 hours of death, although subsequent information may adjust this grading during the investigation, the majority are correctly attributed through IMEG and the initial serious incident case review 'scoping' meeting.

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Of the 17 deaths which occurred during the previous reporting period, but which were reviewed in the current reporting period, three (representing 0.14%) were judged more likely than not to have been due to problems in the care provided to the patient. This number has been established using the RCA method.

Figures for 2016/17 period:

Total number of deaths at UHS	**2444**	**-**
Total number reviewed (including IMEG)	**2219**	**90.79%**
Number that was sent to TMRG	**68**	**3%**
Number sent to a serious adverse event root cause analysis	**60**	**2.5%**

This number has not previously been reported through this process; however it has been identified internally, using the same methodology as that used for the current reporting period. The final established number of deaths identified through IMEG, TMRG and serious adverse event root cause analysis as being more than likely avoidable is 33, which represents 1.4% of deaths in the period of 2016/17.

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Progress against 2017/18 priorities

This section outlines how we have performed against the delivery of our 2017/18 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.

Each priority related 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.

Patient experience

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

Our aims were:

1. Standard information to be generated to set expectations on admission.

2. Standard information to be provided 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 Integrated Discharge Bureau.

4. Clear timelines between each stage of the process to be established.

5. We aimed 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.

Our achievements for 2017/18 were

In 2017/18 the Managing Complex Discharge Policy was reviewed against the NHS England template and updated accordingly. This policy includes standard information to be given to patients on admission regarding discharge planning, explaining who is available to support them with each process and how to access this. The policy also explains the escalation process for staff to follow where discharge planning becomes a conflict between the patients and the organisation. Clear timelines between escalations are outlined. Training slides have been agreed between partners and UHS and system training is being planned for the coming months, into the new financial year.

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Each clinical ward area now has access to a discharge officer, senior discharge officer, continuing healthcare coordinators and team leaders, all in post within the IDB to support the wards with discharge planning. 2017/18 has seen the substantive appointment of two senior managers within the UHS IDB to embed the service improvements projects already underway, to support wards with training and development around complex discharge and to ensure relationships between primary care, hospital services, social services, voluntary services and the private sector continue to grow and thrive. Joint training is now planned between Acute and community Trusts.

In 2017/18 the IDB UHS staff underwent a 7 day working consultation to ensure that complex discharge support was available to wards over weekends. Agreement was gained that 7 day working has a place in complex discharge planning. The consultation was a collaborative and positive staff consultation experience and the service has expanded to be available on a Sunday, with phase 2 reviewing stepping up the service to cover Saturdays also.

Priority two: meeting patients' nutritional and hydration needs

Our aims were

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 chart to all adult inpatient areas
4. Work collaboratively with our new service provider to increase the percentage of patient satisfaction with food

Our achievements for 2017/18 were

The use of the Malnutrition Universal Screening Tool (MUST) has been reviewed and a new simplified version developed to help with compliance. The new version of the tool is due to be printed in the next print run of the nursing assessment documentation and new care plans (red/orange/green denoting escalation of care needs) implemented for all patients. Education is currently in progress prior to the organisational launch of the tool.

Changes to the audit process have also been made this year with the focus now on whether the tool has been completed in the last 7 days, and whether an appropriate care plan has been implemented. Data is collected monthly with all wards asked to submit data on all current inpatients. These results are shared monthly with ward leaders and matrons and have resulted in a slight increase in compliance. However the implementation of the new tool and care plans is expected to improve compliance further.

There has been a focus on ensuring weights and heights of children are measured and recorded accurately on growth charts with implementation of a training programme on the VLE for measuring, recording and interpreting growth in children.

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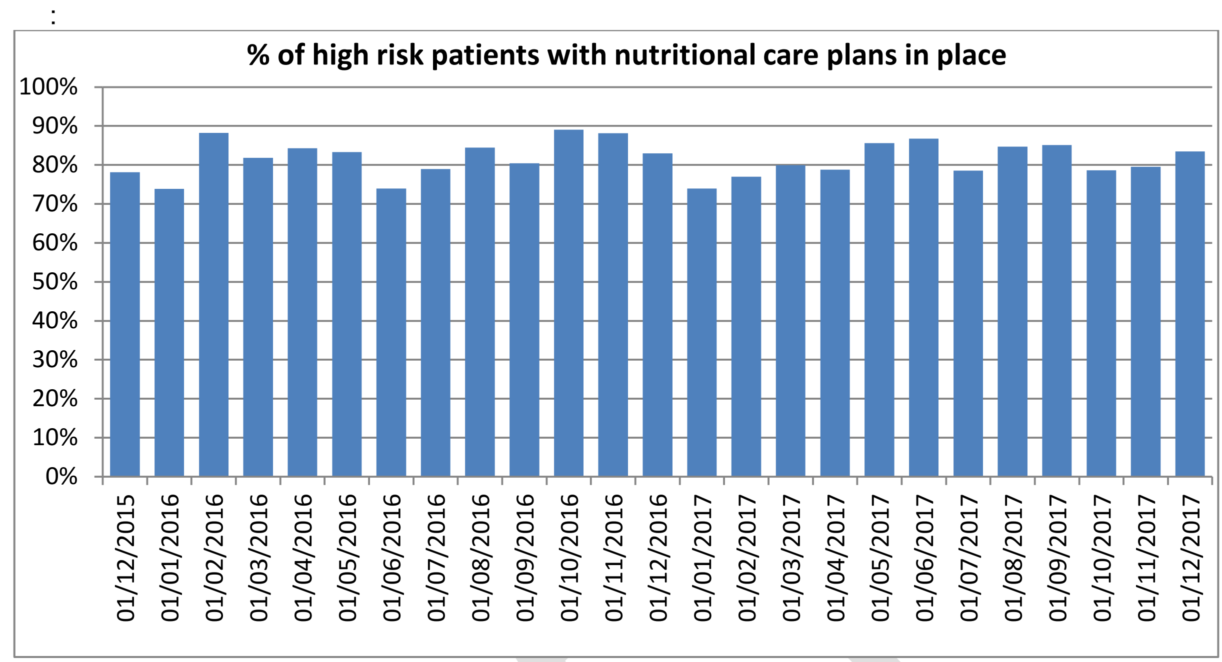

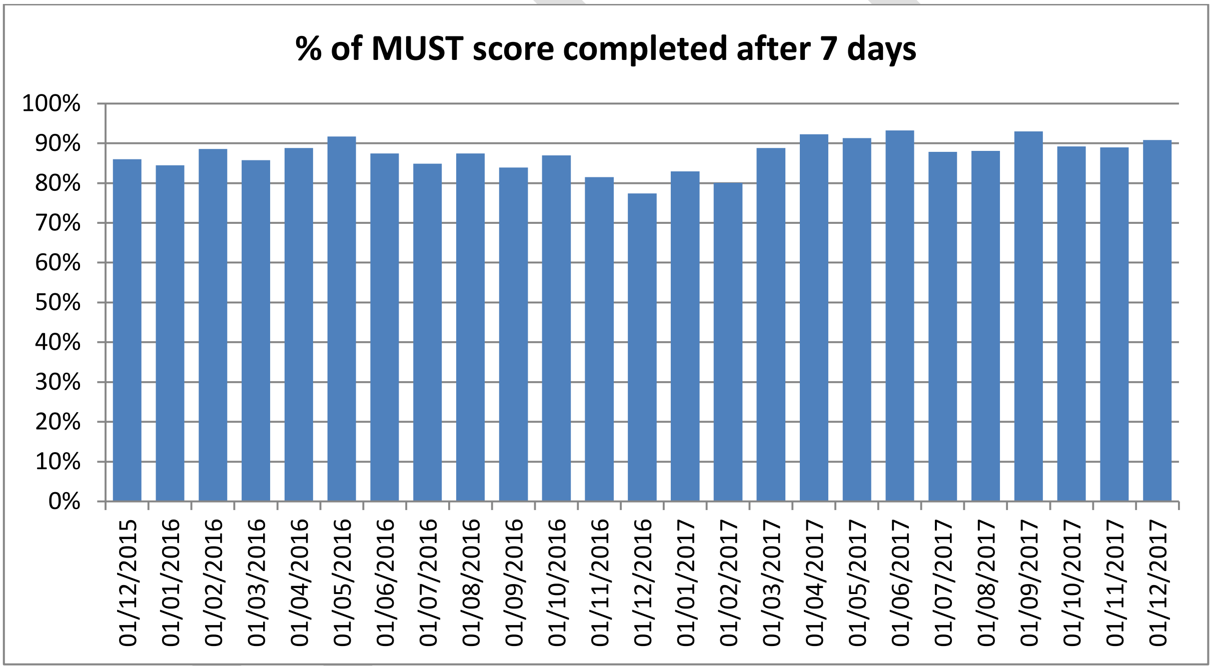

We have undertaken a review of compliance with Protected Meals guidelines, and generated a revised patient meal poster which has been issued to all wards. There is work underway to review mealtime co-ordinator roles and responsibilities in clinical areas to ensure collaborative working with catering providers at mealtimes and ensure patients are prepared for meals.

By September 2017 we had successfully introduced a hydration assessment and chart to all adult inpatient areas. All adult inpatient areas now complete regular self assessment of the completion of the hydration assessment and chart. Acute Kidney Injury (AKI) lead advanced nurse practitioners carry out spot audits on this data. Work is also being completed to add an electronic hydration assessment and chart to the safe track electronic observation system.

This year UHS started working with a new service provider, Serco, The new service went live on the 1 June, 2017, so is still in the early stage of implementation. Early indications show that the quality of the food, taste and availability have been positively acknowledged by staff and patients alike; however no formal audit data is yet available. The contractor is currently planning its first audit of patient satisfaction, which will be circulated on completion. The first PLACE assessment since change of provider is due to take place in April 2018.

Patient satisfaction scores from Serco for January 2018 are included below:

Overall, how would you rate the quality of the hospital food delivered to your bedside?

	No.	%
Very good	93	54.07%
Fairly Good	59	34.30%
Neither good nor poor	12	6.98%
Fairly poor	4	2.33%
Very poor	3	1.74%
Don't know	1	0.58%
Total	**172**	**100.00%**
No responses	5	

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Priority 3: Improving care for vulnerable adults

Our aims were

1. To meet the rising demand of patients presenting in mental health crisis, grow the service, complete a gap analysis of current service delivery and develop a plan to address this.

2. Develop robust training programmes for our staff so they feel well equipped with the clinical skills to support patients, to de-escalate challenging behaviour and refer to other specialist or professional teams.

3. To develop a UHS mental health board to address the challenges and impact for mental health patients and for staff looking after them.

4. To evaluate responsiveness and effectiveness of the enhanced care support team and potentially expand service.

5. Focus on the autism agenda.

6. Develop leadership and evaluate progress with a dementia strategy.

7. Consider a proposal for joining adults and children's safeguarding teams with associated joint governance and meeting structure.

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

9. Introduce carers' passports.

10. Introduce the vulnerable adult champion role.

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

Our achievements for 2017/18 were

A Mental Health Board has been developed in order to scrutinise and improve the quality of the delivery of mental health care within UHS. Whilst the board is in its infancy, its role will include analysis of current service provision as well as a vision for the future provision. In addition, a recent internal mental health quality review was completed which will further inform the development of the mental health strategy. Early achievements include; terms of reference have been agreed and signed off, the board meet bimonthly, task and finish groups focus on key priorities and a mental health dashboard is being developed.

Furthermore, closer joint working across mental health teams and services is being facilitated by:

- The appointment of two mental health nurses with the overall aim of delivering the provision of specialist mental health nursing, practicing within the multidisciplinary team. They provide advice, education and support to patients, their carers and other health care professionals.
- UHS mental health nurses attend a weekly Older Person Mental Health (OPMH) and Acute Mental Health (AMH) allocation, and daily multi-disciplinary team (MDT) meetings to facilitate joint working and working across boundaries.
- UHS admiral nurses (dementia) attend a weekly G7 MDT on G7 Enhanced Care ward and patients from OPMH, admiral nursing and UHS wards are discussed to decide which would most benefit for transfer to OPMH.
- A part-time liaison 8b psychologist has been appointed (February 2018) to better integrate psychology provision in the liaison psychiatry (Adult Mental Health and OPMH) services and enable liaison psychiatry to offer brief psychological interventions and supervision.
- Health psychology continues to offer psychology in a number of specific areas where business cases have been successful in integrating psychology into medical and surgical teams.
- Division of preventative medicine (DOPM) offer a weekly one hour education programme which all nurses working in mental health in UHS and DOPM are welcome to attend.

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- Health psychology offers a psychological supervision/reflective practice group for DOPM nurses to support working effectively with mental health patients.

Education and training achievements include;

- DOPM ran a UHS Mental Health Day with a whole day of speakers in 2017. This was open to all staff at UHS and SHFT locally and received excellent feedback. The intention is to repeat these annually in October on World Mental Health Day.

- DOPM (OPMH and AMH) staff offer bespoke training for clinical teams as requested on mental health topics as part of their commissioned service.

- UHS Dementia Working Group is currently liaising with the education team to monitor UHS staff compliance with mandatory dementia training on VLE, and this is a standing item on the group for oversight purposes.

- The Mental Health Board commissioned a workshop in October 2017 to scope the knowledge and skills of frontline staff around three key areas; mental capacity, absconding and patients detained and admitted under the Mental Health Act.

Conflict resolution and breakaway training has been provided to emergency department (ED) staff and other high risk areas over nine days training in partnership with the UHS training and development team with further days to be arranged. Further key actions undertaken by ED to support staff and de-escalate behaviours include:

- Introducing a ‘code green’ approach for managing acute behavioural disturbance which prompts the involvement of senior nursing and medical staff, alongside security officers, to promote senior decision making.

- Working closely with commissioners and multi-agency partners to improve pre-hospital decision making and management of persons / patients detained under Section 136 of the Mental Health Act. UHS have been part of developing and agreeing S136 pathways for use across Hampshire and within ED at UHS.

- Secured funding for the build of two high risk assessment rooms in ED as a ‘safe space’ environment to de-escalate patients with acute behavioural disturbance.

- Introducing a new protocol for managing psychotic and manic episodes, with associated training.

- Introducing the role of Band 5 Registered Nurses (mental health) as part of the ED workforce to manage patients who present in mental health crisis. Once established in role, the team will provide training to ED healthcare assistants on providing enhanced support to patients in crisis.

There are a number of specialist teams across the Trust to support staff, patients and carers which include; learning disability liaison CNS’s; admiral nurses; mental health CNS’s; vulnerable adults support team (VAST); enhanced care and support team (ECST); and the department of psychological medicine (Southern Health NHS Foundation Trust service).

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Positive progress has been made with the autism agenda. Funding has been secured from West Hampshire CCG to expand the learning disabilities team and this investment was used to develop a focused autism and transition post. The post holder has been appointed and is working closely with the wider learning disabilities team to scope the Trust's requirement around this agenda. The learning disabilities /autism working group will be the forum for developing and driving the strategy and this has been re-launched as part of the new safeguarding governance structure.

A new medicine for older people dementia lead has been appointed who is working closely with the admiral nurses and OPMH liaison to deliver a dementia service. The dementia working group has been re-launched with refreshed membership, the Dementia Champions programme is being re-invigorated ensuring all clinical teams have champions in their area, and development of the 2018-2021 strategy is ongoing. The Mental Health Board will offer scrutiny and oversight of the overall service.

In October 2017 the children's and adult's safeguarding teams were merged in order to facilitate a more holistic, effective and efficient approach to safeguarding within UHS – 'think family'. Whilst the change is in its early stages, the benefits have already been noted and well received, with partner agencies showing interest in developing similar models across Hampshire. A joint governance structure has been developed with the joint safeguarding governance steering group already being well established. This facilitates the learning for complaints, incidents and statutory reviews being shared. A monitoring and evaluation task and finish group has been established with the focus of identifying key performance indicators for safeguarding, development of a 'live' safeguarding dashboard, development of a formal reporting schedule and a formal annual effectiveness programme.

The learning disability, mental health and admiral nurse specialists are working with patient experience to re-launch all support available to carers across the Trust. This includes carer's passports, John's campaign, a carers' café / forum and signposting and support. This area of work is included within both the LD and Dementia strategies.

The vulnerable adults champion role is being reviewed following a change in structure of both the ECST and the safeguarding team.

Additionally, the adult safeguarding team have introduced a daily multi-agency safeguarding huddle with local authority partners to effectively and efficiently triage every referral and incident where a safeguarding concern has been identified.

A whole review of the current Mental Capacity Act and Deprivation of Liberty (DoLS) process has been undertaken following the appointment of a new named nurse for safeguarding adults. This review has highlighted the need for a number of changes to the current process, and we are therefore writing a new policy. Once this is completed and ratified, all training will be updated and modernised.

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Patient safety

Priority four: recognition and management of the deteriorating patient

Our aims were

1. For the consultant body and acuity practice development matron to develop an annual action plan for acuity improvement which would inform training and education and feedback to clinical areas.

2. .To further improve on the recognition and deterioration of patients, with focus on progressing deterioration escalation on electronic systems (ePAMS).

3. Organisational review of Acute Kidney Injury (AKI) and sepsis outcomes.

Our achievements for 2017/18 were

An annual action plan has been successfully developed during 2017/18.

Part of that plan includes supporting the ROAR group who worked with the Academic Health Sciences Network (AHSN) to improve recognition and response to patient deterioration. The AHSN's present a unique opportunity to align education, clinical research, informatics, innovation, training and education and healthcare delivery.

We worked collaboratively with AHSN to speed up the adoption of innovation into practice to improve clinical outcomes and patient experience. During the year AHSN have helped support the development and roll-out of an electronic monitoring system, successfully introducing the mobile electronic observation system MetaVision Safe Track™.

Using mobile devices, nurses of all grades capture observations for their patients directly onto MetaVision Safe Track™, which calculates the MEWS and advises the next appropriate steps regarding escalation and monitoring. Clinicians can review the observational data from any UHS PC, laptop, iPad or iPod, as well as any personal device connected to the hospital Wi-Fi. MetaVision Safe Track™ is currently live on the trauma and orthopaedic, surgery and gynaecology wards (a total of 320 beds) and will next be implemented across medicine as part of the hospital-wide roll-out. Running in parallel is the implementation of the MetaVision PDMS into the intensive care and high dependency units. The major benefit of having both the MetaVision PDMS and MetaVision Safe Track™ is a single patient observation record across all clinical areas, ensuring a complete continuum of care across the Trust.

Other benefits include complete observations capture, accurate and safer MEWS score, ease of clinical handover of patients between MetaVision Safe Track™ wards, quick identification of deteriorating patients and those who are at risk, remote patient management for the out of hours teams, and viewable observations via the UHS Electronic Patient Portal (CHARTS).

Lorna Adams-Jones, Project Lead, said:

"MetaVision Safe Track is easily configurable and has been customised to support our clinical workflow. Our staff have embraced the system with minimal training and have been tremendous. We are excited to roll it out to the remaining wards across our hospital."

We have evaluated the introduction of the system in AMU and note 50% reduction in cardiac arrest and an increase in outreach calls evidences improved earlier recognition of deterioration. This outcome information has been shared with commissioners, AHSN, and partnership hospitals and we continue to monitor early warning escalation across the Trust and feedback findings each month to clinical areas for learning.

Sepsis and AKI assessments and alerting tools have continued to be developed, with full fluid balance charting functionality on the Metavision Safe Track™ system nearing completion. We aim to implement this later in the year.

AKI and sepsis outcomes have improved (see priority six) and it is the recognition of deterioration in both conditions that is key.

Training and development has been supported with the delivery of the new Senior ALARM course which targets senior nursing staff across UHS and focuses on simulation training on leadership and patient clinical deterioration. In addition, there is a much more robust process for thematic interrogation of incident reports and sharing of learning via the ROAR group and through governance groups across the Trust.

Priority five: National standards for safer invasive procedure (NatSSIPs - national safety standards for invasive procedures)

Our aims were

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.

Our achievements for 2017/18 were

NatSSIPs have been developed and implemented in all theatres and areas carrying out invasive procedures under general anaesthetic or in catheter labs across the Trust over the last two years. They follow a standardised format, however, following the first round of implementation audits of specific areas (cardiac surgery, ophthalmology, obstetrics) it was found that major differences in practice consistently rendered parts of the standard NatSSIPs checklist irrelevant. Consequently staff have been permitted to modify the format to remove questions that are of no value and replace them with specific questions that enhance the safety of their practice.

Audit

A rolling audit programme has been introduced and refined within the main theatre areas. This has deliberately set the bar at a high level with a multiple point review of each stage of the process carried out by a small number of trained observers. The levels of complete compliance within each stage of the 2017 audit are outlined below.

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SPECIALITY	OVERALL	TEAM BRIEF	SIGN IN	TIME OUT	SIGN OUT
ENT/OMF	79%	83%	94%	73%	74%
Thoracic	73%	94%	91%	59%	70%
Urology	76%	80%	100%	66%	63%
Paediatrics	81%	91%	91%	83%	69%
Orthopaedics	71%	79%	91%	62%	69%
Paeds Orthopaedics	66%	81%	87%	53%	64%
Neuro	75%	70%	98%	78%	63%
General/HPB/Upper G.I/CEPOD	82%	85%	95%	71%	85%
Vascular	94%	96%	100%	93%	88%
Average Score 2017	**77%**	**84%**	**94%**	**71%**	**72%**

The questionnaire includes subjective assessments of engagement, behaviour and communication as well as objective assessment of compliance with attendance, completion of checklists and tasks. The overall scores shown above reflect that, whilst our theatres consistently have a very good safety record, there are still significant areas for improvement in order to achieve ideal practice in all areas. It would have been easy to design an audit tool that simply addressed whether or not we completed checklists and which would have shown near 100% compliance in all areas, however this would have missed the point of the introduction of the safety standards which should serve to improve communication, benefit team working and change culture within the theatre environment.

In the first round of audit this observational tool did not involve early feedback to the teams, this has been addressed in the revised observational tool, which has increased engagement with the theatre team, allowing the observer to challenge practice and feedback where appropriate following each stage of the process. This then helps to facilitate discussion and learning. The revised audit tool being used in 2018 also identifies notable areas of positive practice for feedback, encouragement and wider dissemination.

Ongoing areas for development identified by our 2017 audit:

- Use of paper documentation during checks
- Clinician engagement in some areas
- Surgeon stating the operation without looking at the consent form during time out
- Surgical handover if the consultant leaves before the sign out phase.
- ‘Timing’ of ‘Sign Out’
- Handover processes

The audit data has been fed back to each theatre and sub-specialty and presented during the educational half day programme.

Development of the debrief at the end of the theatre list has been the last major step in the introduction of NatSSIPs within the Trust. Whilst this has been established practice in some theatres, this has been a minority and the NatSSIPs steps are being formally revised in order to make this mandatory within all theatres from 1 April, 2018.

The second round of theatre audit has started and will also involve cascade training of additional observers to facilitate further audits as this evolves into an observational feedback tool that can be used outside of the formal annual audit process.

Cardiac theatres, eye theatres and Princess Anne theatres will all be included in the 2018 theatre audit, with minor alterations to the observational tool.

Interventional radiology, neurosciences and cardiac catheter labs all perform procedures under general anaesthetic in a catheter lab environment where NatSSIPs apply; these areas have developed a further modification to our NatSSIPs standard which is relevant to their way of working. An audit tool based upon the main theatres observational audit tool is being piloted by the cardiology team and will be used in other catheter lab areas.

LocSSIPs - local safety standards for invasive procedures

LocSSIPs are the more abbreviated set of stop points and checks prior to invasive procedures that are performed either by a solo practitioner or outside of a theatre environment.

A core three-step framework has been established for LocSSIPs:

- Sign in (team brief)
- Time out (knife to skin/procedure start)
- Sign out (completion of procedure)with a series of prompting questions to ensure:

- completion of consent/agreement to proceed
- confirmation of procedure and patient identity
- review of appropriateness of procedure, supervision and competencies
- preoperative, intraoperative and post-operative checks
- availability of equipment and monitoring
- escalation and recovery pathways
- post-procedure requirements

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This three-step framework is backed up by procedure specific questions. The core questions and procedure specific questions are widely available in all areas carrying out invasive procedures as laminated cards as well as on MetaVision.

There has been a stepwise adoption and introduction of these across the hospital, with early uptake from endoscopy, surgery, intensive care, radiology, dermatology and the emergency department. They have also been developed and are in the process of being implemented in cancer care, neurosciences, AMU, medicine for people, specialist medicine, paediatrics, obstetrics and gynaecology.

All areas within the Trust are expected to be using LocSSIPs where appropriate by the end of Q4 2017/18. Implementation is overseen by the LocSSIPs working group with delegation to the divisional, care group and specialty leads as appropriate.

There are some minor invasive procedures (such as venous cannulation, adult bladder catheterisation) where it has been agreed that LocSSIPs do not apply. Each division has provided a list of those procedures where this is not required which has subsequently been assessed and agreed by the working group. Completion of LocSSIPs requires documentation in the notes, for speed and efficiency in some areas of the hospital this will be documented using a sticker that is completed and placed in the patient medical notes

Audit of LocSSIPs will predominantly be a notes based retrospective audit of documentation as to whether LocSSIPs were followed. This is because in many areas procedures are only being performed infrequently and therefore it is not practical for the use of an observational tool.

Areas performing high numbers of procedures (such as radiology and endoscopy) will be possible to assess using an observer completing an observational audit tool.

Audits will commence in April 2018 in critical care, emergency department, endoscopy, neuroradiology and cardiac catheter labs.

Priority six: recognising and treating sepsis

Our aims were

Our aim throughout 2017/18 was to improve our recognition of patients at risk of sepsis and, as a consequence, allow the early management of septic patients recognising that if patients with sepsis are treated quickly mortality is reduced. We used the national sepsis CQUIN as a framework to drive improvement and worked towards a Trust-wide, systematic approach for the identification and appropriate treatment of life-threatening infections. At the same time we worked to reduce the chance of the development of strains of bacteria that are resistant to antibiotics. These priorities were discussed in depth with the UHS Quality Committee.

Through this we aimed to reduce death and morbidity related to sepsis in all areas of the hospital, reducing patient length of stay, critical care length of stay and thus improve patient experience and outcome.

Our achievements for 2017/18 were

The national sepsis CQUIN started in 2015 and continues until 2019. Over this time the CQUIN requirement has changed and enabled UHS to drive awareness amongst staff and service users as to the importance of recognising sepsis.

This year we have refined and embedded our sepsis screening tool. The roll out of the paper tool was phased over the year to ensure all areas received full education and support prior to its implementation. To support this the Trust ensured a clinical lead (consultant intensivist) oversaw the projects and created secondment roles for one band 7 sepsis nurse, one band 6 sepsis nurse and a band 4 data analyst. Alongside this the medical division recruited a substantive band 6 sepsis nurse within their education team and the pharmacy department recruited an antimicrobial resistance nurse.

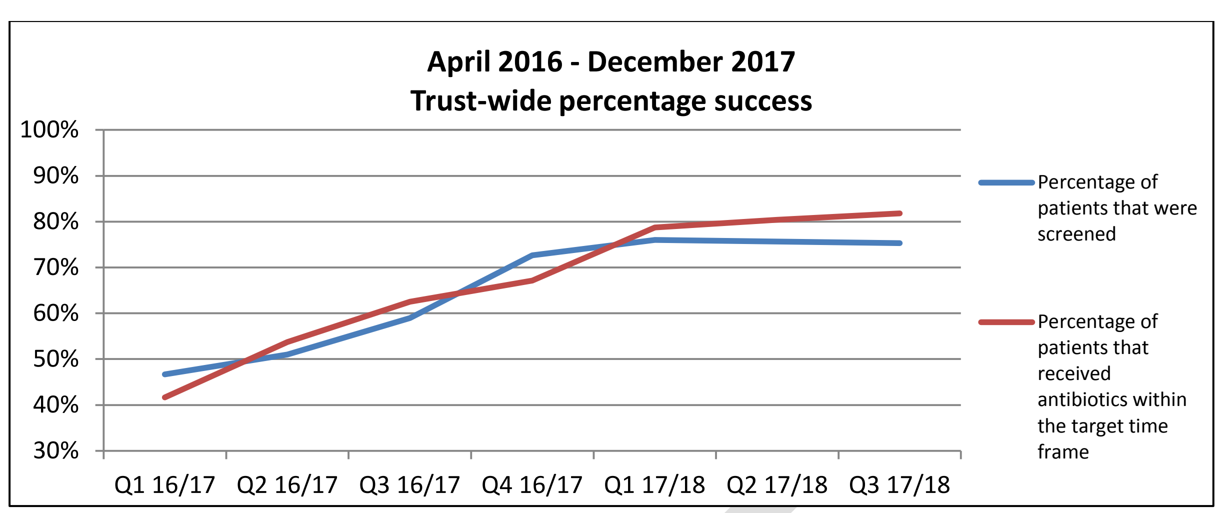
A sepsis working group was previously established which had excellent engagement from ward based nurses, medical consultants (ICU, AMU, surgery, paediatrics, ED and neurosciences), consultant pharmacist, consultant microbiologists, consultant infectious diseases, antimicrobial resistance nurse, critical care outreach team, and specialist nurses. This year the group has amalgamated into the Trust acuity group – ROAR (Recognise, Observe, Assess and React) as the work stream of sepsis cannot work in isolation but needs to be aligned with the deteriorating patient work stream.

All paper screening tools have gone through a number of PDSA cycles and the adult tool is now included in the escalation of clinical deterioration form with the aim to improve escalation and recognition of a deteriorating patient. The tool is now also included in the Trust's electronic Doctors Work List.

The Trust had previously developed sepsis electronic learning packages for both adult and child health patients in 2015. These are now well established. Antimicrobial resistance cards for staff have also now been developed. Sepsis boxes were trialled the acute admission areas –ED, AMU, ASU, and PAU and maternity, however the uptake in use of these boxes has not seen a significant increase in the management of sepsis and so has not been rolled out to the rest of the Trust.

The CQUIN time scale for delivery of antibiotics was reduced from 90 minutes to 60 minutes in April 2017, which for the Trust has since shown a slower increase in achievement for timely administration of antibiotics.

The graph below shows the overall Trust percentage for achievements for both sepsis screening and timely antibiotic delivery from April 2016.



CQUIN percentage achievements Q2 2015 – Q3 2017

	Emergency screening	Emergency antibiotics	Inpatient screening	Inpatient antibiotics
Q2 2015/16	24%	46%	-	-
Q3 2015/16	51%	61%	-	-
Q4 2015/16	90%	70%	-	-
Q1 2016/17	85%	36%	8%	47%
Q2 2016/17	90%	45%	12%	66%
Q3 2016/17	93%	56%	25%	73%
Q4 2016/17	94%	61%	51%	80%
Q1 2017/18	91%	78%	61%	79%
Q2 2017/18	93%	85%	58%	76%
Q3 2017/18	92%	76%	59%	89%

Text code - Green is full CQUIN target achieved, amber partial CQUIN target achieved

The CQUIN data will continue to show areas of achievement and areas for improvement. UHS has been recognised by NHS England's medical director for clinical effectiveness as being one of the Trusts which has seen the greatest improvements in sepsis recognition and treatment.

The data that is collected for the CQUIN is only a small part of the data we collect for each patient where we look at time of observations, time of sepsis tool completion, time of review by medical team, sepsis biomarkers, outreach review, sepsis six care bundle delivery, antibiotics started, three day antibiotic review, etc. This data enables a wider data set that is shared internally to divisions and care groups to identify where recognition and management of patients can be improved. This information is also shared with the Trust acuity group (ROAR), Patient Safety Steering Group, Quality Governance Steering Group and Trust Board to enable escalation of concerns and support for required developments.

Sepsis has been added as a separate cause code onto the electronic adverse event reporting system which enables sepsis incidents to be easily identified and reviewed. All patients who have sepsis as a

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cause of death that have been through the IMEG process (Internal Medical Examiners Group) are reviewed by the sepsis clinical nurses and investigated as required.

Favourable Event Reporting Forms (FERF) is written for staff, teams or wards that have provided excellent recognition, care and management to a patient.

The Trust is in the process of rolling out an electronic observation system to all wards. The sepsis screening tool will be included on this system thus providing a mandatory screening tool which should improve compliance similar to that seen within the ED.

We can demonstrate that mortality and length of stay has decreased – data pending April 2018

Clinical outcomes

Priority seven: report outcome measures in every speciality across the hospital

Our aims were

To continue developing the work streams across all clinical specialities and to establish an outcomes group to provide a greater level of scrutiny and assurance.

That every speciality would identify outcomes that are specific to their clinical service – these can be nationally reported or locally developed outcomes.

Each care group would be able to present their outcomes to a newly established outcomes scrutiny group on an annual basis, demonstrating progress against the identified outcomes.

Our achievements for 2017/18 were

An outcomes group was established with a rolling programme which ensures that all care groups attend on an annual basis to present their outcomes. This group reports into the quality committee.

More specialities are identifying outcomes each quarter. This remains work in progress.

All care groups have presented their outcomes to the scrutiny group during 2017/18 and the programme for 2018/19 ensures that this will continue. This will allow care groups to update their progress against identified outcomes since being presented in 2017/18.

Priority eight: Improve care for patients at the end of life

Our aims were

Eight priorities were set in the 2015/16 UHS Quality Account for End of Life Care.

1. Deliver our new five year UHS End of Life Care Strategy so that education and training in care of the dying are delivered for clinical and front-line non-clinical staff caring for dying patients. The scope and level will vary according to staff group and the frequency that they are involved with care of dying patients and their families.

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

3. Enhancing our pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met.

4. Facilitating discussions with patients and families about their wishes relating to their preferred place of care whilst dying. This will include discussion about what is safe and feasible. This will enable increased numbers of dying patients to be discharged home or be transferred to an alternative place of their choice in a timely manner.

5. Working with relatives and carers to hear their voice about their experiences of end of life care and their ideas for improvement.

6. Continue to participate in and inform the national work stream around the emergency care and treatment plan, working alongside Wessex CLAHRC into the use of treatment escalation plans (TEP).

7. Replicating the National Care of the Dying Audit locally in 2017 ahead of the anticipated next national audit round.

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.

Our achievements for 2017/18 were

There has been progress in all domains. The Trust Board have acknowledged that end of life care is a field which requires continuous quality improvement.

We have started delivering our new five year UHS End of Life Care Strategy which includes:

- Role specific mandatory training has been agreed for all staff groups from April 2018.
- We are providing increased education on end of life care including: all FY1 and FY2 Doctors, weeklong situational and more formal teaching on a ward by ward basis.
- In November 2017 we held our fifth annual End of Life Care conference for UHS staff which was both well attended and positively evaluated.
- The Hospital Palliative Care Team clinical activity continues to rise year on year (1912 new referrals in 2014/15, 2094 in 2015/16 and 2230 in 2016/17) providing even more opportunities for the team to teach situationally and influence the care of far more people than they see.
- An enhanced proactive palliative care team service for the UHS cystic fibrosis service commenced in January 2018.

We have progressed our intention to discuss with the patient, if well enough and appropriate, with family, carers or other advocates that they are approaching the end of life:

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- Our most recent comparison of UHS Dying in Hospital Audits of the care of patients who died in June 2015 and in September 2016 (repeating previous National Audit) shows improvement from 81% to 91% in the recognition of dying exceeding the national target of 83%.
- The percentage of notes in which there was documented evidence of discussion with the patient that they would probably die in the coming hours or days was 29% in both audits against the national target of 20%. A large percentage of patients were deemed too ill to have such a discussion.
- The percentage when this was discussed with a nominated person important to the patient increased from 80% in 2015 to 87 % in 2016 against a national target of 79%.

We have enhanced our pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met. In 2018, the Spiritual Care Team diversified its service; employing Christian chaplains of varying denominations, the team now also employs those of other faiths and none. Specifically, Muslim and Hindu Assistant Chaplains have been appointed as well as a Humanist Pastoral Carer. Whilst all chaplaincy includes generic care, Muslim, Hindu and the non-religious now have dedicated spiritual care staff available should they require this.

Facilitating discussions with patients and families about their wishes relating to their preferred place of care whilst dying has been an area of focus in 2017/18. Whilst we believe there are more discussions initiated about individuals' preferences at the end of life, there is no single system to record these preferences and, in any case, those discussions are usually best placed to occur in the community. Of those patients from UHS 2016 Dying in Hospital Audit, only one out of 77 patients was admitted from the community with an advance care plan (ACP).

We are concerned about the number of patients who are unable to be discharged home when approaching the very end of their life due to social care constraints and are interrogating the data to identify the root causes of this. The number of adult patients dying in the Trust is increasing. In 2015/16 there were 2,111 adult deaths of whom 364 died in Countess Mountbatten House (CMH), in 2016/17 2,341 with 415 deaths at CMH. The proportion of patients referred to and followed up by the Hospital Palliative Care Team (HPCT) who die in hospital has increased; 541 (25.8%) and 634 (28.4%) of HPCT referrals died in SGH in 2015/16 and 2016/17 respectively. The number and percentage have continued to rise 590 deaths (30.6 %) of HPCT referrals in the first 10 months of 2017/18.

The HPCT was directly involved in the care of 86 of the 215 (40%) adult patients who died in SGH/PAH as inpatients in December 2017.

In order to improve our working relationships with relatives and carers we conducted a survey of bereaved relatives. 160 questionnaires were handed out during February 2017, with a response rate of over 50%. Over 90% of respondents rated their relative's care as good or very good for the majority of the questions. Feedback about specific ward areas was sent to relevant clinical leaders so they could learn from both the accolades and any negative comments. In addition we ensured the feedback was shared across all the clinical areas to improve practice.

In July 2017 we also held the second of the UHS CEO patient lunches for bereaved relatives, which is held on a three yearly cycle. Relatives were given the opportunity to discuss directly with the CEO

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their experience of the care for both the dying person and themselves. Where necessary the CEO asked for some of those who were involved to communicate with families and to harness their ideas about improvement. One family is now working with us to improve the 'Coping with Dying' information for relatives.

In 2017/18 we committed to continue to participate in and inform the national work stream around the emergency care and treatment plan, working alongside Wessex CLAHRC into the use of treatment escalation plans (TEP). We have actively been part of the local, regional and national work streams for TEP throughout the year.

During 2017/18 we replicated the National Care of the Dying Audit locally i ahead of the anticipated next national audit round. We carried out this audit using data from the notes of 77 adult patients who had died in September 2016. On the whole the results showed an improvement compared to the audit of those who died in June 2015, and in some domains we exceeded the national targets. Where the results suggested a need for improvement this has been incorporated into our End of Life Care Action Plan

In order to assess the use of the individualised end of life care plan we have carried out a baseline audit of staff knowledge and experience of the UHS End of Life Care Plan to establish standards for practice. We have developed an education programme which we are implementing and will then re - audit and use the results to inform continuing improvement in the care of the dying.

Priority nine: reduce the impact of deconditioning and immobilisation on the frail elderly

Our aims were

1. Increasing ambulatory care at the front door.

2. Increasing the identification and better understanding of frailty.

3. Initiatives to positively encourage mobilisation on the wards including Implementation of the 'Eat Drink, Move and End 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, wellbeing, and reduce their length of stay.

Our achievements for 2017/18 were

During 2017/18 we re-launched our present ambulatory pathways aimed at increasing ambulatory care (AEC) at the front door. We rolled out AEC clinics seven days a week and reviewed the headache pathway with ED colleagues and looked at diabetes and superficial thrombophlebitis.

Our biggest success in 2017/18 is the introduction of the Eat, Drink, Move initiative. This is part of a national initiative linked to #endpjparalysis and #last1000days looking at how we can value every moment of our patient's time while they are in hospital. The initiative is headed up nationwide by Professor Brian Dolan and has taken on great momentum over recent months. It is important because 65% of patients admitted to hospital are 65 or older , and a person over 80 who spends 10 days in a hospital bed will lose 10% of muscle mass. This could be the difference between going

home and going to a home. UHS has taken on this concept and following permission from the Heart of England NHS Trust have used their ’Eat, Drink, Move‘ campaign focussing on the importance of eating and drinking well while in hospital. We are working closely with the dieticians and Serco to ensure this is happening.

The initiative also links to the Red to Green days and SAFER ward rounds, ensuring that a patient’s hospital journey is moving forward at all times. SAFER is a bundle of interventions to ensure better discharge, including all patients having a daily senior review in the morning; all patients being given an expected discharge date and clinical criteria for discharge; efficient patient flow ensuring patients are in the right place at the right time; patients are sent home when it is safe and timely to do so; and any patients in for extended lengths of stay are reviewed by a senior multidisciplinary team to work to get them home.

Linked in to this, in 2017 the Trust became one of five pilot sites for the Helpforce initiative. This is a national company which is developing the invaluable role volunteer’s play in hospitals to enhance patient experience. At UHS we already have an established, extensive volunteer service that undertakes a huge variety of roles. In 2016/17 we participated in the SOMOVE study, looking at the feasibility of training volunteers to encourage patients to mobilise and prompt them to complete bed and chair exercise programmes. This study was highly successful and demonstrated a significant increase in the activity levels of those patients involved.

Priorities for improvement 2018/19

In order to determine our priorities for improvement we have consulted with a number of stakeholders including our Trust quality committee, our Trust Board, our Trust executive committee, commissioners and patient representatives (through our Healthwatch group), and our governors. The quality committee on behalf of the board approved the priorities and there will be regular reports on progress to the committee throughout the year.

We have developed this year’s Quality Improvement Framework (appendix one) to ensure that our quality priorities are aligned with feedback from patient surveys and complaints, as well as incidents. We have used our progress against last year’s priorities to help decide which priorities need continuing focus in 2018/19. Priorities are built around our ambitions and intention to deliver well-led, 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 2018/19 quality priorities.

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Patient experience

Priority one: Improving the experience of discharge

Why we have chosen this priority

Getting discharge right is a challenge facing most acute providers. The multi-agency and multi-faceted nature of the discharge process combines to cause delayed transfers of care, avoidable hold ups, and other process issues that keep patients from going home, keep beds filled when there is no longer a clinical need for the patient to be in them, and ultimately impacts on a patient's overall experience of care.

Many of the problems are outside of our control, with the lack of availability of ongoing community and residential care the biggest factor in delayed transfers of care at UHS. But there are things within the Trust that we know we can continue to improve.

We know from our patients that our discharge experience requires improvement. In the latest National Inpatient Survey results, published in 2017, the Trust underperformed when compared to other Trusts. In particular, patients reported concerns about:

- Discharges being delayed due to a wait for medicines and / or patient transport
- Information given to patients about their medication and side effects to watch out for
- Patients reporting that they knew what to expect regarding their care after leaving hospital
- Family members or carers being given the appropriate amount of information about a patient's condition and ongoing care needs

We also know that sometimes we do not work as effectively with our care and nursing home colleagues as we could. This has an impact on the quality of discharge when sending residents back to their care home. This is evidenced by the increasing number of concerns raised to us by care and nursing homes about poor discharge.

Finally, we recognise that our systems and processes do not always work towards an effective and timely discharge. Delays in review, dispensing medications, and arranging transport all create avoidable hold-ups in getting patients home. Because of these factors, we will continue our focus on discharge in 2018/19 to ensure we deliver the best possible discharge experience for our patients.

What are we trying to achieve

Improving patients' experience of discharge is an important part of our work to improve the efficiency, safety, and timeliness of the discharge process itself. We want our patients, and their relatives and carers, to be fully informed and involved in their discharge from hospital. There are many varied but related factors that impact upon the experience of discharge, and our work ranges across a number of different areas outlined below.

Great discharge starts at admission, and UHS is working on embedding the SAFER patient flow initiative to improve the safety and effectiveness of our discharge process.

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A core element of SAFER is ensuring that patients know what is wrong with them, what is going to be done, what they need to go home, and when they can expect to go home.

To actively encourage patients to be involved with their discharge planning, we will provide patients with a checklist to start thinking about what they will need to ensure a timely discharge. The checklist will be included in a new inpatient welcome booklet that will provide patients with information about their stay. The booklet will encourage patients to start thinking about, and planning for their discharge home from the day they are admitted. By thinking ahead we can work to remove avoidable delays. This could range from ensuring that transport is arranged, asking friends or relatives to ensure there is food in the fridge and the heating is on at home, to being clear on medications and their side effects.

We know some patients do not have family support, so we will be developing a discharge volunteer role. These volunteers will support patients in preparing and planning for discharge by ensuring that all of the patient's questions have been answered and all arrangements have been made to enable a safe and positive discharge.

We will also be looking to improve our collaborative working with local care and nursing homes, to ensure a coordinated and joined up approach to discharge to homes. This will include a number of engagement activities, including a care home survey to help triangulate key barriers and obstacles to smooth and safe discharge back to care, nursing, and residential homes.

We will also improve our nursing discharge checklist to ensure patients receive the right information about their medication. This will enable patients to leave the hospital knowing what medication they have been given, how to take it, and what side effects to look out for.

Continue to work with the wards to ensure Complex Discharge Policy is being followed appropriately
Continue to develop the DO, SDO and CHC team to be able to further support patients with timely and relevant information regarding their discharge plans.

Finally, we know that patients want to get home quickly on the day of their discharge, and we are working to ensure that for patients for whom it is safe to do so, we discharge home before lunch. This will require more efficient working and collaboration between clinical teams, ward staff, and pharmacy, but will not only improve patient experience but increase our flow and capacity.

What will success look like

Our aim is for every patient to leave hospital in a timely and safe manner, knowing what has been done, what to look out for, and who to contact if they have any questions. We want our patients to leave having been fully informed and prepared for their discharge, and for the discharge process itself to enhance and not detract from their overall experience of care.

How we will monitor and measure progress

We will continue to monitor patient feedback through the annual National Inpatient Survey, as well as locally through our own inpatient survey. We will focus questions on how prepared patients feel about their discharge and how informed they have been kept about the process. Oversight of performance will be through our quality governance steering group, Trust executive committee, and ultimately Trust Board.

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As we continue to embed SAFER, we will track how well we are meeting the estimated day of discharge and how successfully we have removed avoidable obstacles to sending patients home.

We will thematically review calls to our medicines helpline to ensure that patients are being given the right information about their medications when they are discharge.

We will continue to work with local care homes and our commissioners to ensure that our work is collaborative, effective, and joined up, and that discharges to homes are safe, and will monitor the number of concerns being raised to us.

Priority two: Improving end of life care

Why we have chosen this priority

We have outline recent achievements in end of life care in priority seven, however there are some significant areas where we acknowledge we still need to improve.

We are committed to a standard whereby any person in our care thought to be approaching their last days of life will receive individual care based on their needs, delivered with compassion and sensitivity by our staff. We also aim to improve the regular and effective communication between staff and the dying person and those close to them.

We know from patient feedback that we usually get it right:

”All the staff from resus/majors and especially AMU1 were so caring & patient. They took time to listen to our Dad's wishes & listened to the family”.

“The doctor on duty the morning my mother died had such a lovely caring attitude over the phone when he informed me her passing was near. Thank you for all everyone did in the short time Mum was with you”.

“The care received was exceptional. We could not have asked for more and the person concerned died in peace, with dignity and in the most tranquil way possible”.

But there are still some areas where our feedback prompts us to improve:

Communication:

”We all knew what the outcome was going to be but when we ask to see the doctor we were left waiting a very long time if they came at all. I told them I lived in Exeter but every time I phoned I was told the same thing, that he had a quiet night which was not always the case. I feel very strongly that they could have given us more time and information”.

Education:

“I feel that the staff had a serious shortfall and needed a lot of training to be able to deal satisfactorily with end of life. It is necessary for staff to understand all aspects about their patient

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and try to understand the emotional distress that families are suffering. It is important the relatives have confidence that staff are in control of the situation and have the knowledge to deal with it".

Meeting the needs of others:

"When it was apparent that Dad was near the end, it would have been nice for him to have been in a separate room so we could have talked without the noise of the other patients".

We believe these are priorities which must be embraced as part of a continuous learning cycle within the organisation.

What we are trying to achieve

Continuing the work started in 2017/18 we aim to continue to improve our care of dying patients and their families and the way this is communicated and documented. We will work towards better formal and informal mechanisms to engage with and hear the voice of patients and families, including families who have been bereaved. This will be achieved through:

- A complete revision of the UHS Individualised End of Life Care Plan including the development of a workable electronic version which can be shared with patients (if well enough) and their families, ideally with a section which can be completed by the families.
- Working with bereaved relatives to learn from their experiences.
- The development of both role specific mandated end of life care education and of communication skills training focused on talking to very ill patients and families about uncertainty and dying.
- Auditing the use of the UHS Individualised End of Life Care Plan and using the results to drive continuous improvement in the care of dying.
- Participation in the National Audit of Care at the End of Life 2018/19 which will audit in-patient hospital deaths in April 2018.
- Utilising the PICKER methodology and system to establish a rolling survey for bereaved families to feedback about their experience.
- Continuing the CEO Listening Lunches for bereaved families.
- Harnessing the feedback from complainants, where their perception is that aspects of end of life care could have been better and where possible working with them to improve.

We recognise we need improved compliance with The NICE Quality Standard 144, 'Care of dying adults in the last days of life' (QS 144 Statement 1 "Adults who have signs and symptoms that suggest that they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering." March 2017). This will be achieved through embedding a 'board to ward' focus on recognising the possibility that a patient may be dying.

In response to the audit of case notes of adult patients who died in September 2016 (UHS Dying in Hospital Audit) we will set up a system through which adults in the last days of life will have their hydration status assessed and documented daily and will have a discussion about the risks and benefits of hydration options.

We aim to facilitate more timely and proactive discussions with patients about their end of life care preferences, including preferred place of care and death, and a cross-organisational infrastructure to record this. This will be achieved through:

- Encouraging patients to talk about their preferences and wishes as they approach the end of their lives.
- Up-skilling the UHS workforce through providing increased opportunities to work alongside the Hospital Palliative Care Team and through communication skills training focused on advance care planning and end of life care.
- Working in partnership with providers of community care, commissioners and the Wessex End of Life Care Network to develop a truly cross-organisational IT system.
- The further development of our 'proactive' palliative care approach for example our new ways of working with our emergency department and AMU, our heart failure team and our regional cystic fibrosis team. Early feedback in February 2018 from a patient with cystic fibrosis seen in outpatient clinic was:

  "it was fantastic and really helpful to see palliative care when I am sort of OK and not just when I have been admitted in a crisis."

At UHS we are setting ourselves the goal to ensure that end of life care remains a key priority for the Trust and that we are known as a "dying friendly hospital." This will be achieved through:

- The development of a better corporate structure for End of Life Care within UHS.
- Continuing to raise awareness locally, nationally and further afield, to promote the quality of palliative and end of life care in UHS.
- Collaborative working with our clinical academic colleagues and the Wessex CLARHC.

Last year we worked hard to grow our spiritual care team. We would like to develop the service further and be able to offer comprehensive out of hours service provision by the spiritual care team. By continuing to engage with local religious and faith leaders we will explore ways of meeting the out of hours demand for spiritual care, which mainly relates to the care of dying patients and their families.

What will success look like

1. Staff will be competent and compassionate in caring for patients and their families at the end of life.
2. Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan which will include:

- Personal goals and wishes
- Preferred care settings
- Current and anticipated preferences for symptom management and maintaining hydration
- Needs for care after death

3. Whenever possible patients we will support patients to be cared for in their preferred place of care.

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. Each adult patient will have an agreed individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support.

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

7 The National Care of the Dying Audit results will have improved from the previous National and UHS audits.

How we will monitor and measure progress and where we will report that progress

1 We will record the training delivered and attended as part of role specific mandatory end of life care education across divisions and staff groups to demonstrate we are meeting the Trust's target levels. Education Leads report to the End of life Care Board on their divisional compliance with role specific End of Life care education.

2 We will carry out spot audits of case notes of patients recognised as approaching the end of life monitoring:

- The quality of documentation, including the UHS Individualised End of Life Care Plan.
- Anticipatory prescribing
- Communication between the health care team and patients and their families
- Discussions about care preferences including preferred place of death
- Assessment of hydration and nutrition requirements and each patient's ability to eat and drink.

3 We will participate in the National Care of the Dying Audit and benchmark our performance against the national picture and our previous results.

4 An annual End of Life Care Action Plan will drive our continued quality improvement and be shared quarterly with senior divisional management and executive teams. Reports of progress will be presented through the Trust's End of Life Care Groups to the Trust's executive committee and the Board of Governors. Reports and action plans will be cascaded through divisional and care group mechanisms to ward level.

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Priority three: Shared decision making

Why have we chosen this priority

Shared decision making (SDM) has been defined by the National Shared Decision Making Collaborative as:

'"a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preferences." (NICE 2015)

The shared decision making process is a conversation which takes place in the "black box" of consultation. The conversation draws on each of the participants' skills and expertise. The clinician brings knowledge and insight of diagnosis, pathology, treatment options available, and evidence-based information about risks and outcome probabilities, and the patient brings knowledge and insight of their personal values, outcome preferences, and experience of illness, social circumstances, and attitude to risks. (Coulter and Collins 2011).

There are a number of policy drivers supporting the business case to ensure high quality shared decision making is delivered to patients. These include:

- Benefits in improved allocative efficiency and effective value. These improvements are delivered by mitigating the risk of market failure in the "black box" of consultation from asymmetrical information. (Blomgvist 1991; Gafni, Charles and Whelan 1998; Lee 1995; and Mulley, Trimble, and Elwyn 2012).
- Statutory duties of CCGs and NHS England to promote patient choice and the duty to promote involvement of patients and carers in decisions about prevention and diagnosis of their illness, and in their treatment and care. (Health and Social Care Act 2012 s23(1)(13H) and s25(1)(14U)).
- Statutory duties of providers to deliver person-centred care to patients, including: delivering care and treatment which reflects their preferences; collaboratively assessing needs and preferences for care and treatment with the patient; and supporting patients to make decisions about their care to the maximum extent possible. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2936 reg 9).
- The contractual requirement for providers to deliver against regulation 9, outlined in the NHS Standard Contract (Full Version) Service Conditions SC10.
- The common law duty to obtain informed consent which, following the judicial ruling of the UK Supreme Court, includes the need to present options and risks up-front to patients. There is also a vicarious liability for those who make provision for those services. (Montgomery v Lanarkshire Health Board 2015).

A shared decision making approach to making decisions in healthcare is a departure from traditional, paternalistic, models of healthcare services. Effective delivery of high quality shared decision making needs culture change across whole pathways and services.

Shared decision making may already be happening in the NHS in England, but the quality is not routinely monitored, and there is no national reporting for shared decision making. Contractual levers such as CQUIN present an opportunity for us to promote shared decision making, lead quality improvement and meet our statutory duties.

What we are trying to achieve

NHSE have asked us to carry out the Shared Decision Making CQUIN for two years, with year one focusing on transcatheter aortic valve implantation (cardiology) and neuro-oncology teams.

Our approach to achieving this will begin with planning. A working group has been established to agree on which parts of the pathway (decision nodes) present different treatment options and review tools. An implementation plan will be written and submitted to commissioners which will include a team building and training plan for staff, and agreement of a plan for the mechanisms for gathering, and analysing information about decisions made to ensure evaluation.

We will then undertake a pilot to test and evaluate the use of our SDM tool and further develop it to meet shared patient and service needs.

What will success look like

This is a difficult one to answer. NHSE themselves are unsure of how to measure the success of this CQUIN as effectively it is a culture change. We are expected to survey patients before and after, beginning to use SDM in consultations. However, we will not be penalised if the post-SDM questionnaires show no improvement. The same applies to the staff questionnaires that were administered before and after SDM training, no penalty applies for failing to show an improvement post-SDM training.

We have been advised to try and apply the principles of SDM within consultations with the help of a Decision/Option Grid which states simply benefit/risks of each option. Clinicians in both departments have developed these Option Grids and use them as an aide memoire in consultations. Our aim is to ensure that the patient is fully informed and is a 50/50 partner in decisions involving their healthcare.

How we will monitor and measure progress and where we will report that progress

We produce quarterly reports for NHSE which accomplish that purpose. These reports go to the clinicians involved and to NHSE via contracting. We will also report to our commissioners on progress against our implementation plan including any new patient cohorts.

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Patient safety

Priority four: recognition and management of the deteriorating patient

Why have we 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. Patients who are at risk of deteriorating 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 deterioration is identified is of crucial importance to minimise the likelihood of serious adverse events, including cardiac arrest and death.

Managing the risks associated with the deteriorating patient has been identified as a recurring theme through incident reporting, serious incident investigations and complaints during 2016/17 and 2017/18.

We are committed to building on the significant progress made as described in priority four (2017/18). This progress has meant that we are now in a position to identify our most useful tool to focus on in identifying and preventing deterioration, which is (MEWS). However, although we have used this tool within the Trust since 2000, there are least six different modified MEWS algorithms used across UHS and we currently sit as an outlier across the region for not adopting the Royal College of Physicians National Early Warning System (NEWS) tool.

We recognise now that the identification of deterioration starts in the community, and that systems need to work together with a single scoring system from community through to acute hospitals. To deliver the best quality for our patients we need a standardised assessment method which is streamlined, speaks the same language across primary and secondary care, helps streamline handing over care and which can utilise healthcare resources more effectively. The NEWS tool offers this refinement.

What we are trying to achieve

- Ability to track deterioration more precisely.
- Whole systems approach to deterioration, escalation and response.
- Better outcomes for patients – reduction in higher scoring acuity levels.
- Standardisation of NEWS 2 across Trust.
- Ability to facilitate early detection, diagnosis and escalation.
- Reduction in safety errors.
- Share key patient information.

What will success look like

- One tool across Trust for adult patients (excluding paediatrics and obstetrics).
- Seamless language from community to acute hospitals and back out.
- Ability to track patient's deterioration.

- Research and audit associated with whole systems deterioration.
- Collaborative pan pathway system.
- Evidence based prioritisation of resources.
- Seamless transitions of care.
- Align hospitals within UHS and region.
- Close working with Wessex Academic Health Sciences network to develop this community of practice.

How we will monitor and measure progress and where we will report that progress

- Reduction in patient safety matters associated with deterioration.
- Monitoring of where we have rolled out across UHS.
- Gain feedback from partners.
- Monitoring number of outreach calls and expect an increase.
- Monitor cardiac arrests and expect a reduction

Priority five: Keeping patients eating, drinking and moving

Why have we chosen this priority

Our success with this priority in 2017/18 has established an excellent baseline for continued improvement. In 2018/19 we are looking at developing the role of patient support volunteers who will be multi-trained, enabling them to undertake the roles of mobility volunteers, meal time assistants and time for you involvement. This volunteer role will be enhancing the work undertaken through the Eat drink move initiative.

What we are trying to achieve

Through these projects we hope to continue to promote physical activity of patients in hospital to reduce the risk of deconditioning and the consequences of this.

What will success look like

- Enhanced patient safety
- Improved reports of patient satisfaction
- More timely discharges
- Reduced length of stay
- More timely admissions for other patients
- Reduced laundry costs where hospital gowns/pyjamas are used

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In addition, it would lead to enhanced mental wellbeing of people as they are encouraged to take greater responsibility for their own health and become active participants in their personal health journey. Many more of their red days would be green days and in the last 1,000 days, each and every day counts.

We will be monitoring length of stay across the areas taking up this initiative, as well as looking at patient experience, the percentage of patient up and dressed in their own clothes, pressure ulcer and falls rates and rates of discharge to own residence. In addition to changes in these outcomes, we will be looking for a change in culture, where patients being dressed in their own clothes and moving around the ward is the norm.

The initiative will be rolled out area by area with medicine for older people (MOP) and acute medical unit (AMU) already starting, and surgery, orthopaedics and stroke anticipated to follow April 2018. Training sessions will be offered to all ward staff to encourage them to embrace the change.

Success will be a change in culture so that all patients who are well enough are up, dressed and moving around the ward safely. All patients will be offered snacks and drinks at intervals throughout the day and there will be a variety that will meet the patients' dietary needs. It is hoped there will be an improvement in the outcome measures mentioned above which will enhance the improvements made with the roll out of the SAFER board rounds and red to green days.

How we will monitor and measure progress and where we will report that progress

Data has been collected on MOP prior to intervention to gather a baseline. This was monitored monthly for five months and is now reviewed every quarter. The intention is to gather data pre implementation in all areas so we can track the improvement. This will be reported to the Eat drink move working party and the clinical area. By November 2018 we will produce a report that will summarise the improvements made across the different areas with the roll out of this initiative. It is important to remember that Eat drink move is not all about outcome measures but rather an improved experience for the patient which will become part of the embedded culture at UHS.

Priority six: Delivery of the national safety strategy for maternity care

Why have we chosen this priority

Maternity is different from other clinical specialities as most pregnant women are generally healthy and pregnancy is a natural physiological process that usually culminates in the birth of a healthy baby.

We receive excellent feedback for our maternity services via our Friends and Family feedback:

"Very happy with all the midwives. There is a strong team of staff. They should all be very proud of themselves. Very attentive and extremely helpful and informative with everything. Midwives deserve a pat on the back. The team made me feel confident and helped me massively with the right techniques".

"Cannot thank all the staff enough for being amazing, helping me deliver the baby and providing extra support with breast feeding. Thank you all so much".

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"Great care from labour ward HDU and Lyndhurst, including all staff I was in contact with. Very supportive and understanding".

"All staff absolutely fantastic. You would not have known the ward was full. Took the time to call us all by name at all times. We had an exceptional, caring experience from start to finish".

"The entire team for my c-section was professional, supportive and absolutely wonderful. The post care was exceptionally good. Many thanks".

However we remain aware of the potential for safety issues for this patient cohort. The vast majority of deaths and injuries in maternity care are unexpected outcomes, but where a death or injury could have been avoided the consequence for both families and the professionals involved can be devastating. Trusts that are able to demonstrate compliance with recommendations made with the Maternity Safety Strategy and NHS Resolutions 10 criteria, are likely to deliver safer maternity services and may be expected to have fewer cases of brain injuries or other harm which can lead to negligence claims.

Maternity safety has always been a fundamental driver within maternity at UHS.Since 2015 we have signed up to the Department of Health's (DoH) ambition to halve the number of stillbirths, neonatal deaths and brain injuries that occur during or soon after birth, as well as maternal deaths, by 2030. This forms part of our sign up to safety initiative. We have attended all of the quality improvement workshops with NHS Improvements and we have an agreed Quality Improvement plan in place.

What we are trying to achieve

Safety incidents within maternity services have lasting impacts on women their families and staff. Therefore the service recognises that in the coming year there needs to be a greater focus on leadership, culture in learning, reviewing data and good review processes alongside openness, honesty and good communication. We are committed to providing a focus on patient safety, professional and public accountability, whilst acting responsibly when things go wrong. The maternity service understands that it is important that the response to all incidents is one of openness and learning with a drive to reduce future risk for patients, support for patients, staff and anyone who may suffer as a consequence.

In addition we plan to continue to drive quality improvement by becoming part of the Wessex Maternity Community of Practice to provide a regional forum to profile QI and patient safety in support of Local Maternity Systems in Wessex.

What will success look like?

All women, babies and families across maternity care settings will have a safe, reliable and quality healthcare experience. We will have created the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system, including SHIP collaborative. We will

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also be contributing to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

How we will monitor and measure progress and where we will report that progress

The maternity service is developing an action plan to ensure monitoring and deliver of all of the separate elements highlighted within the November 2017 Safer Maternity Care National Maternity Safety Strategy Progress and Next Steps Report, including the 10 criteria for the CNST discount. The action plan will be monitored and scrutinised. We plan to deliver this action plan by end of May 2018. Monitoring will be lead nationally by the Maternity Transformation Programme and locally monitored through the UHS Women and Newborn Governance Group with oversight from the divisional management team (DMT) and QGSG as requested.

Compliance with the criteria will be assessed through a verification process that will be completed by the end of June 2018.

Priorities for clinical effectiveness

Priority seven: antimicrobial resistance (AMR)

Why have we chosen this priority

In Europe 25,000 people die each year as a result of hospital acquired infections from five key resistant bacteria. Globally a failure to address the problem of bacteria resistance could cost 10 million deaths by 2015, at a financial cost of 366 trillion.

Total antibiotic consumption in hospitals based in England has been increasing steadily and these increases in prescribing ultra broad-spectrum agents have coincided with increased antibiotic resistance in the UK. Antimicrobial resistance (AMR) is the ability of micro-organisms to withstand antimicrobial treatments such as antibiotics. This resistance occurs as bacteria, for example, adapt and find ways to survive the effects of an antibiotic, meaning the drug no longer works to fight the infection it was previously used to treat. The more an antibiotic is used, the more bacteria become resistant to it.

The consequences of AMR include increasing treatment failure for the most commonplace infections, such as urinary tract infections and decreasing the treatment options available where antibiotics are vital, such as during cancer treatment when patients are prone to infection. Without effective antibiotics, even minor surgery and routine operations could become high risk procedures if serious infections cannot be treated

The world's largest healthcare incentive scheme to prevent the growing problem of antibiotic resistance was launched last year. The programme offers hospitals incentive funding worth up to £150 million to support expert pharmacists and clinicians review and reduce inappropriate prescribing. Providers will also receive payments for gathering and sharing evidence of antibiotic consumption, and review within 72 hours of the beginning of treatment.

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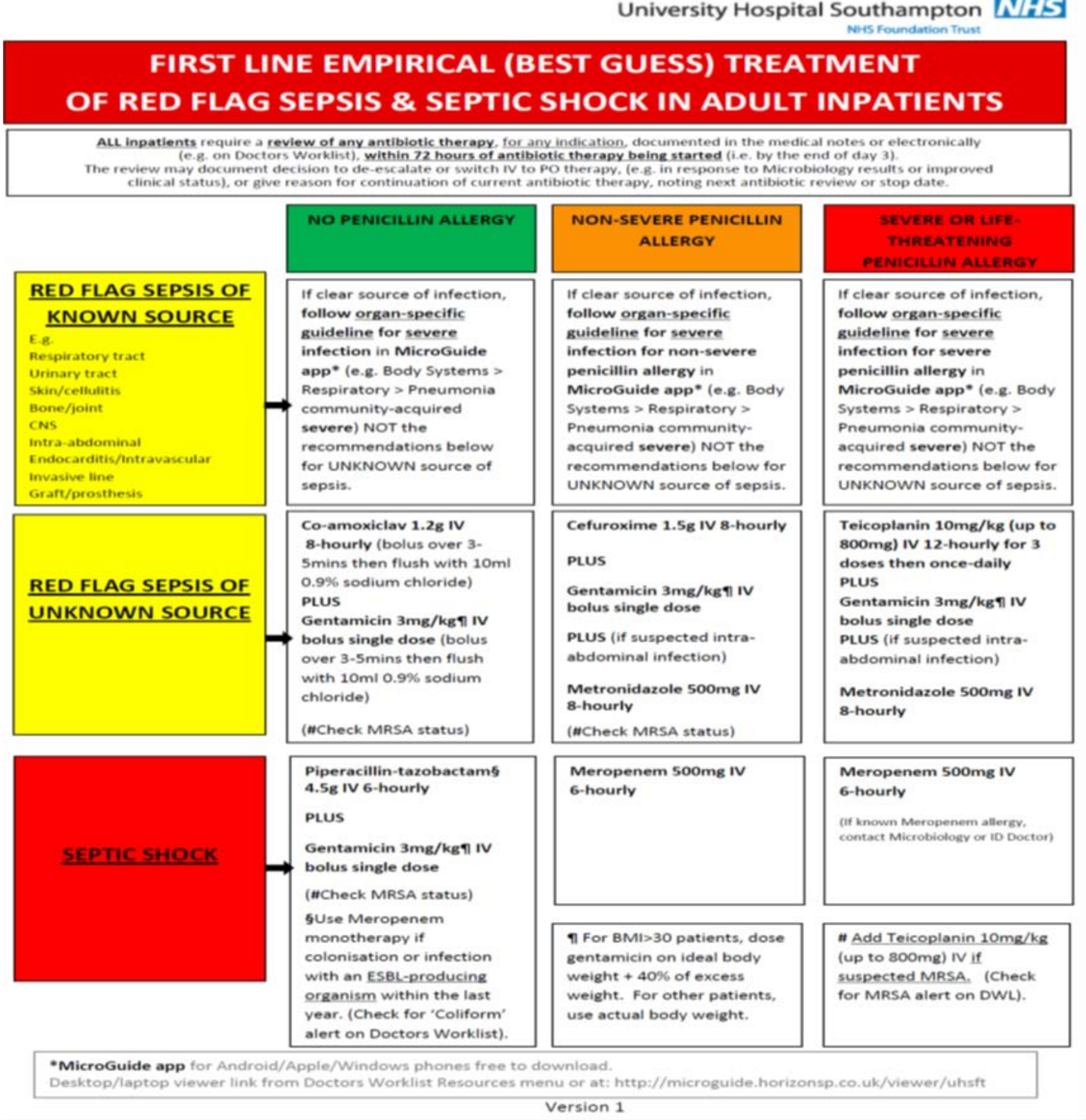
Given the measurable impact to our patients and the additional financial resource available to support us delivering we have chosen this as a priority this year to ensure our practice is exemplary.

What we are trying to achieve

Our ultimate aim is driven by the 2020 UK AMR 'goal' to cut inappropriate prescribing of antibiotics by 50%. Our approach to achieving this is via:

- Face-to-face teaching targeting junior medical staff.
- Regular presentations at consultant meetings for education purposes.
- Ongoing antibiotic stewardship ward rounds.
- Revision of Trust sepsis guidelines to bring them in line with the most current evidence.



University Hospital Southampton NHS
NHS Foundation Trust

FIRST LINE EMPIRICAL (BEST GUESS) TREATMENT OF RED FLAG SEPSIS & SEPTIC SHOCK IN ADULT INPATIENTS

ALL inpatients require a **review of any antibiotic therapy**, for any indication, documented in the medical notes or electronically (e.g. on Doctors Worklist), **within 72 hours of antibiotic therapy being started** (i.e. by the end of day 3). The review may document decision to de-escalate or switch IV to PO therapy, (e.g. in response to Microbiology results or improved clinical status), or give reason for continuation of current antibiotic therapy, noting next antibiotic review or stop date.

	NO PENICILLIN ALLERGY	NON-SEVERE PENICILLIN ALLERGY	SEVERE OR LIFE-THREATENING PENICILLIN ALLERGY
RED FLAG SEPSIS OF KNOWN SOURCE E.g. Respiratory tract Urinary tract Skin/cellulitis Bone/joint CNS Intra-abdominal Endocarditis/Intravascular Invasive line Graft/prosthesis	If clear source of infection, **follow organ-specific guideline for severe infection** in **MicroGuide app*** (e.g. Body Systems > Respiratory > Pneumonia community-acquired **severe**) NOT the recommendations below for UNKNOWN source of sepsis.	If clear source of infection, **follow organ-specific guideline for severe infection for non-severe penicillin allergy** in **MicroGuide app*** (e.g. Body Systems > Respiratory > Pneumonia community-acquired **severe**) NOT the recommendations below for UNKNOWN source of sepsis.	If clear source of infection, **follow organ-specific guideline for severe infection for severe penicillin allergy** in **MicroGuide app*** (e.g. Body Systems > Respiratory > Pneumonia community-acquired **severe**) NOT the recommendations below for UNKNOWN source of sepsis.
RED FLAG SEPSIS OF UNKNOWN SOURCE	**Co-amoxiclav 1.2g IV 8-hourly** (bolus over 3-5mins then flush with 10ml 0.9% sodium chloride) **PLUS** **Gentamicin 3mg/kg¶ IV bolus single dose** (bolus over 3-5mins then flush with 10ml 0.9% sodium chloride) (#Check MRSA status)	**Cefuroxime 1.5g IV 8-hourly** **PLUS** **Gentamicin 3mg/kg¶ IV bolus single dose** **PLUS** (if suspected intra-abdominal infection) **Metronidazole 500mg IV 8-hourly** (#Check MRSA status)	**Teicoplanin 10mg/kg (up to 800mg) IV 12-hourly for 3 doses then once-daily** **PLUS** **Gentamicin 3mg/kg¶ IV bolus single dose** **PLUS** (if suspected intra-abdominal infection) **Metronidazole 500mg IV 8-hourly**
SEPTIC SHOCK	**Piperacillin-tazobactam§ 4.5g IV 6-hourly** **PLUS** **Gentamicin 3mg/kg¶ IV bolus single dose** (#Check MRSA status) §Use Meropenem monotherapy if colonisation or infection with an ESBL-producing organism within the last year. (Check for 'Coliform' alert on Doctors Worklist).	**Meropenem 500mg IV 6-hourly**	**Meropenem 500mg IV 6-hourly** (If known Meropenem allergy, contact Microbiology or ID Doctor)
		¶ For BMI>30 patients, dose gentamicin on ideal body weight + 40% of excess weight. For other patients, use actual body weight.	# Add Teicoplanin 10mg/kg (up to 800mg) IV if suspected MRSA. (Check for MRSA alert on DWL).

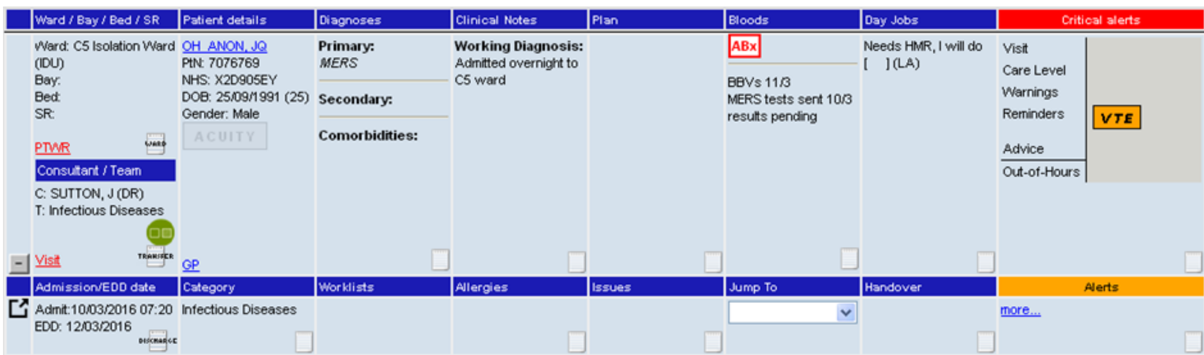
***MicroGuide app** for Android/Apple/Windows phones free to download.
Desktop/laptop viewer link from Doctors Worklist Resources menu or at: http://microguide.horizonsp.co.uk/viewer/uhsft

Version 1

- e-prescribing course lengths (e.g. "trimethoprim for 3 days") to be embedded in the e-prescribing system to guide prescribers. Using e-prescribing to support appropriate durations

with new default options for oral antibiotics to encourage shorter course lengths and prompt patient review.

- Pre-72 hour antibiotic review prompt on Doctors' Work list.



ABx	Patient has started antibiotics, review will be required in the next 48 hours.
ABx	48 hours have elapsed since prescription and review must be completed.
ABx	Review has been completed and patient is still on antibiotics.
ABx	Review has been completed and patient is no longer on antibiotics.

- Pharmacist-led audits of pre-72 hour antibiotic reviews.

- A business case to be submitted to senior Trust leaders for additional nursing/pharmacy/data analyst support.

- Appoint a Band 6 nurse to a new antimicrobial stewardship specialist role to lead on nursing engagement with AMS.

- Appoint a part time data analyst to support pharmacists in data surveillance and antibiotic consumption data submission to Public Health England.

- Micro Guide app to be updated to reflect revised UHS sepsis guideline.

- Revised maternity services sepsis guidelines to be generated.

What will success look like

The percentage of UHS patients who receive a dose of antibiotics on any given day will have decreased further and the prescription of ultra-broad spectrum antibacterial agents without appropriate indication will have stopped. The 'just in case' antibiotic prescribing culture will no longer be seen. 90% of UHS patients will have had a documented antibiotic review within 72 hours and the percentage of UHS patients who receive a dose of an antibiotic on any given day will have dropped to 40%.

Standardised mortality for pneumonia, urinary tract infections and septicaemia will all continue to fall.

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How we will monitor progress

We will be compliant with the 2018/19 CQUIN for AMR.

Priority eight: Every outpatient encounter adds value

Why have we chosen this priority

UHS sees in excess of 500,000 outpatient (OP) appointments per year and as clinical practice develops more and more patients need to be followed up, such as ophthalmology.

There is evidence already in existence that shows that OP services can transform to ensure every OP encounter adds value, is more responsive, produces less inappropriate visits to hospital and ensures patients are signposted to the right clinician at the right time and right place.

Transforming the patient experience will rely on closer integration, planning and co-ordination of services across a spectrum of clinical settings at national, regional and local level.

Better access to clinical decision making support and specialist advice will significantly impact patients getting the right treatment and removing unnecessary steps from their journey. Maximising the roles of the wider multidisciplinary team to help achieve this will be crucial to ensuring the patient has access to the right clinician first time, and in removing unnecessary delays in their outpatient journey. Whilst some new roles have been adopted or extended this has not been at scale. Extending the range of training and development to opportunities will be essential in delivering a modern workforce, which ensures the extended multidisciplinary teams have the skills, confidence and capacity to work to the full range of their competencies.

Our sustainability and transformation partnerships (STPs) have signed up to reduce outpatient appointments by 20% but increasing the value of every encounter.

What we are trying to achieve

By following up patients based on clinical need rather than set periods of time we hope to provide better access to care and to avoid outpatient appointments which add no value.

Technology allows us to monitor patient's progress remotely rather than relying on a routine follow-up, which we hope will help reduce the stress and expense of patient travel when this isn't necessary.

What will success look like

- Patients managing their own care and connecting with the hospital via new technology.
- 'Priority patients' getting quicker access to limited resources.
- Pathways redesigned based on patient feedback (patient reported outcomes).
- Every outpatient encounter adding value.

How we will monitor and measure progress and where we will report that progress

- Attendance data will be tracked to measure changes in pathways (and reported to the Transformation PMO)

- Patient reported outcomes will be monitored at a service level to understand the impact of new pathways.
- RTT access times will be monitored at a service level.
- Progress will be reported to both our internal and system level Outpatient Transformation Boards.
- Patient surveys will reflect improvement in their experience.

Priority nine: Best use of resources

Why we have chosen this priority

As public-sector organisations NHS Trusts and NHS foundation trusts are expected to demonstrate to their patients, communities and taxpayers that they are delivering value for money, evidencing both efficiency and effectiveness. This is even more important in times of fiscal constraint. NHS Improvement and the Care Quality Commission (CQC) believe there is significant potential for more productive use of resources across the NHS, which would improve quality of care for patients.

In August 2017 NHS Improvement published their Use of Resources assessments document which aims to help patients, providers and regulators understand how effectively Trusts are using their resources to provide high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of operational productivity .

They will do this by assessing how financially sustainable trusts are, how well they are meeting financial controls, and how efficiently they use their finances, workforce, estates and facilities, data and procurement to deliver high quality care for patients. Initially, their approach will focus on acute non-specialist services due to the availability and quality of data in this area.

What are we trying to achieve

- An improved focus on better quality, sustainable care and outcomes for patients.
- For UHS to be proportionate, minimising regulatory burden, and draw on existing data collections where possible.
- To be clear what 'good' looks like – using data from the Model Hospital and Insight Dashboard to help guide improvement in the use of resources and focusing on quality.
- To promote good practice to aid continuous innovation and improvement.

What will success look like

The Use of Resource domain of our next CQC inspection will achieve a rating which is reflective of the organisations' achievements.

PENDING

Conclusion

Response to the Quality Account from Southampton City and West Hampshire Commissioning Groups

Response to the Quality Account from our lead governor on behalf of the Council of Governors

Response to the Quality Account from HealthWatch Southampton

Response to the Quality Account from the Health overview and Scrutiny Panel

Statement of directors' responsibilities for the quality report

The quality report must include a statement of directors' responsibilities, in the following form of words:

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:

1. board minutes and papers for the period April 2016 to May 2017
2. papers relating to quality reported to the board over the period April 2016 to March 2017
3. feedback from commissioners dated 8th May 2017
4. feedback from governors dated 3rd April 2017
5. feedback from local HealthWatch organisations dated 1st May 2017
6. feedback from Overview and Scrutiny Committee dated 27th April 2017
7. the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21st June 2016
8. the national patient survey June 2016
9. the national staff survey March 2017
10. the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2017

- 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

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- 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.

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By order of the board

Appendix One

Quality Improvement Framework

University Hospital Southampton NHS
NHS Foundation Trust

Our Quality Improvement Framework 2018 – 2019
The UHS Way

The QIF is a tool to engage and communicate with staff and patients about transformation projects to improve the quality of care planned for 2018/19. 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 QIF 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
- Looking after people is at the centre of everything we do and because of this, and the busy, challenging environment we work in, we recognise that supporting caring for and developing our staff is crucial to delivery of the QIF

University Hospital Southampton NHS
NHS Foundation Trust

Our Quality Improvement Framework 2018 – 2019
The UHS Way

Well Led	• Embedding our values • Best use of resources
Safe	• Recognition and management of the deteriorating patient • Deliver the national safer maternity strategy
Responsive	• Embedding SAFER bundle and improving experience of discharge • Keeping patients eating, drinking and moving
Effective	• Every outpatient encounter adds value • Antimicrobial resistance
Caring	• Shared decision making • Improving end of life care

Appendix two: Quality performance data

Two of the agreed metrics used last year are no longer available as we do not collect this information any more:

- Patient Safety Indicator - Falls Assessment tool
- Nutrition % of patients with nutritional screening in 24hrs (as average of monthly %)

For the latter we have replaced it with: Nutrition- % Patients with a care plan in place.

All the Core Indicators are updated with the most recent publications from NHS digital/NHS England/NHS Improvement/Gov.uk with the exception of emergency readmissions which has still not been updated by NHS digital – their data portal says "this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review".

Patient safety indicators					
	2014/15	2015/16	2016/17	2017/18 YTD (Jan Inclusive)	2017/18 benchmark
Serious Incidents Requiring Investigation (SIRI)	35	54	63	25	25 for whole year
Never Events	2	7	3	1	0
Healthcare Associated Infection MRSA bacteraemia reduction	5	3	1	1	0
Healthcare Associated Infection Census" (as average of monthly %)	357%	363%	361%	322%	100%
Healthcare Associated Infection Clostridium difficile reduction	37	35	38	27	43 for whole year
Avoidable Hospital Acquired 33* Grade III and IV Pressure Ulcers	26	36	11	12	30 for whole year
Falls - Avoidable Falls	9	3	0	5	1 a month. 12 for whole year
Thromboprophylaxis (VTE) % Patients Assessed (CQUIN)	95.35%	95.18%	94.87%	93.77%	>=95%
Thromboprophylaxis (VTE) Pharmacological prophylaxis (as average of monthly %)	99.46%	97.75%	95.19%	93.55%	>=95%

	Apr - Sep 2015	Oct 2015 - Mar 2016	Apr - Sep 2016	Oct 2016 - Mar 2017
UHS				
Rate Incidents per 1000 admissions	31.50	41.40	44.50	43.90
Number Incidents	5911	7930	8519	8594
Number Severe Harm	54	74	54	47
% Severe harm or death	0.91%	0.93%	0.63%	0.55%
Highest Scores (Non-Specialist Trusts)				
Rate Incidents per 1000 admissions	74.70	75.90	71.80	69.00
Number Incidents	12080	11998	13485	14506
Number Severe Harm	89	94	98	92
% Severe harm or death	2.92%	2.04%	1.73%	2.13%
Lowest Scores (Non-Specialist Trusts)				
Rate Incidents per 1000 admissions	18.10	14.80	21.10	23.10
Number Incidents	1559	1499	1485	1301
Number Severe Harm	2	0	1	1
% Severe harm or death	0.07%	0.00%	0.02%	0.03%
National Ave (Non-Specialist Trusts)				
Rate Incidents per 1000 admissions	39.30	39.60	40.77	41.10
Number Incidents	4647.43	4817.60	4954.89	5122.38
Number Severe Harm	19.98	19.43	18.50	19.29
% Severe harm or death	0.47%	0.43%	0.40%	0.40%

NB: UHS is part of the acute (non specialist) cluster now (1 of 136 organisations) – the Acute Teaching Trusts cluster ended in 2014 when the NRLS had an internal reconfiguration of how they benchmark organisations.

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Cdiff per 100,000 bed days

Table 8b: Financial year counts and rates of C. difficile infection (patients aged 2 years and over) by acute trust – Trust apportioned cases only

	201314	201415	201516	201617
UHS	9	11.8	9.7	9.8
National Average	14.7	15	14.9	13.2
Highest Trust Score	37.1	62.6	67.2	82.7
Lowest Trust Score	0	0	0	0
Lowest Trust Score (non-zero)	0.9	2.8	0.8	1.2

MRSA screening

2016/17	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	201617
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%
2017/18	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	201718
Eligible patients	16173	15967	15505	4554	52199
Screened for MRSA	56735	37888	54167	19330	168120
% achieved	350.80%	237.29%	349.35%	424.46%	322.08%

Patient experience indicators					
	2014/15	2015/16	2016/17	2017/18 YTD (Jan Inclusive)	2017/18 benchmark
National Friends & Family Test Response Rate					
Emergency department	37.94%	10.76%	6.21%	6.67%	>10%
Inpatients	25.15%	21.74%	20.28%	18.36%	>20%
Maternity		23.38%	29.07%	32.01%	>20%
Percentage of patients recommending UHS to their friends & family					
Emergency department		92.26%	95.42%	97.06%	>90%
Inpatients		96.16%	96.68%	97.10%	>90%
Maternity		95.81%	97.66%	97.50%	>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 %)	13.47%	13%	11.34%	15.56%	<=15%
Same Sex Accommodation (Non clinically justified breaches)	10	5	3	99	20 a month
Nutrition: % Patients with a care plan in place	88%	82%	80%	82%	

Staff FFT					
Staff Recommends Care %	2016/17 Q1	2016/17 Q2	2016/17 Q4	2017/18 Q1	2017/18 Q2
UHS	91%	92%	92%	93%	93%
Highest Score	100%	100%	98%	100%	100%
Lowest Score	50%	44%	44%	55%	43%

Inpatient Survey		
	2015-16	2016-17
UHS	71.70	67.40
Average (All Providers)	69.64	68.14
Lowest Score (All Providers)	58.90	60.00
Highest Score (All Providers)	86.20	85.20

RHM	RESPONSE RATE														
Emergency department															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	19.60%	14.30%	8.94%	4.81%	5.23%	9.52%	6.02%	4.39%	1.88%	15.50%	3.43%		11.96%	6.21%	6.70%
National Average	21.15%	14.55%	13.05%	12.72%	12.99%	13.19%	12.18%	12.45%	12.66%	12.94%	12.41%		14.90%	10.62%	10.48%
Highest Trust	100.00%	45.12%	44.57%	47.22%	44.43%	45.31%	45.03%	45.46%	44.85%	47.15%	58.73%		100.00%	100.00%	100.00%
Lowest Trust	0.03%	0.18%	0.02%	0.19%	0.07%	0.00%	0.23%	0.46%	0.00%	0.30%	0.00%		0.00%	0.00%	0.00%
Inpatient and day case															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	22.66%	20.64%	21.22%	22.54%	20.79%	19.11%	19.87%	17.30%	20.76%	18.23%	16.23%		21.74%	19.73%	18.40%
National Average	20.51%	26.08%	24.43%	24.43%	25.77%	25.12%	24.26%	24.32%	26.08%	25.97%	24.27%		23.87%	17.29%	17.37%
Highest Trust	100.00%	100.00%	125.00%	100.00%	100.00%	100.00%	96.67%	100.00%	472.73%	124.49%	100.00%		100.00%	100.00%	100.00%
Lowest Trust	0.06%	4.16%	4.66%	4.56%	4.75%	3.27%	1.70%	3.83%	3.10%	3.10%	2.61%		0.00%	0.00%	0.00%
RHM	POSITIVE														
A&E															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	94.53%	92.27%	94.04%	93.73%	93.79%	96.34%	94.82%	96.17%	96.61%	97.14%	96.94%		93.74%	95.42%	97.06%
National Average	90.82%	88.14%	87.07%	84.91%	85.95%	86.01%	86.04%	87.02%	87.29%	86.74%	86.35%		87.74%	73.09%	72.56%
Highest Trust	100.00%	100.00%	100.00%	100.00%	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%	45.75%	46.25%	56.76%		33.33%	42.75%	45.75%
Inpatient and day case															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	95.81%	83.04%	96.10%	96.48%	96.35%	96.23%	97.19%	96.83%	96.84%	97.13%	97.30%		92.92%	96.68%	97.07%
National Average	92.61%	95.71%	95.61%	95.70%	95.79%	95.60%	95.54%	95.75%	96.08%	95.85%	95.74%		95.11%	65.71%	64.93%
Highest Trust	100.00%	100.00%	100.00%	100.00%	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%	75.89%	71.97%	64.29%		61.40%	66.86%	64.29%

RHM	NEGATIVE														
A&E															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	2.10%	2.72%	3.12%	2.95%	3.03%	1.89%	2.49%	1.59%	1.81%	1.31%	1.65%		2.54%	2.24%	1.42%
National Average	4.15%	6.09%	6.89%	8.37%	7.62%	7.61%	7.63%	7.01%	6.99%	7.22%	7.60%		6.37%	5.31%	5.27%
Highest Trust	29.13%	26.11%	34.78%	37.23%	37.69%	33.31%	41.03%	32.28%	32.97%	31.03%	31.82%		37.23%	41.03%	32.97%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%
Inpatient and day case															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	1.33%	0.88%	1.41%	1.07%	1.08%	1.23%	0.75%	0.79%	0.72%	0.77%	1.14%		1.18%	1.00%	0.86%
National Average	3.30%	1.43%	1.48%	1.47%	1.44%	1.56%	1.53%	1.51%	1.37%	1.52%	1.58%		1.80%	1.24%	1.23%
Highest Trust	21.05%	9.34%	10.00%	11.11%	10.55%	13.01%	8.59%	9.54%	17.78%	12.50%	26.19%		21.05%	13.01%	26.19%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%

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Patient outcome indicators					
	2014/15	2015/16	2016/17	2017/18 YTD (Jan Inclusive)	2017/18 benchmark
Emergency readmissions, within 28 days (as average of monthly %)	10.40%	10.10%	10.59%	10.83%	<=10%
Hospital Standardised Mortality Rate (HSMR) University Hospital Southampton NHS Foundation Trust	105.19	102.5	95.4	95.57	100
Hospital Standardised Mortality Rate (HSMR) Southampton General Hospital	97.64	93.63	88.3	89.91	<100
Hospital Mortality Rate (%)	1.76	1.63	1.7	1.7	1.61
Patient Reported outcome measures. PROMS hip replacement data contributed	74.10%	86.70%	74.00%	63.00%	>=50%
Knee replacement data contributed	105.90%	103.90%	104.40%	70.00%	>=50%

Past annual figures benchmarked against their own FY Benchmark. Ongoing annual year benchmarked against latest month.

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
	January 16 - December 16		April 16 - March 17		July 16 - June 17			
	Value	OD Banding	Value	OD Banding	Value	OD Banding		
UHS	0.96	2	0.95	2	0.94	2		
National Ave	1.00	2	1.00	2	1.00	2		
Highest Trust Score	1.19	1	1.21	1	1.23	1		
Lowest Trust Score	0.69	3	0.71	3	0.73	3		

VTE	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
UHS	95.04%	95.12%	94.61%	95.09%
National Ave (Acute Providers)	95.64%	95.45%	95.57%	95.54%
Highest Trust Score) (Acute Providers	100.00%	100.00%	100.00%	100.00%
Lowest Trust Score (Acute Providers)	80.61%	72.14%	76.48%	63.02%
	Q1 2017/18	Q2 2017/18		
UHS	94.48%	93.47%		
National Ave (Acute Providers)	95.09%	95.19%		
Highest Trust Score) (Acute Providers	100.00%	100.00%		
Lowest Trust Score (Acute Providers)	51.38%	71.88%		

PROMS

	2015/16	2016/17 Provisional
UHS	20.77	20.92
National Ave (All Providers)	20.88	21.32
Highest Trust Score (All Providers)	24.75	25.07
Lowest Trust Score (All Providers)	9.36	10.26

PROMS

	2015/16	2016/17 Provisional
UHS	15.06	16.42
National Ave (All Providers)	16.20	16.38
Highest Trust Score (All Providers)	19.97	19.88
Lowest Trust Score (All Providers)	8.33	8.62

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

	January 15 - Dec-15	April 15 - Mar-16	July 15 - Jun-16	October 15 - Sep-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
	Jan 15 - Dec-16	Apr 16 - Mar-17	Jul 16 - Jun-17	

UHS	45.6	50.1	48.1
National Ave	30.3	30.9	31.2
Highest Trust Score	55.9	56.9	58.6
Lowest Trust Score	7.3	11.1	11.2

		2016/17	2017/18 YTD
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway		92.0%	89.7%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		89.6%	89.1%
All cancers- 62 day wait for first treatment from:	Urgent GP referral for suspected cancer	83.0%	86.3%
	NHS Cancer Screening Service referral	96.1%	93.8%
C.difficile variance from plan		-11.6%	-19.4%
Maximum 6-week wait for diagnostic procedure		99.3%	98.5%

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Appendix three: CQUIN data

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 and inpatients	National	£174,000
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	£174,000
CCGs	Staff health and wellbeing - staffing	To achieve an improvement in two of the three NHSE annual staff survey questions using a baseline survey responses from the 2016 staff survey. Need to improve by 5% points in two of the following questions. 9a = Does your organisation take positive action on health and wellbeing 9b – In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	National	£233,000
CCGs	Staff health and 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	£233,000
CCGs	Staff health and wellbeing – flu vaccine	Achieve a 70% uptake on the flu vaccine for frontline clinical staff	National	£233,000
CCGs	Antimicrobial Stewardship 4a	Reduction in antibiotic consumption per 1,000 admissions	National	£175,000
CCGs	Antimicrobial Stewardship 4b	Empiric review of antibiotic prescription	National	£175,000
CCG's	E-Referral	Deliver directly-bookable services to all patients referred from GP and community services	National	£688,000

CCG's	Advice & Guidance	To set up and operate A&G services for non urgent GP referrals, allowing GP's to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative. A&G in the context of this CQUIN refers to structured, non urgent, electronic A&G provided via telephone, email or an online system	National	££698,000
CCG's	Improving services for people with mental health needs who present to A&E	Having identified the top 0.25% of people who attend emergency department (ED) most frequently, review and identify the cohort for whom mental health interventions would have the greatest impact. Review and develop a joint care plan for each person within this cohort including a focus on preventing avoidable ED attendances. Strengthen existing/develop new services to support this cohort. Reduce the number of attendances to ED frequent attendees by 20% ensuring this reduction is sustainable. Also improving the quality of ED diagnostic coding	National	£698,000
CCG's	Improving proactive and safe discharge	Map and streamline existing discharge pathway, roll out protocols in partnership across local systems (acute, community, NHS care home providers). Establishing a process for collection of baseline for responsiveness of community services to provide discharge to assess services. Undertake clinical audit of discharge to assess to ensure appropriate referrals We need to agree trajectories which reflect impact of implementation of local initiatives for: Achieving 70% national target for discharge to usual place of residence (without increasing admissions)	Local	£698,000
CCG's	Sustainability & Transformation Plans	Reinforcing the critical role providers have in developing and implementing local STP's. Encouraging providers and commissioners to work together to achieve financial balance and to complement the introduction of system control as STP Level	Local	£2,792,000

NHSE	Medicines Optimisation	Transitioning to new arrangements for the use and management of medicines commissioned by specialised services. Adoption of best value generic/biologic products of 90% new patients and 80% of existing patients	Local	£722,000
WHCCG	Shared Decision Making	To develop a condition specific resource to ensure that all treatment options are discussed with patients. TAVI and neuro to be used for the purpose of these years CQUIN. Training staff in how to work with patients to ensure they are aware of the treatment options. Developing a method of recording the data and assessing success	Local	£580,000
WHCCG	Chemotherapy Decision making	Using a specific group of patients, decisions regarding the start and continuation of further treatment to be made in direct consultation of further treatment to be made in direct consultation with peers and then as a shared decisions with the patient, these discussions to be documented. To review our existing chemotherapy practice in relation to the decisions for these groups of patients and put in place procedures to allow for effective and documented peer discussion where not currently in	Local	£190,000
NHSE	Spinal Surgery	To set up a regional documented Spinal MDT with the set-up of a regional policy to manage spinal emergencies including transfer and emergency imaging. All specialised and non specialised spinal surgery to be entered onto the British Spine Registry or Spine Tango and that all elective specialised spinal surgery within the network should have the agreement of the regional MDT either by individual or mandatory audit.	Local	£162,000
NHSE	Enhanced Supportive Care	Identify a cohort of patients newly diagnosed with a terminal illness and record how many are referred to the ESC service at the point of diagnosis. To involve the ESC team from an early stage and use cutting edge evidence based practice in supportive care and technology to improve communication. 80% of the eligible cohort to be referred to the ESC team	Local	£356,000

NHSE	CF Adherence	Extension of randomized trial providing services for cystic fibrosis patients	Local	£271,000
NHSE	HCV	Extension of 2016/17 CQUIN to manage the Infrastructure governance and partnership working across the healthcare providers	Local	£3,914,000
NHSE	SACT	Dose banding principles using local and national dose banding tables	Local	£309,000
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	£162,000
NHSE	Dental	100% attendance at Oral Surgery Network meetings	Local	£25,000
NHSE	Dental	Reviewing and improving as required the standard and appropriateness of dental referrals into secondary care. The work will be fed through the MCN and recommendations/improvements rolled out across the network group as appropriate. It is also a requirement that this should include an undertaking of an audit of referrals, including the quality of these referrals, , received to identify whether levels of treatment complexity are appropriate for secondary care services	Local	£25,000
NHSE	Public Health	Reducing inequalities and increasing overall coverage of screening programs. The CQUIN is relevant to three screening programs Breast, AA and Bowel	Local	£134,000
			Total	**£13,821,000**

Appendix four: Clinical audit and confidential enquiries data

	Total number of NCAs UHS were eligible to participate in (n=57)	Eligible (57)	Participated (55 = 96%)	% Actual cases submitted / expected submissions
1.	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	Continuous 100%
2.	BAUS Cystectomy	✓	✓	Continuous
3.	BAUS Nephrectomy Audit	✓	✓	Continuous
4.	BAUS Percutaneous Nephrolithotomy	✓	✓	Continuous
5.	BAUS Radical Prostatectomy Audit	✓	✓	Continuous
6.	BAUS Female Stress Urinary Incontinence Audit	✓	✓	Continuous
7.	BAUS Urethroplasty	✓	✓	Continuous
8.	Bowel cancer (NBOCAP)	✓	✓	100%
9.	Cardiac Rhythm Management (CRM)	✓	✓	Continuous
10.	Case Mix Programme (CMP)	✓	✓	
11.	College of Emergency Medicine (CEM)- Fractured neck of femur	✓	✓	In progress
12.	College of Emergency Medicine (CEM)- Pain in children	✓	✓	In progress
13.	College of Emergency Medicine (CEM)- Procedural sedation in adults	✓	✓	In progress
14.	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	✓	✓	In progress
15.	Coronary Angioplasty (NICOR)	✓	✓	100%
16.	Diabetes Foot-care	✓	X	Incompatible data systems
17.	Diabetes in pregnancy (NPID)	✓	✓	100%
18.	Diabetes Transition	✓	✓	100%
19.	Diabetes Inpatient Audit (NADIA)	✓	✓	100% one day snapshot
20.	Diabetes (Paediatric) RCPCH NPDA	✓	✓	In progress
21.	Elective surgery (National PROMs Programme) hips and knees	✓	✓	85% continuous
22.	Endocrine and Thyroid National audit	✓	✓	Continuous
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	✓	✓	continuous
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)	✓	✓	
29.	Lung cancer (NLCA) (LUCADA)	✓	✓	Continuous

30.	Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	An average of 1400 cases per year
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 – cancer in children and young adults (0-25 years)	✓	✓	100%
34.	Medical and Surgical Clinical Outcome review programme NCEPOD – Peri-operative diabetes	✓	✓	ongoing
35.	National Adult Cardiac Surgery Audit	✓	✓	In progress
36.	National Audit of Dementia	✓	✓	Continuous
37.	National Cardiac Arrest Audit (NCAA)	✓	✓	100%
38.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - *Secondary Workstream*	✓	✓	continuous
39.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - *Pulmonary Rehabilitation Audit*	✓	✓	continuous
40.	National Comparative Audit of blood Transfusion 2015 Audit of Patient Blood Management in Scheduled Surgery (NCABT)	✓	✓	100%
	National Comparative Audit of blood Transfusion 2016 Audit of Red Cell and Platelet Transfusion in Haematology	✓	✓	100%
41.	National Clinical Audit of Specialist Rehabilitation for patients with complex needs following major injury (NCASRI)	✓	✓	
42.	National Emergency Laparotomy Audit (NELA)	✓	✓	continuous
43.	National Heart Failure Audit	✓	✓	continuous
44.	National Joint Registry (NJR)	✓	✓	90%
45.	National Maternity and Perinatal Audit	✓	✓	100%
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)	✓	✓	
50.	Neurosurgical National Audit programme	✓	✓	
51.	Oesophago-gastric cancer (NAOGC) (NOGGA)	✓	✓	continuous
52.	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	In progress
53.	Renal replacement therapy (Renal Registry)	✓	✓	100%
54.	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP *Clinical patient Audit*	✓	✓	207 expected every quarter
55.	Sentinel Stroke National Audit Programme (SSNAP) SSNAP *Post Acute Organisational Audit*	✓	✓	90%
56.	Serious Hazards of Transfusion (SHOT) UK National haemovigilance scheme *(this is not an audit but an incident reporting database)*	✓	✓	All incidents
57.	UK Parkinson's	✓	X	Data not submitted

Appendix five: 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
- Lymington New Forest Hospital - Surgical patient pathway and outpatients Wellworthy Road Lymington Hampshire SO41 8QD

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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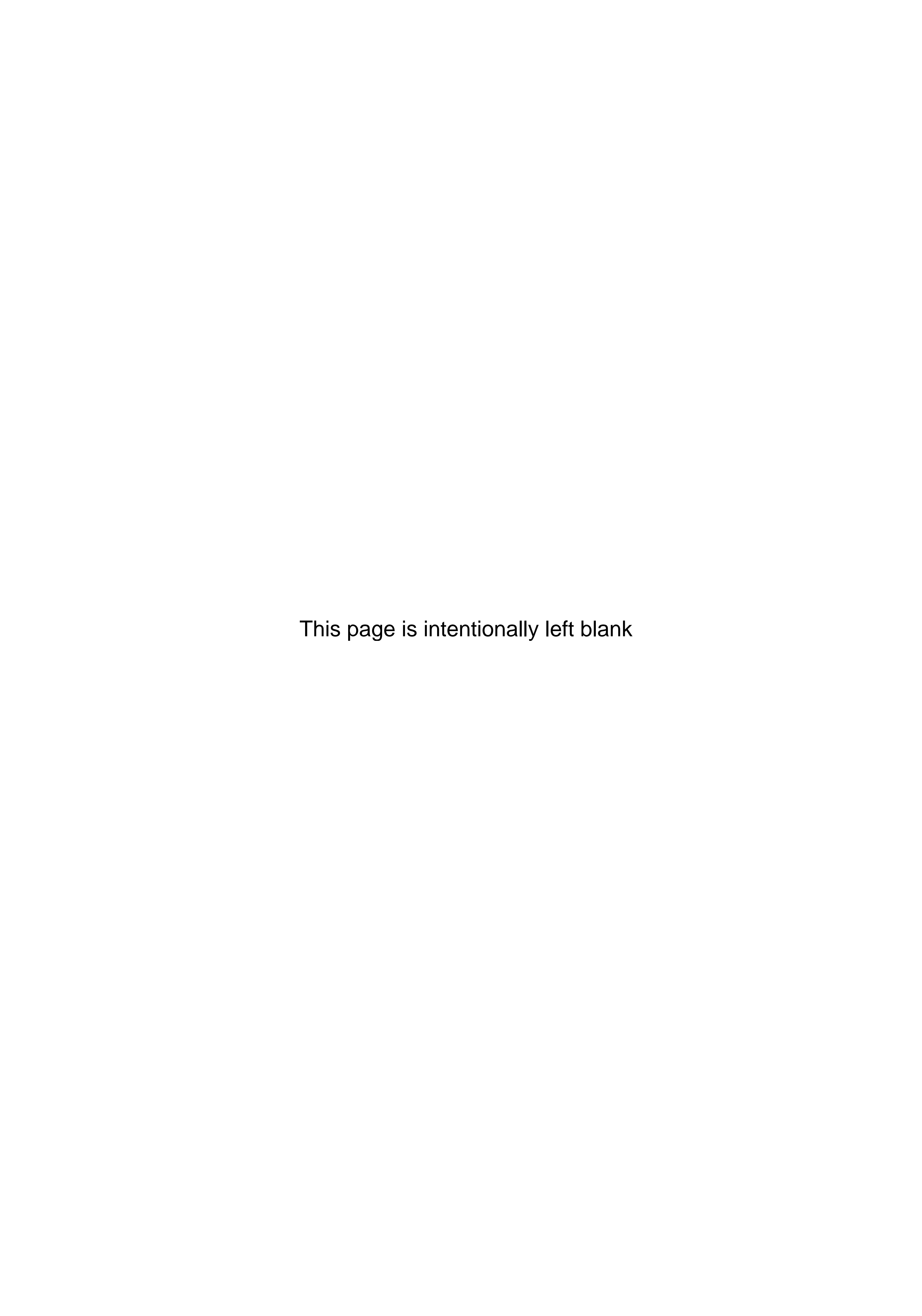
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Secondary Care
Quality Account 2017-2018

Commitment to quality

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Introduction

Foreword from Managing Director for Health Care

Our service locations

Our approach to quality

What is a Quality Account?

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.

This Quality Account is our annual report to our ultimate stakeholders – the public – on the quality of the services our hospitals provide. It describes our key achievements during 2017/18 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.

Foreword

Jim Easton

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As I write this in January 2018, the challenges facing the NHS have probably never been greater.

The need for clinical providers to respond effectively to the pressures within the system, while relentlessly maintaining focus on patient safety, quality and governance is paramount.

At Care UK, we provide a wider range of healthcare services to NHS patients than any other UK organisation. More than ……..million people are supported by Care UK teams working in primary, urgent and Secondary Care in an exceptionally diverse range of settings.

We recognise the responsibility that comes from playing such an extensive role supporting NHS organisations.

Through our organisation, our colleagues show tremendous commitment to the ethos of the health service, and to the values which drive our organisation – by delivering effective care which achieves the best possible outcome for each individual patient.

Care UK is committed to always acting as a learning organisation, with a rigorous and robust approach to the review, audit and reporting of our performance, outcomes and the experience of the patients we serve.

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.

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:

- Nine elective surgery independent sector treatment centres, on behalf of the NHS
- Two minor injury units
- CATS services

In the year April 2017 to March 2018 Care UK's treatment centres carried out:

- ………. day case procedures
- ……….. inpatient procedures
- ……….. outpatient consultations, including telephone consultations

Achievements 2017-2018

We are pleased to report hip related surgical site infections rate of 0.45%, this compares to the national infection rate of 0.68% and in relation to knees, an infections rate of 0.40%, which compares to the national infection rate of 0.70%.

In addition our Post-Discharge Questionnaire (PDQ) return rate for hips is 85.9% compared to 76.1% nationally and PDQ return rate for knees is 85.1% compared to 74.5% nationally.

Care UK has had no cases of MRSA bacteraemia or C. difficile in its 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 2018-2019

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:

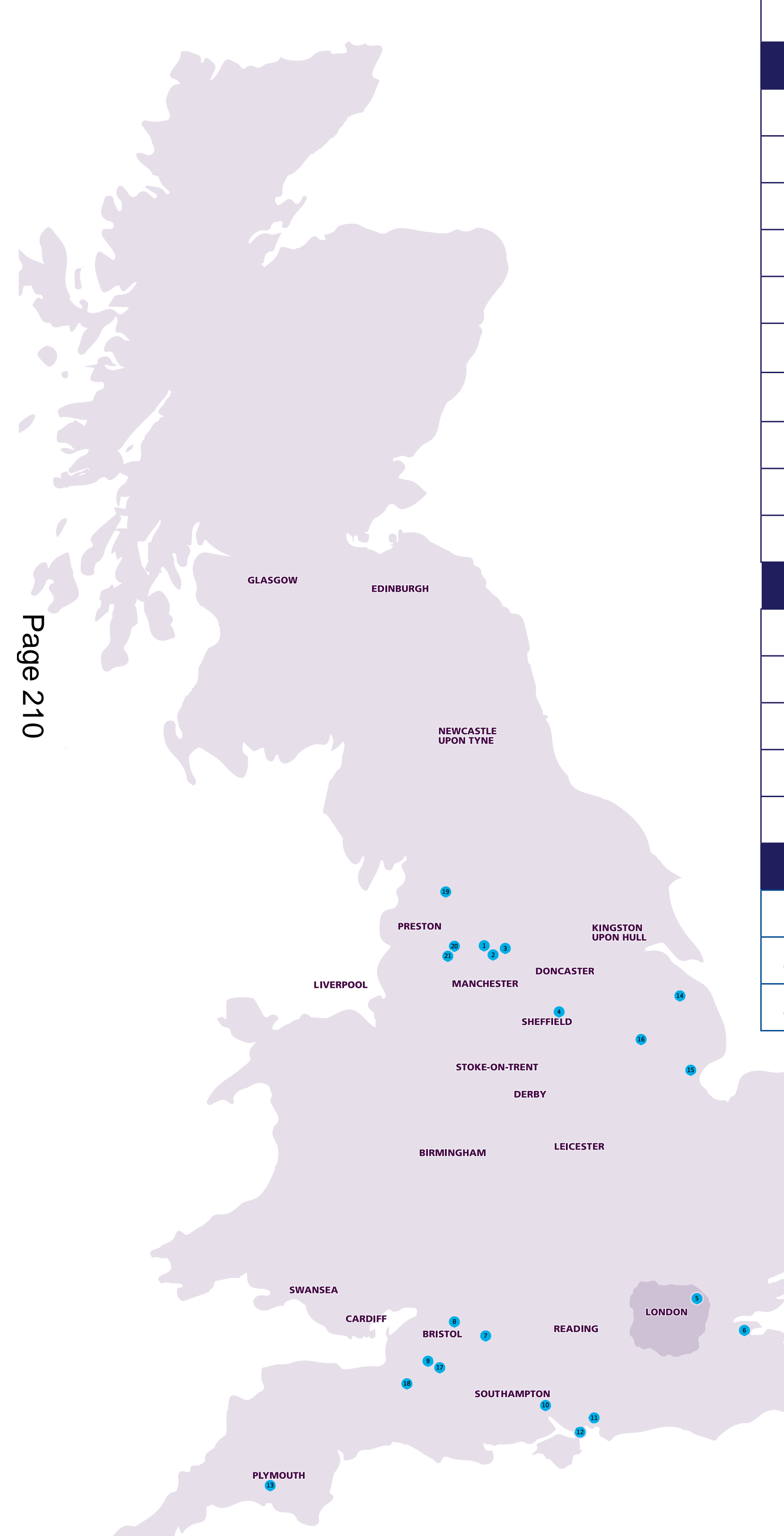
- Safe
- Effective
- Caring
- Responsive
- Well-led

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

Our locations



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	Clinical Assessment and Treatment Services
1	Rochdale Ophthalmology Service, Heywood
2	Rochdale Ophthalmology Head Office, Rochdale
3	Rochdale Ophthalmology Service, Rochdale
	NHS Treatment Centres
4	Barlborough NHS Treatment Centre, Barlborough
5	North East London NHS Treatment Centre, Ilford
6	Will Adams NHS Treatment Centre, Gillingham
7	Devizes NHS Treatment Centre, Devizes
8	Emersons Green NHS Treatment Centre, Bristol
9	Shepton Mallet NHS Treatment Centre, Shepton Mallet
10	Southampton NHS Treatment Centre & MIIU, Southampton
11	Havant NHS Diagnostic Centre, Havant
12	St Mary's NHS Treatment Centre & MIIU, Portsmouth
13	Peninsula NHS Treatment Centre, Plymouth
	Satellite Clinics
14	Barlborough Satellite Clinc, Louth
15	Barlborough Satellite Clinc, Boston
16	Barlborough Satellite Clinc, Lincoln
17	Shepton Mallet Satellie Clinic, Frome
18	Shepton Mallet Satellie Clinic, South Petherton
	Macular Services
19	North West Macular Services, Preston
20	
21	North West Macular Service, Chorley

Our approach to quality

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.

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 2017/18 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 great care looks like, and what you can expect if you need to use our services.

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 lessons 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 Secondary Care medical director.

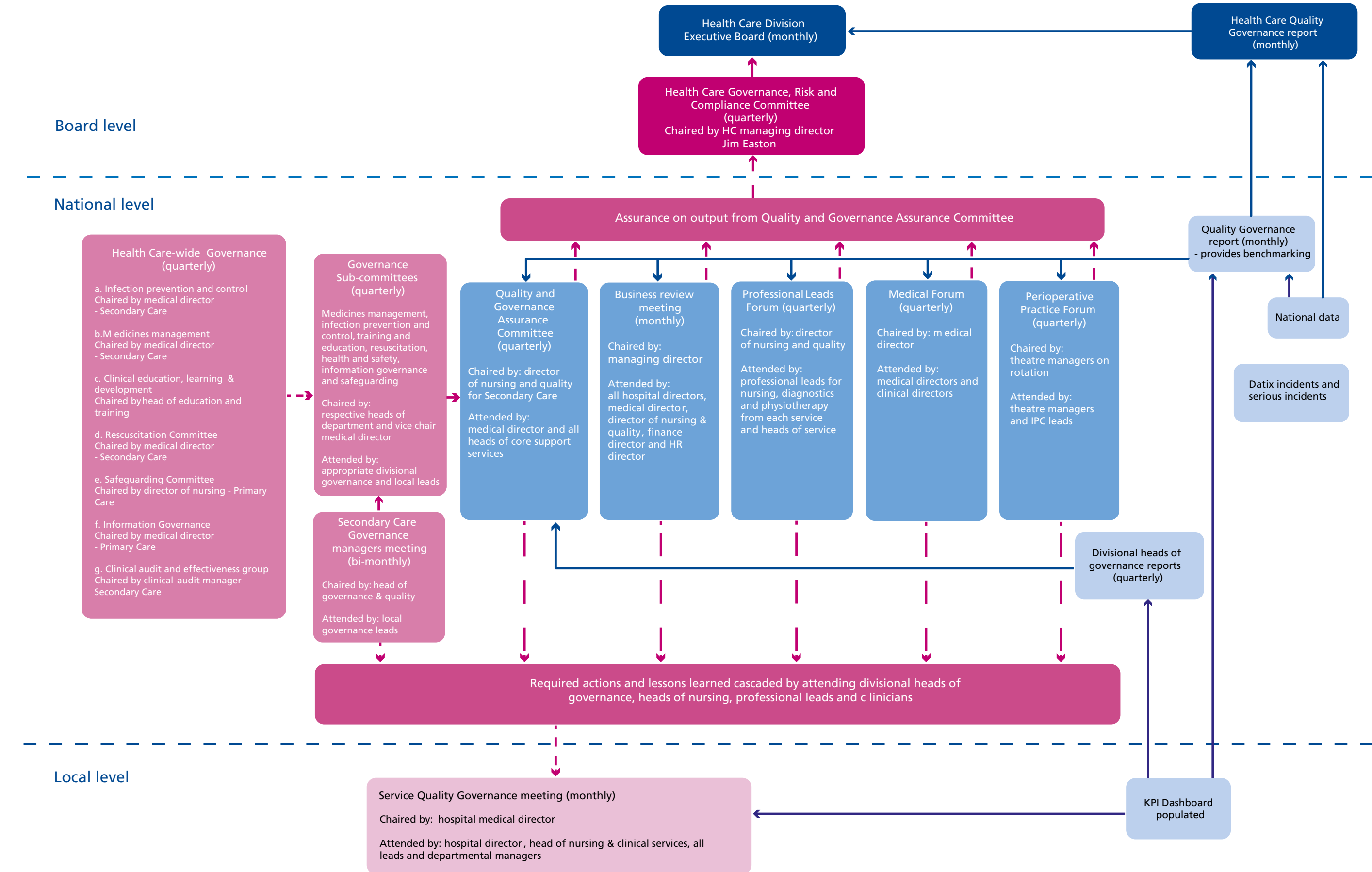
'Shared learning' and 'shared good practice' is also a fixed agenda item at our quarterly professional leads meeting.

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.

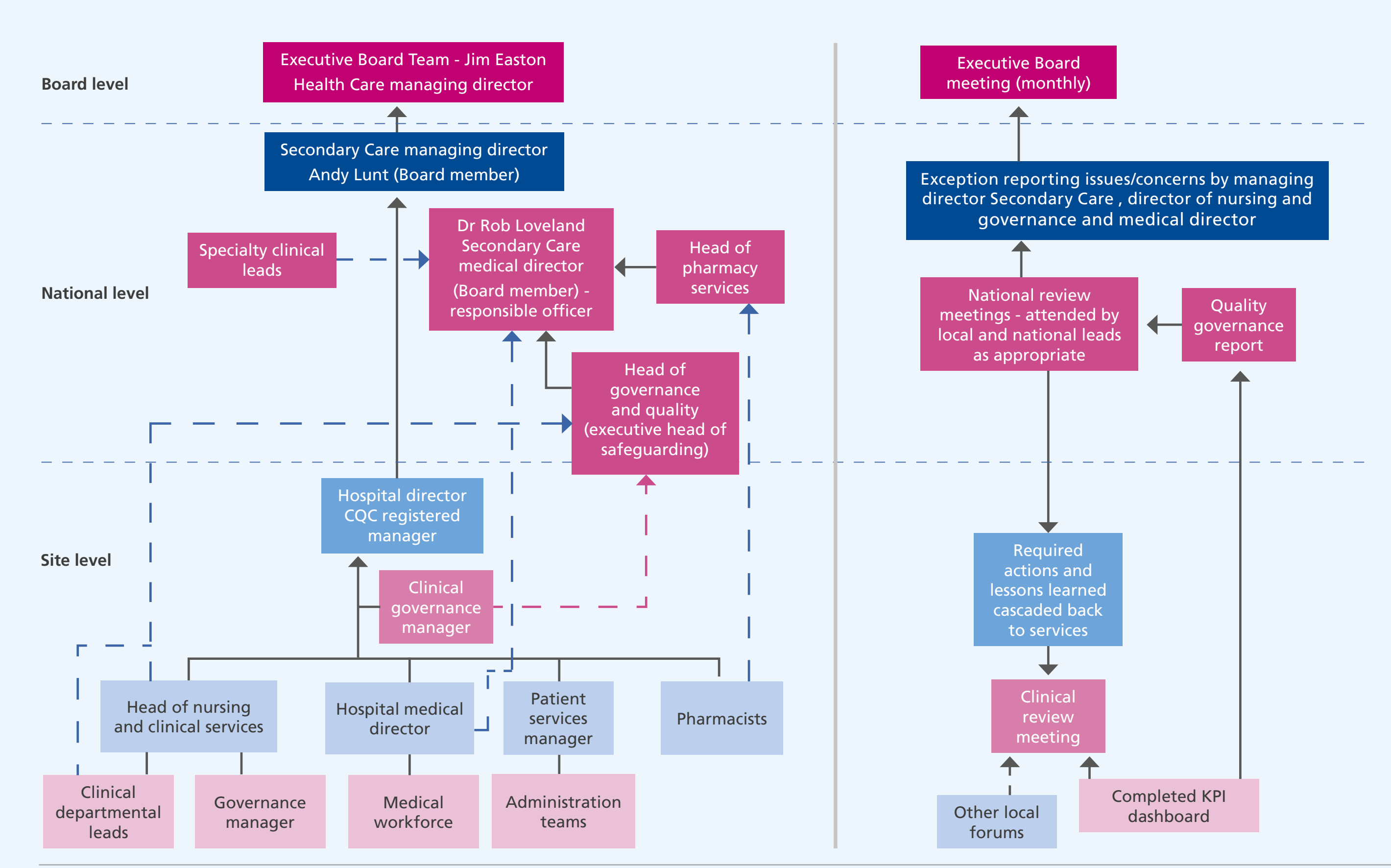
Exception reports are received and reviewed from all key service areas, with particular attention being paid to patients' safety.

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.

Secondary Care quality and governance review and assurance framework



Reporting and management structures within Secondary Care



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 includes 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.

Looking back

Review of last year's priorities

Review of last year's priorities

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

These were 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.

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.

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. Control to be recorded and evaluated electronically and key points of shared learning distributed 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 of relevant fields.	All sites with eDischarge template in place and relevant fields able to be populated electronically.
Effective	The implementation of the national eDischarge template and population of relevant fields. Improvements in the identification and dissemination of shared learning from serious incidents ensuring all valuable and safety-critical learning opportunities have been achieved across all services.	All sites with eDischarge template in place and relevant fields able to be populated electronically. • Local action plans are developed following investigation. The action plans are implemented within defined timeframes locally and monitored accordingly • Serious incident (SI) investigation outcomes will be shared broadly across all services; helping to improve shared learning and understanding of how incidents occur and, importantly, to reduce future SI incidents 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 clinical employees who are vaccinated against flu.

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Safe

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

What were we trying to improve?
To demonstrate clean and safe services are in place with evidence of maintenance of standards across services.

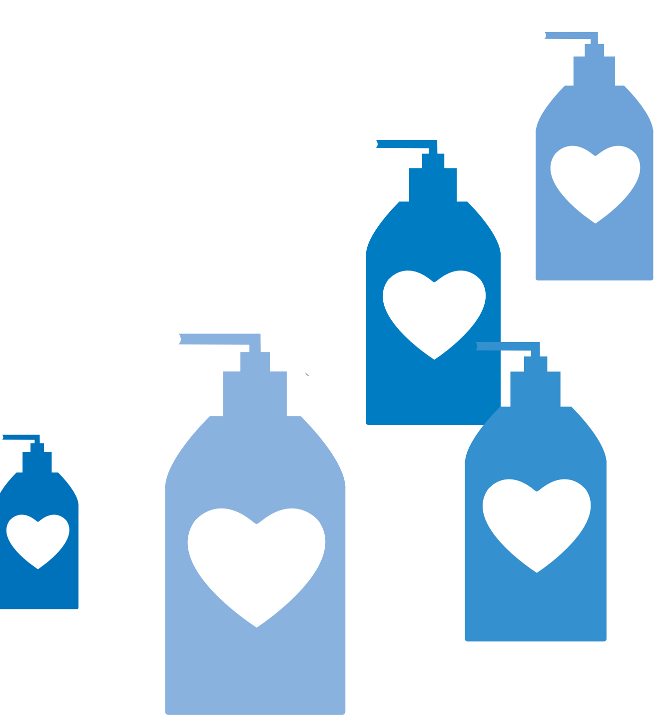
What does success look like?
An electronic audit tool has been developed based on the national standards of cleanliness so it is measurable across services and consistent with the standards expected in the NHS, and although not implemented this year we are confident that the cleanliness of our services is being maintained and monitored through additional measures.

The patient-led assessors gave us an overall score of above 99% for the cleanliness of our Secondary Care sites for the second year running.

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 2016 scores.

We will work to embed the electronic audit tool in the coming year in conjunction with the implementation of an overall audit application for staff to utilise more fully. iAuditor is an app used to empower staff within services. Combined with a web platform, iAuditor provides visibility and insights to help raise safety and quality standards across the organisation. Staff are able to collect consistent data, standardise operations, send reports, identify failed areas and get problems resolved.

How we monitored 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



Responsive

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

The Care UK Secondary Care Business Systems team are in the process of standardising the eDischarge template in-line with NHS Digital - Transfer of Care Initiative.

At present four treatment centres (Shepton Mallet, Emersons Green, Devizes, and Peninsula) are all sending eDischarge correspondence in the Transfer of Care initiative (Implementing eDischarge Summary Headings in England) format.

The remaining Secondary Care sites are in the process of having the eDischarge template updated, delivery of the new template to the remaining sites is estimated to be completed by May 2018.

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Improvements include standardisation of the presentation of information. Making it easier for referrers to locate information upon receipt/review of the correspondence – both clinical and non-clinical. Improved patient care and safety due to the availability of complete, accurate and timely information.

Reduction in the risk of missing or inappropriate critical clinical information. Success will be the successful delivery of the template to all Secondary Care services within Care UK that send eDischarge correspondence. Success will also include the new correspondence template being accepted by the intended recipients MESH mailbox.

Progress of electronic transmissions will be monitored through Keystone – this is the application which Care UK uses to transmit eDischarge correspondence to referrers MESH mailboxes. Transmissions of correspondence by this application are fully auditable/ reportable.

Effective

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

Progress:
There have been a number of developments to support the identification and circulation of shared learning following serious incidents across Secondary Care .

To ensure consistency of data relating to the incident, a reporting form has been developed within the Datix reporting system. This allows the capture of relevant data fields to populate a word document with key shared learning points included. This document can be shared easily with staff at relevant meetings.

The governance managers across Secondary Care services have monthly updates from the Head of Governance and Quality where these shared learning documents are included from all services. This allows the Governance Managers to share at the local quality assurance meetings the lessons learned and to determine if any additional actions are required locally.

There has also been the development of a shared learning page within My Care UK, the Care UK intranet, which allows staff to access the most recent shared learning documents or to search historic documents for trending purposes locally.

Serious incident management
When serious incidents are identified at a local level a 48 hour call with the Secondary Care Medical Director and Head of Governance and quality is instigated.

This has happened in all serious incidents reported within Secondary Care since April 2017. During this call any immediate actions are identified and shared with local services as required. This allows immediate action to be taken rather than waiting for a complete investigation and root cause analysis being completed prior to sharing potential learning for sites.

All serious incidents have locally owned action plans following a serious incident which is discussed and monitored via local meetings with the Commissioners. Key actions and recommendations from serious incidents are also shared at bi-monthly Governance Managers meetings to allow dissemination of any learning.

Any new serious incidents are reported to the Board via the monthly report and then monitored via the service monthly performance meetings chaired by the managing director supported by the Secondary Care Medical Director. The services are required to provide monthly updates on the progress of any open investigations including confirmation of the final sign off from the commissioners.

Further work is underway to expand on the use of the Datix system to monitor and manage action plans following investigations. This will support the ongoing review of actions to ensure completion.

With the publication of the new never events list from NHSE to be applied from February 2018 the LocSSIPs will be reviewed to ensure any additional requirements are implemented.

There has not been a demonstrable reduction in the number of serious incidents in the past year although shared learning from the incidents is routinely being disseminated between services in a more effective manner.

Caring

Priority - Identification of dignity champions in each service.

Progress:
All services have effectively identified their respective dignity champions at a local level. Five treatment centres have active action plans in place following a dedicated dignity audit. Although, the four remaining treatment centres have not completed a dedicated dignity audit, each has incorporated benchmarks within their PLACE audit schedule.

All Heads of Nursing highlighted their progress within the Professional Leads meeting and are supporting the move to include a quality priority linked to dignity in 2018.

For example, Barlborough Treatment Centre has now introduced a robust action plan following their audit. The implementation of a dignity-focused patient questionnaire, alongside quarterly meetings with the respective dignity champions to discuss the outcomes, has enabled them to effectively determine where changes need to take place.

The key aims for Dignity champions and the pledges from the Dignity Council are also discussed and 'Ten Dignity Dos' have been provided to all areas within the centre.

North East London Treatment Centre, despite not having completed a dedicated audit, has a range of projects in place with a dignity focus. Examples of this are: changing the flow of their outpatients department so that patients have a private room to prepare for intimate examination, instituted single sex endoscopy lists, and changing visiting times on the inpatient ward so that washes can be carried out before all visitors attend the unit.

These figures will be reported via monthly performance meetings.

Well-led

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

What were we trying to improve?

Through increased vaccination of our frontline employees, we hope to minimise the risk of vulnerable patients contracting the virus while 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 does success look like?

Our target is a 5% increase in employees who are vaccinated against flu.

How we monitored progress?

Flu champions in each service will monitor influenza immunisation of employees locally. These figures will be reported via monthly performance meetings.

Having a flu strategy - preventing staff being affected

Vaccination of at-risk groups and children can offer some protection against infection. The NHS plans each year for the demands of flu across England in its annual programme. The Care UK main strategy falls in-line with this programme.

The flu programme is a coordinated and evidence based approach to planning for the demands of flu across England. Each year the NHS services and partners prepare for the unpredictability of flu. For most healthy people, flu is an unpleasant but usually self-limiting disease with recovery generally within a week.

However, there is a particular risk of severe illness from catching flu for: older people, the very young, pregnant women, those with underlying disease, particularly chronic respiratory or cardiac disease and those who are immunosuppressed.

The Care UK flu strategy included the necessary key elements: education and training, procurement and delivery, troubleshooting and myth busting, data collection and communication/marketing.

How to avoid spreading the flu

Flu is very infectious and easily spread to other people. You're more likely to give it to others in the first five days.

Flu is spread by germs from coughs and sneezes, which can live on hands and surfaces for 24 hours. To reduce the risk of spreading flu:

- wash your hands often with warm water and soap
- use tissues to trap germs when you cough or sneeze
- bin used tissues as quickly as possible.

Within Care UK, the communication and marketing arm of the strategy allowed a number of key messages to be delivered to front line staff, informing colleagues on how to prevent flu spreading.

Increasing awareness - 'bursting the myths'

Educating and informing staff, patients and the public on the benefits of flu vaccination is a difficult yet crucial part of the flu season.

Within Care UK, each service had a dedicated 'Flu Champion' which allowed for local and regional discussion to be had to expel some of this preconceived myths.

Thanks to "herd immunity," so long as a large majority of people are immunized in any population, even the unimmunized minority will be protected. With so many people protected, an infectious disease will never get a chance to establish itself in reservoirs from which to spread. This is important because there will always be a portion of the population – that can't receive vaccines.

But if too many people don't vaccinate themselves or their children, they contribute to a collective danger, opening up opportunities for viruses and to survive in a population and spread. Vaccines are one of the great pillars of modern medicine.

Life used to be especially brutal for children before vaccines, with huge portions being felled by diseases like measles, smallpox, whooping cough, or rubella, to name just a few. Today these ailments can be completely prevented with a simple injection or in the case of influenza, a nose spray in children.

Within Care UK a lot of effort has gone into ensuring all sites, services and staff were informed of the importance of obtaining their vaccine.

Protecting our patients

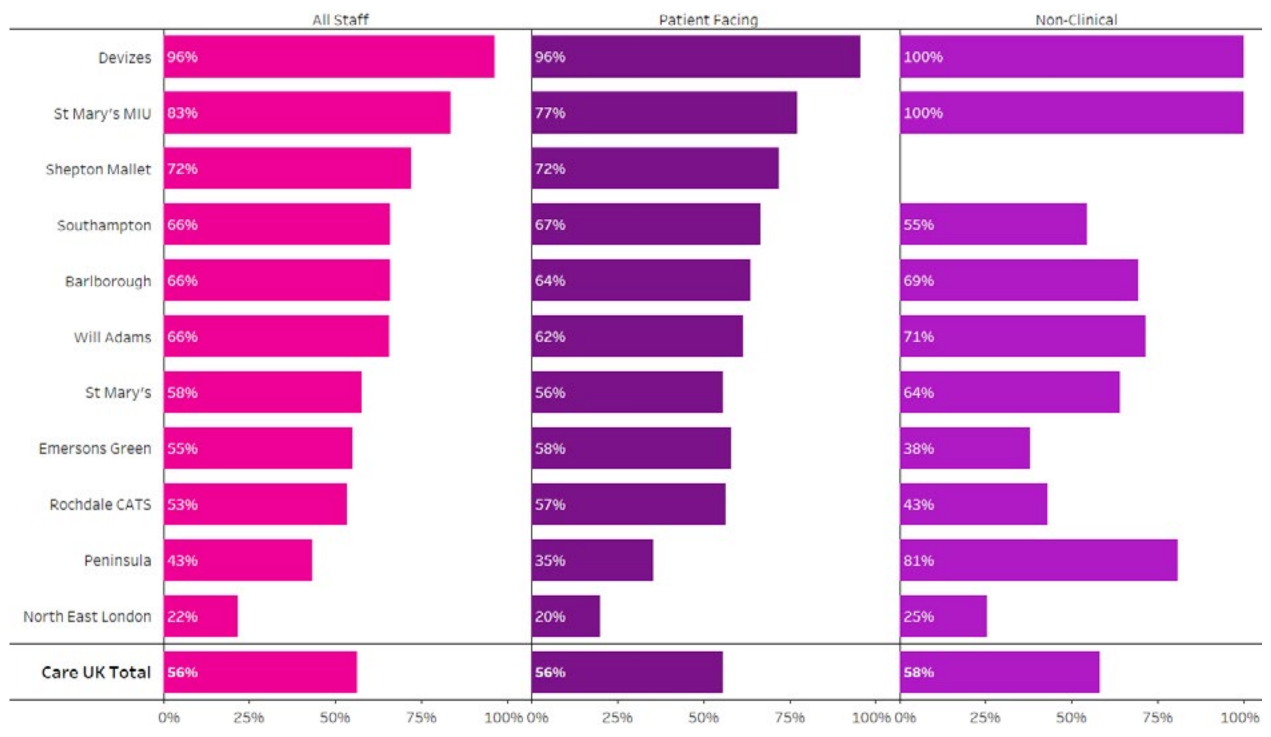
We are currently in the midst of the flu season and at December 2017 the current uptake and vaccination rate within Secondary Care is at 56% of all staff being vaccinated. Work remains on-going at implementing more staff within the months of January, February and March 2018.

Front-facing colleagues have been prioritised over non-front facing, although a strong focus on all staff being vaccinated remains.

Great work has been happening with staff taking up the flu vaccine this year. At the end of December, of the 421 hospitalised confirmed influenza cases reported by NHS England within their Trust Hospital, 242 were attributable to Influenza A and 179 due to influenza B. This rate was continuing to rise, and at Care UK we made it a clinical priority to vaccinate all staff.

With Care UK, colleagues across Primary and Secondary Care , Infection Control, Business Systems and Marketing departments have worked collaboratively to ensure a full and complete strategy for flu vaccination was implemented successfully.

This year's vaccine offers good protection in most people against influenza virus strains and remains a cornerstone to safe care this year.



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Beyond the quality priorities

Other areas of quality

Other areas of quality

Diagnostic services

Care UK provides a range of diagnostic imaging services within its NHS treatment centres including: plain film X-ray; non-obstetric ultrasound and magnetic resonance imaging.

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, made up of consultant radiologists, radiographers sonographers and support staff are all highly experienced healthcare professionals, registered with their respective professional bodies where required.

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 usually 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 have been supported by an experienced divisional team which includes: a clinical director and advisor for Radiology (position vacant); and a diagnostic imaging lead who oversees all diagnostic imaging services within Care UK's Health Care Division. In addition support can be obtained from external providers.

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 our imaging services and the reports that we send to our patients and referring clinicians.

During the reporting period (April 2017-March 2018) 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.

It has 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.

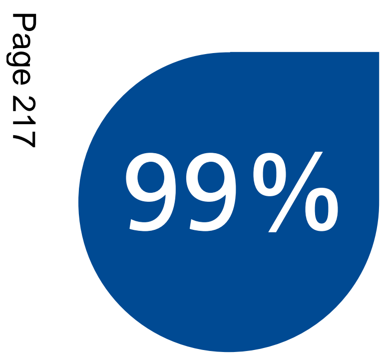
We are also developing an internal peer review system for our sonographer workforce that will enable clinicians to 'quality assure' each other's clinical practice, observing colleagues when undertaking a range of ultrasound examinations and providing professional feedback to drive continuous quality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

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

Thanks to that, we are pleased to report that our discrepancy/error rates for the reporting of imaging examinations remain at a very low rate. We are wholly assured that the quality of our reporting is well above any suggested threshold within the published evidence on this topic, and that we continue to provide a high standard imaging service to our patients.

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.

Outcomes from the QA programme continue to be excellent:



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.

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.

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.

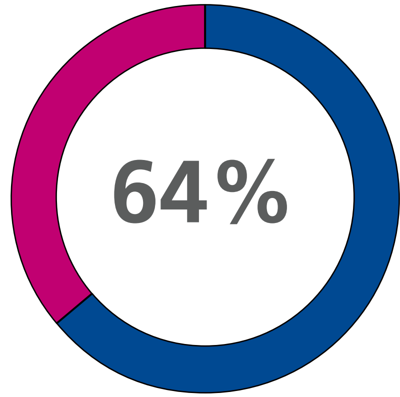
Employee engagement

The annual Care UK employee survey, "Over to you!" mirrors the NHS Employee Survey in terms of questions relating to equality and diversity. This survey not only informs us about what our colleagues 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: 'areas 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 annually and in 2017 our engagement index in Secondary Care was 64% which was a slight reduction from the prior year (66%) but was nevertheless above the national average for organisations of our scope and scale (59%).



Survey content is comparable to, and in certain sections mirrors, the NHS National Staff Survey content.

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 organisational priority, and know what to do if they wish to raise a formal concern at work regarding the provision of health care services.

Broadly speaking, results compare favourably to the NHS staff survey outcomes and in particular with regard to the care of patients being the top priority, employee health and well-being, providing the tools and materials required to do the job, and feeling able to raise a complaint (Whistleblowing).

Whilst the outcomes to our equality and diversity questions (sourced directly from the Workforce Race Equality Standards) were broadly comparable to outcomes in the last NHS survey, we 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 began in October 2016 and will be rolled out on an on-going incremental basis to the end of September 2018; ensuring that equality and diversity retains an organisational profile and continues to be central to our everyday working lives.

Pharmacy intervention (implemented during 2017)

Clinical pharmacy skills in the NHS and its partner organisations are currently in high demand. This isn't surprising in the context of polypharmacy, suboptimal medicines use, medication error, preventable medication related admissions to hospitals, increasing antimicrobial resistance and huge and rising therapeutic costs. The knowledge and skills of the pharmacist are central to optimising medicines use to create better outcomes for patients and better value for the care being delivered at all levels throughout the health system.

Background

In common with other healthcare professions, there is notable variability in the consistency with which pharmaceutical services are provided, and how medicines optimisation is implemented amongst many organisations providing care.

Lord Carter's final report on NHS productivity and efficiency, published in February 2016, identified significant variations in practice, availability and deployment of Secondary Care pharmacy services across the country.

We know that the limited availability of patient-facing Secondary Care pharmacy services can lead to patients missing doses of important medicines, lack of support for medical and nursing staff, low levels of medicines reconciliation, delayed transfers of care and poor support for patients at hospital discharge, failed surgeries and treatment modalities and a real risk to patients from potential medicine-related harm.

Pharmacist driven interventions in the care of patients in Secondary Care settings have been shown to reduce the risks associated with medicines.

Objective

To understand, standardise and stratify the input pharmacists and their teams provide on frontline patient care activities.

Aims

A clear clinical definition of pharmacist interventions was made. This, along with typical medicine incidents that were recorded historically, allowed us to ensure a distinct differentiation.

- A Pharmaceutical Clinical Intervention is the process of a pharmacist identifying, and making a recommendation in an attempt to prevent or resolve a medicine-related problem. The pharmacist recommendation may result in a change in the patient's medication therapy, by means of administration, dosage regimen, form, quantity or even an addition.
- Medication incidents are those which actually caused harm or had the potential to cause harm involving an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicines advice.

It is the professional responsibility of the pharmacist to differentiate between clinical intervention and medicine incident and record them appropriately.

Action/Methodology

Utilising Datix - the staple and recognised patient safety platform that produces web-based incident reporting and risk management software for health and social care organisations - the pharmacy teams across the division and colleagues from Risk Management/IT were able to develop an innovative tool on the Datix platform. This tool allowed a concise virtual catalogue of the types of interventions from individual sites, thus allowing appropriate data entry and collection.

Using this tool, the teams were tasked with recording all their clinical and patient-facing interventions. This data has helped to drive improvements, standardise practice and identify gaps in practice.

Outcomes/Achievements

Below is the total number of interventions and their subtypes that were recorded in 2017. Some of the most commonly made interventions across the Secondary Care division were:

- Missed/incomplete medication allergy status recording
- Incomplete prescription writing or identified errors on prescriptions
- Failed medicines reconciliation- failed medicine history taking when patients are initially admitted
- Pain medication review - pharmacy teams intervening to improve/advise on pain medications

The data captured allowed teams locally and as an entire Secondary Care division to drive improvements in some of the key areas of medicine practice. Examples of improvements from the intervention data included:

- System wide prescription template change - resulting in clearer allergy status recording and a communication tool to allow pharmacy and medical teams to discuss any prescription related errors
- Creation of an new medicine related training delivered by local pharmacy teams, covering: medicines reconciliation, pain medication and importance of getting the correct medicine history from patients
- Appropriate monitoring of inpatient medication charts to make sure all medicines administrated during a patient's stay is correct and safe
- Improved governance and peer-to-peer discussions at sites to ensure clinical practice is constantly challenged and continuosly improving.

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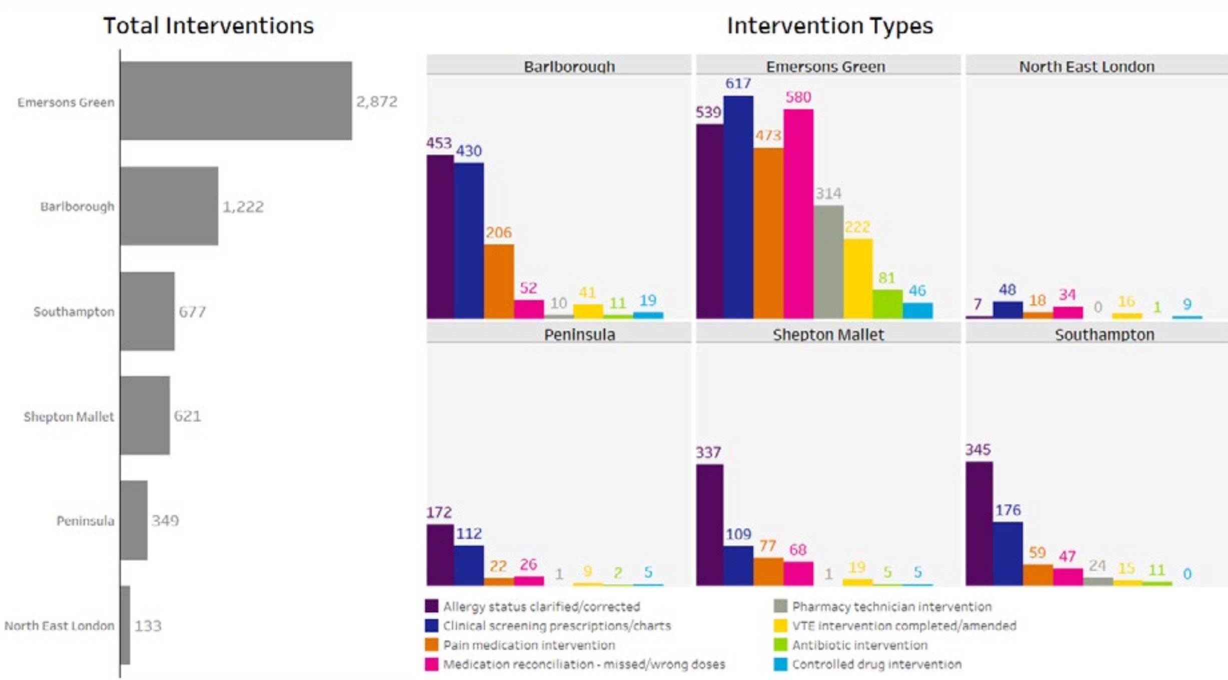
Pharmacy Interventions - January to December 2017



Summary

Secondary Care pharmacy services should operate in a standardised, efficient and consistent manner. Their input and intervention is pivotal amongst the multi-disciplinary team in ensuring patients achieve the best outcomes from their medicines and harm/risk is reduced. Through the optimal use of medicines, technology and workforce, alongside collaboration between providers, unnecessary variation in services can be avoided. This will not only deliver value based healthcare but also good clinical outcomes for all patients.

Healthcare heart

In 2015 Care UK standardised its Risk Management approach by asking all services to record threats to specific Secondary Care Objectives on their local risk registers. These corporate objectives, outlined in the Risk Management Strategy and Policy, were SMART (specific, measurable, actionable, realistic and time-bound) and covered a mixture of clinical, operational and strategic goals.

Since the introduction of the policy and strategy each centre has established a comprehensive register of key risks with documented contributing factors, controls and action plans. Compliance with the new policy and process is reported on a monthly basis to ensure continued good practice.

However, these risk registers were largely managed by senior management teams and governance managers, which was in part a reflection of the high-level nature of the objectives. Often clinical staff felt that these objectives did not reflect the full range of measurements we use to identify risk and success at all levels of the organisation.

They were not fully aligned to our internal performance and quality reports and, as such managing the risk register felt like an additional activity or a corporate process, rather than something to be owned by all staff.

In order to improve how we communicate why we do what we do to our stakeholders, we looked at our existing measurements and grouped these into a set of meaningful objectives that could be understood by all staff. The objectives were no longer SMART but instead were underpinned by a set of Key Performance or Risk Indicators.

The objectives were aligned to the CQC's key lines of enquiry so that we can explicitly demonstrate to the regulator that what we do every day delivers the expected standard of care. These objectives were developed in consultation with the quality and governance leaders within Primary and Secondary Care.

Although not technically a balanced scorecard, it is inspired by this methodology and will be used to communicate our values and aspirations to all internal and external stakeholders in a way that is easy to understand. The model explains in a simple way that we deliver high-quality care which is compliant with regulatory standards through a sustainable business model that puts the patient at the heart of everything we do.

The objectives will be used for inducting new staff, identifying risks and organising performance and quality reports at all levels so that risk management is aligned with other management activity and owned by all staff. Vitally the patient is central to the process with the key of ensuring the patient is at the heart of everything we do.

Healthcare Heart

Caring

Effective

Responsive

Safe

Well-led

Post Patterson

Care UK has now, in the absence of any guidance from regulatory authorities, initiated a concerted response between Human Resources (HR) and the Office of the Responsible Officer (RO).

As the risk is primarily related to those external consultants working for Care UK, who are not attached to us as a designated body, the following measures have been put in place.

All appointments or attachments can only be made through central offices. All checks in-line with the NHS standards are completed by HR. A new updated data base of all Self Employed Medical Practitioners (SEMPs) has been created and this will be monitored and updated monthly.

All SEMPs are required to, and have complied with since 1st January, lodge the most up-to-date copy of their last appraisal summary with the central office.

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In addition they have all completed and submitted a signed probity statement indicating that the work conducted at Care UK is clinical work that is consistent with their normal scope of practice for which they have been appropriately trained and experienced.

It is also stated that they are in good standing and not the subject of any current concerns or investigations/restrictions. If this statement shows any concerns, that these have been discussed and evaluated by the local medical director.

All consultants who work for Care UK through either agency, chambers or SLA arrangements, will have submitted to the lead similar details which the lead is then responsible for accounting to the local MD that there are no concerns about any of the doctors so engaged.

All employment processes are reviewed at the Decision Making Group of the RO Office by RO staff and HR directors to ensure compliance with these requirements.

Endoscopy

Care UK undertakes endoscopy procedures at eight units across the south of England. These are mainly diagnostic procedures undertaken at the request of GPs or our clinicians. In addition some sites work collaboratively with local NHS Trusts to reduce waiting times for their patients.

Quality standards are carefully monitored within endoscopy. Each unit reports monthly on ten key performance indicators. These indicators are reviewed by the clinical director and reported to the senior management team, to ensure procedures are completed appropriately and that waiting times are maintained (six weeks for routine tests, two weeks for urgent tests).

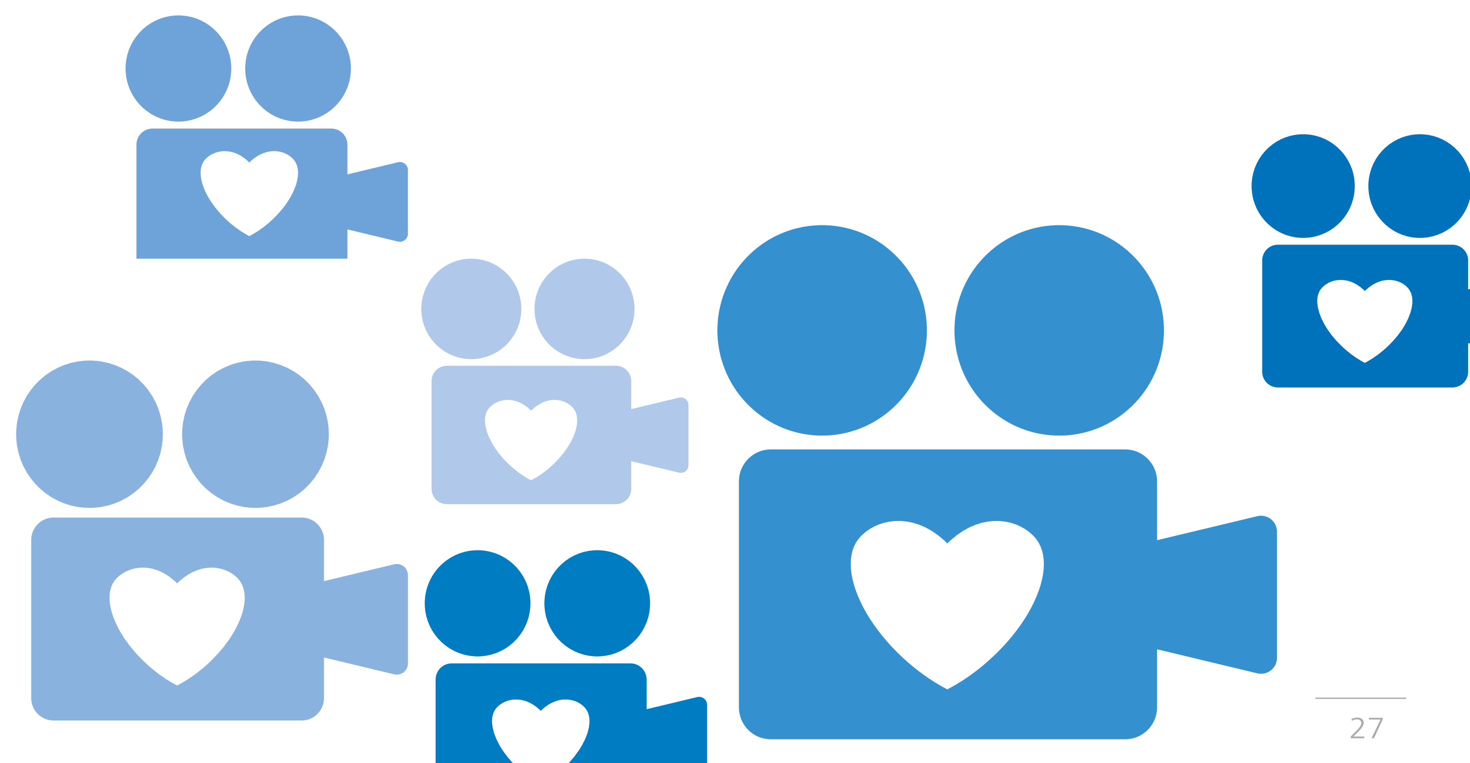
Endoscopy units have the option of applying for formal accreditation by the Joint Advisory Group for Gastrointestinal Endoscopy (JAG) which is the national group overseeing all endoscopy units.

Achieving accreditation requires units to demonstrate compliance with numerous standards, and to have clear policies and operating procedures to deliver safe and effective endoscopies.

Patient feedback also plays a key role in maintaining these standards. Currently six of our units have achieved and maintained full accreditation with JAG, and the remaining two are working towards achieving this in 2018.

As part of this process individual endoscopists are carefully monitored against 25 different standards. These are reported on and reviewed by the clinical director twice a year to ensure all our endoscopists are maintaining their practice.

Issues relating to endoscopy are managed through local clinical governance arrangements, and learning is shared across all sites at a quarterly endoscopy forum. Any serious concerns are escalated to the Care UK senior management team.



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Patient and public experience

Complaints management

Friends and Family test

Marketing to patients

Complaints management

Our patients are at the heart of everything we do and by listening to the people we care for, we will improve our services and continue to make them safer and more responsive.

We will learn lessons that will benefit everyone – not only the people to whom we provide services, but our commissioners, our staff and all our other stakeholders. Sharing and learning from what our patients tell us will support our planning and the delivery of care in all our services and facilities.

To us, the principles of excellence in complaint handling are simple.

- We must get things right first time, meeting all our legal and regulatory responsibilities, with clear leadership from the Board and executive. We must have clear and strong governance arrangements with unambiguous roles and responsibilities so that everyone in our organisation understands the importance of managing the concerns of our patients.
- By being patient focused, we will have a complaints procedure that is straightforward and outcome driven. Wherever possible, we will endeavour to satisfy the person who has made the complaint. We will listen to what our patients say and deal with complaints promptly and with sensitivity.
- We will be open and accountable, explaining how a complaint can be made and how to proceed if the person who has made the complaint feels that our response is unsatisfactory. We will provide information about how independent conciliation services and other advice can be obtained.
- By acting fairly and proportionately, we will treat the person who has made a complaint impartially and fairly, striving to investigate matters thoroughly and to reach conclusions quickly. We will also treat any staff member who has been complained about equitably.
- Putting things right - acknowledging our mistakes and apologising where we need to, will be a key part of any remedy required. Our responses will be prompt, appropriate and proportionate.
- By seeking continuous improvement, using the feedback and the lessons arising from complaints, we will improve service design and delivery. We will have systems in place to record, analyse and regularly report on what we have learnt. Where appropriate, we will tell the person who has made a complaint about these lessons and what changes we have made to prevent similar things happening again.

Care UK has a policy in place to provide Care UK staff with the information they need to ensure that Care UK meets or exceeds the requirements of:

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- Hospital Complaints Procedure Act (Scotland) 1985
- Social Services and Wellbeing (Wales) Act 2014

It sets out how Care UK manages, responds to and learns from complaints made about its services. The management of all complaints, investigations and responses will be conducted to the timescales set out in these regulations.

Care UK is committed to providing high-quality services and will strive to ensure that all compliments, concerns and complaints are addressed, resolved and shared as quickly as possible.

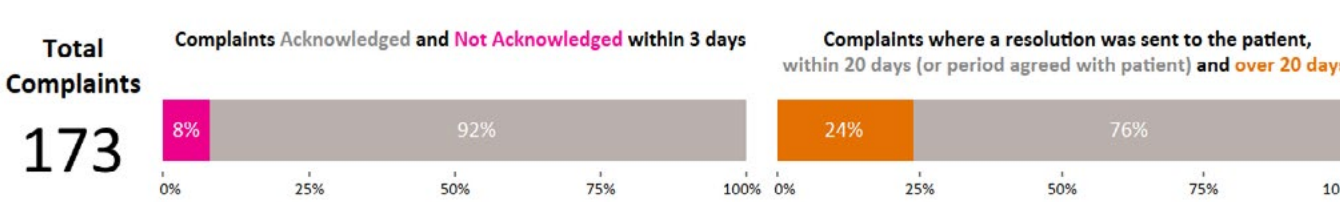
Potential lessons will be shared within the organisation to promote learning and improve quality and safety of care.

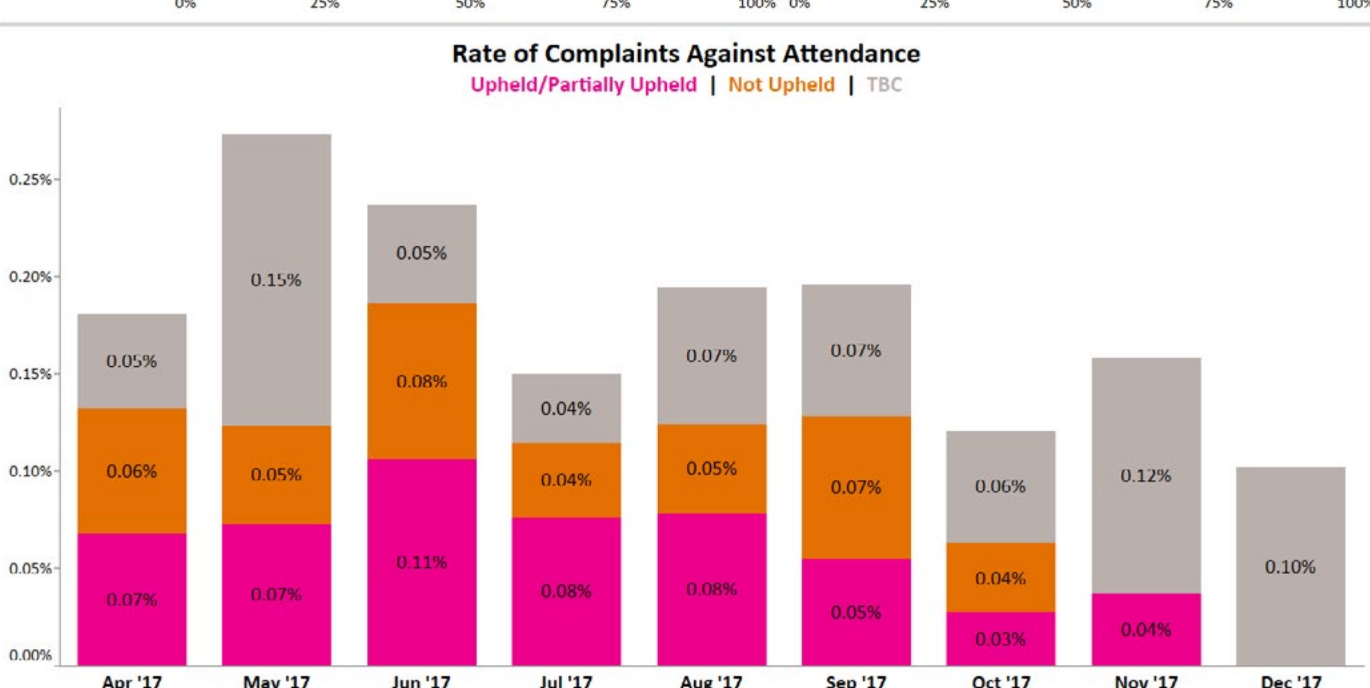
Complaints will be dealt with on an individual basis and will be investigated fully, transparently and impartially. When something has gone wrong it is vital to establish the facts about what happened in a systematic manner.

Most complaints will be investigated by someone from the service or division involved, but for serious complaints it may sometimes be necessary to involve an independent investigator.

Complaints trends are monitored both locally and nationally to determine actions which need to be initiated to address concerns and complaints raised by patients.

Whilst the results are encouraging it is recognised that Care UK services want to improve on these results and have identified an improvement in managing complaints as a quality priority for the coming year.





Friends and Family test

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use our services should have the opportunity to provide feedback on their experience.

It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming our services and supporting patient choice.

In Care UK services we gather data from inpatient wards, day wards and outpatient attendances. This data is reviewed on a monthly basis and displayed in patient areas to illustrate how many patients would recommend the services.

This data is also used in conjunction with patient comments received and is aligned to the patient notice boards which demonstrate what actions have been taken as a result of patient feedback received.

The FFT data is submitted to the NHS digital portal to enable Care UK services to be measured in-line with all NHS services. The feedback gathered through the FFT is being used in NHS organisations across the country to stimulate local improvement and empower staff to carry out the sorts of changes that make a real difference to patients and their care.

While the results from Care UK will not be statistically comparable against other organisations because of the various data collection methods, FFT continues to provide a broad measure of patient experience which can be used alongside other data to inform service improvement and patient choice.

Friends and Family - Would Recommend - April 2017 to January 2018

Below NHS Response Rate | Above NHS Response Rate

	April 2017	May 2017	June 2017	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018
Daycase	99%	99%	99%	99%	99%	98%	98%	98%	98%	99%
Inpatient	99%	99%	99%	99%	100%	100%	100%	100%	99%	99%
Outpatient	99%	99%	98%	99%	99%	99%	99%	99%	99%	99%

NHS Benchmark Figures: www.england.nhs.uk/fft/friends-and-family-test-data/

Marketing to patients

As part of our commitment to providing high-quality care, we make a concerted effort to ensure that patients know exactly what we offer, and can access all the information they need. We implement various marketing campaigns and activities to help keep people abreast of the services available to them and how we are doing.

New websites

In 2017 we launched brand new websites for each of our NHS treatment centres. This project was driven by a desire to make our sites more accessible, user friendly and intuitive for both patients and healthcare professionals.

With a completely new layout, clearly guiding users through the different pages and helping them to find what they are looking for, we have transformed the user experience and made our websites much more beneficial to anyone using them.

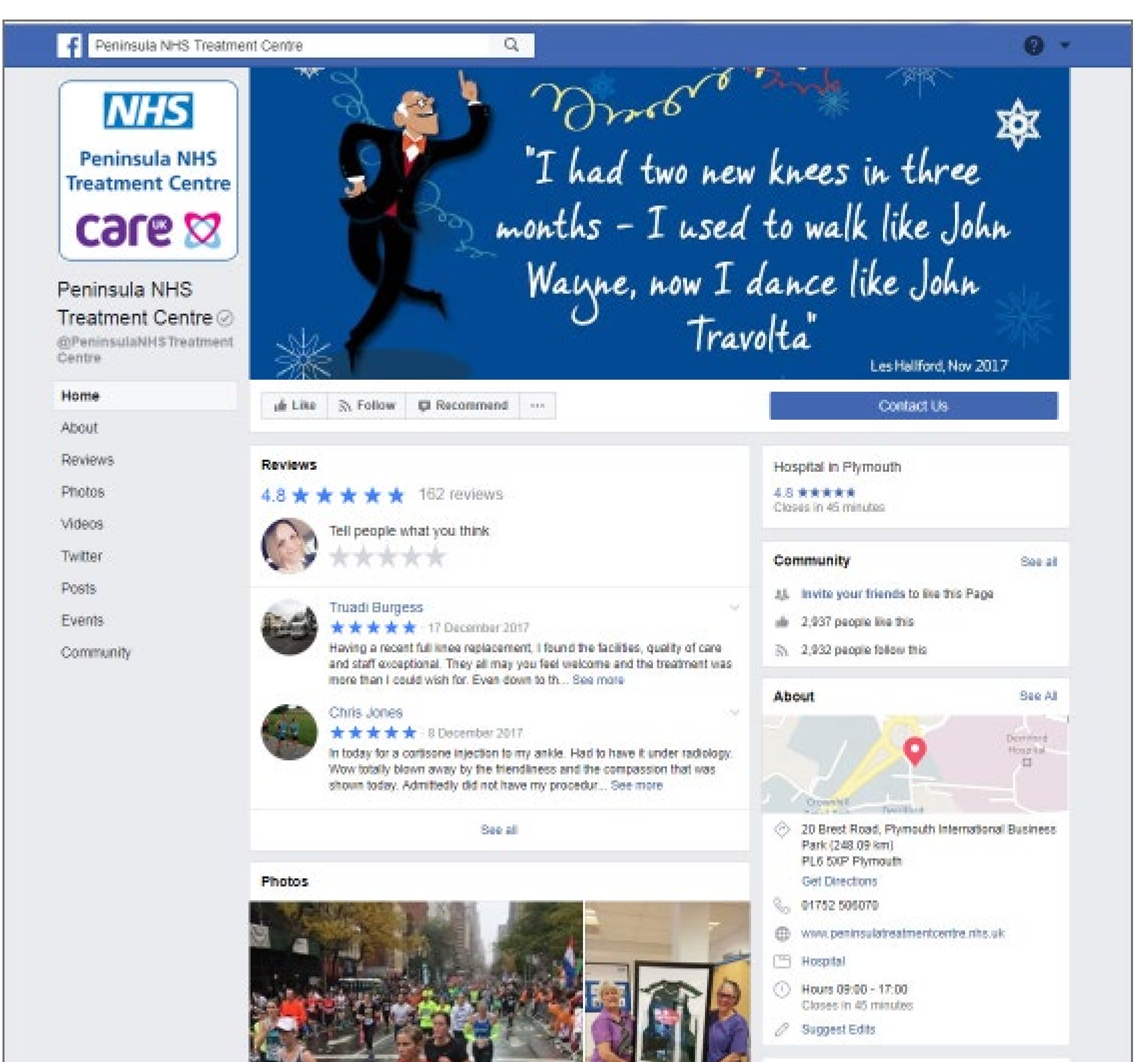
Patients have even commented on the enhanced look and feel and ease of use. Our performance data, including CQC reports, Friends and Family Test results and NHS Choices ratings are also easier to find than before.

Patient choice campaign

In order to help raise awareness of patient choice, and inform people of their right to choose when and where they access NHS services, we launched a marketing campaign across various channels to educate as many people as possible about this initiative. We know that choosing where to be treated can have a positive impact on a patient's outcomes, and wanted to let more people know that they have this option.

Facebook pages

Facebook remains the most popular social media channel in the UK, and is a place for people to discover information and interact. We developed Facebook pages for each of our treatment centres in 2016, and have successfully grown our followers month on month ever since. We share informative, educational content with users and give them the chance to raise concerns or share their experience of our services in a public forum. We make sure that all queries are responded to swiftly, and have been delighted to see so many people engaging with us on this platform.



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Looking forward

Next year's priorities

Next year's priorities

Care UK's Secondary Care Health Care Division has identified five new quality improvement priorities for 2018-2019.

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
Caring	To revisit the dignity audit and review the associated action plan.	That a dignity audit has been completed locally with comparison to the original results to determine improvement.
Well-led	To improve the uptake of the winter flu vaccination and immunisation of all clinical employees across treatment centres.	Flu champions in each service will monitor influenza immunisation of employees locally. These figures will be reported via monthly performance meetings.
Safe	Implementation of electronic reporting to NRLS to measure incident rates and outcomes in relation to NHS comparison services.	These reports will be observed via monthly monitoring and dashboards.
Effective	To implement an improved and augmented enhanced recovery programme across treatment centres.	Clinical outcomes in relation to key identified milestones.
Responsive	95% of patient complaints will be acknowledged within three working days and 95% of patient complaints are answered in 20 working days, or a date agreed with the patient.	That more than 95% of complaints received are acknowledged and answered within the timeframes stipulated.

Caring

Priority - to revisit the dignity audit and review the associated action plan.

What are we trying to improve?
To promote dignity and respect for patients to ensure their individual needs are identified.

What will success look like?
An action plan has been completed and all services have a robust plan in place.

How will we monitor progress?
That a dignity audit has been completed locally with comparison to the original results to determine improvement. This will be monitored via the Professional Leads meeting through the audit manager.

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 while 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?
Our target is a 5% increase in employees who are vaccinated against flu.

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

Safe

Priority - implementation of electronic reporting to NRLS to measure incident rates and outcomes in relation to NHS comparison services.

What are we trying to improve?
To demonstrate safe services are in place with evidence of incident trend reviews completed at a local level.

What will success look like?
Benchmarking across treatment centres in comparison to NHS services.

How will we monitor progress?
These reports will be monitored via monthly monitoring and dashboards with a quarterly report through the Secondary Care Governance Quality and Assurance meeting.

Effective

Priority - to implement an improved and augmented enhanced recovery programme across treatment centres.

What are we trying to improve?
At least 5% of eligible hip and knee arthroplasty patients are discharged within 24 hours whilst achieving identified key milestones.

What will success look like?
That 5% of eligible hip and knee arthroplasty patients are discharged within 24 hours whilst achieving identified key milestones and a measurable reduction in catheterization rate.

How will we monitor progress?
This pathway will be monitored through a number of clinical forums to review the clinical outcomes achieved in addition to a quarterly review at the Secondary Care Governance Quality and Assurance meeting.

Responsive

Priority - 95% of patient complaints will be acknowledged within three working days and 95% of patient complaints are answered in 20 working days, or a date agreed with the patient.

What are we trying to improve?
To ensure patient complaints are answered in a timely manner.

What will success look like?
That more than 95% of complaints received are acknowledged and answered within the timeframes stipulated.

How will we monitor progress?
This will be monitored via the Secondary Care Governance Quality and Assurance meeting on a quarterly basis, in addition to the monthly business reviews.

Quality and effectiveness

National and regulatory requirements

CQC inspections

National and regulatory requirements

Regulatory statements for our services 2017-2018

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 2017 - March 2018, Care UK provided or sub-contracted all of the services listed on page 6 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 and MIU's complete annual mandatory safeguarding training via a combination of online courses (eLearning) and face to face training. This training follows national guidance documents relating to children, adults and vulnerable people.

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 employees.
- 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.

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.

CQC ratings to follow.

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 2017/18 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 2017/18 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).

Information governance data quality

We take our responsibilities very seriously to protect and maintain the confidentiality of patient information in an accountable and transparent manner.

The Caldicott Guardian, who is responsible for the security of patient information, leads this work and is supported by the SIRO and Data Protection Officer committed to the highest standards.

Over the past year we have continued to encourage staff on the importance of an open and transparent reporting culture. And as a result we have had a total of 52 internal IT Security incidents within the year and have had six SIRI Level 2 reportable incidents which the ICO has closed with no actions taken against us.

Two of the incidents are being pursued by the ICO Criminal Investigators against the Individual former staff members under Section 55.

We have continued to enhance our security and governance to align with the technology evolutions and to address new threats.

To compliment our existing compliance framework of ISO 27001: 2013, our annual IG Toolkit submission for version 14 maintained a 100% Level 3 Compliance.

In 2017 we achieved the Cyber Essentials certification which is industry standard validation of our robust technical cyber security framework in light of the widespread Wannacry attack across our partner NHS operations; Care UK was not affected by the attack.

In light of the changes from the Data Protection Act 1998 to GDPR, we have started to implement and transform our governance framework to ensure that we embrace the fundamental changes the new regulations bring, that is, transparency and accountability.

Our robust GDPR preparations will ensure that our policies, procedures and staff awareness are fit for purpose to meet GDPR compliance going forward.

Patient led assessment of the care environment (PLACE)

Care UK are delighted that every one of our care environments within Care UK treatment centres were scored above 99% for cleanliness in 2017 by our patients.

Cleanliness
The patient-led assessors gave us an overall score of above 99% for the cleanliness of our Secondary Care sites for the second year running.

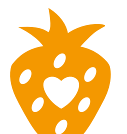
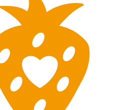
We are immensely proud of this score, which was complemented by an overall score of 97% for the condition, appearance and maintenance of the buildings from which we provide care. These scores reflect our ambition to ever improve on the quality of our services demonstrating an improvement on 2015 scores.

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).

Care UK PLACE Results 2017

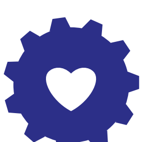
Cleanliness
99.23%

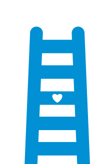
Food
92.90%

Ward food
93.97%

Privacy, dignity and wellbeing
89.03%



Dementia
88.28%

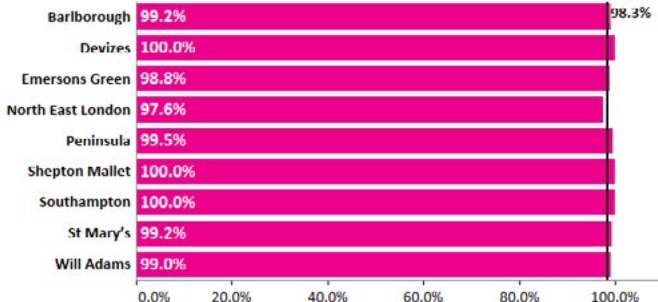


Condition, appearance and maintenance
97.27%

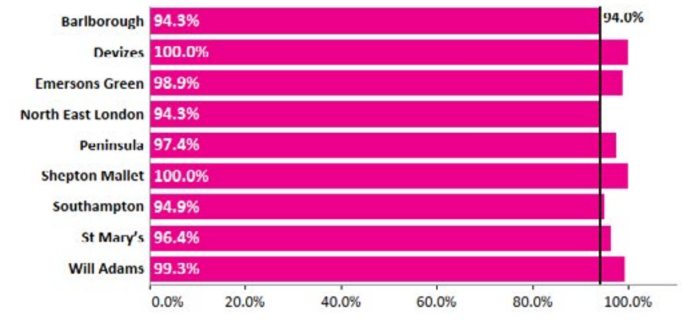
PLACE Scores 2017 - Part 1

Below are the PLACE scores for Care UK. The **national average** is indicated by a black line.

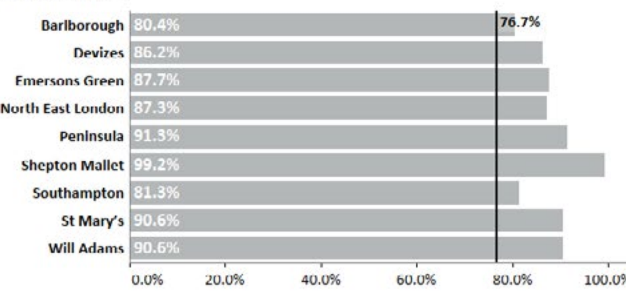
Cleanliness



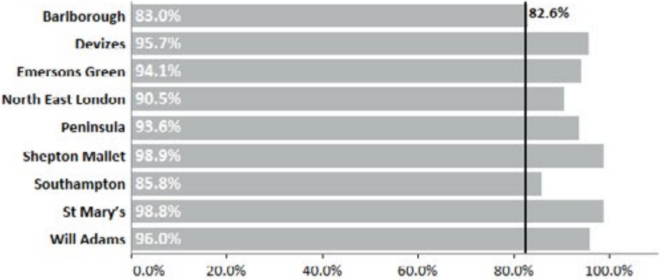
Condition, Appearance and Maintenance



Dementia



Disability



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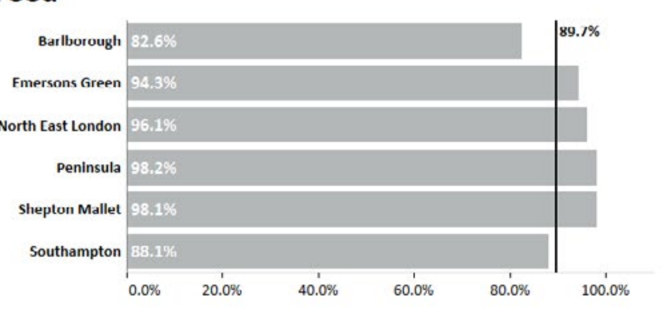
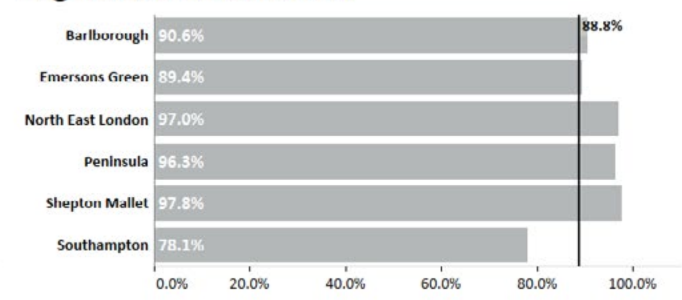
PLACE Scores 2017 - Part 2

Below are the PLACE scores for Care UK. The **national average** is indicated by a black line.
Devizes, **St Mary's**, and **Will Adams** are not scored on food as part of PLACE as they are non-inpatient facilities.

Food

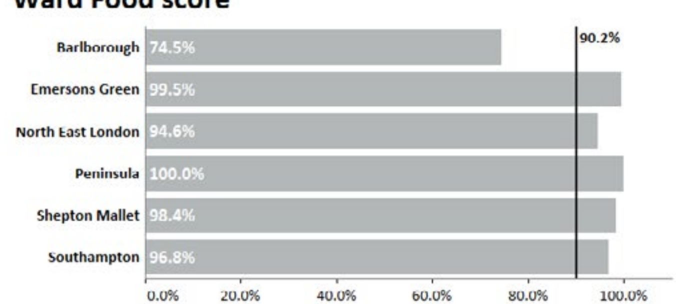


Organisational food score



Privacy, Dignity and Wellbeing

Ward Food score



Local clinical audit

In 2017 Care UK revised the audit programme making it less onerous and more responsive to risk. An exciting new web-based audit platform was also introduced which will allow us to quickly identify lessons and opportunities for improvement.

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.

In 2017 a revised audit schedule was introduced. The new programme set out to reduce unnecessary repetition of audits that were frequently compliant allowing services to focus instead on areas of clinical risk and opportunities for real improvement.

As well as freeing up time for clinicians to establish and complete their own audits, the new schedule also introduced a number of 'triggers' that would prompt more frequent or deeper dive audits when areas requiring improvement were identified.

Care UK also introduced a new web-based audit tool that will further reduce the resource required to complete audits and submit results, as well as providing important insights into specific areas for improvement. The new platform will improve reporting accuracy and works across mobile devices. The new system has an action plan module that allows staff to drive improvement and track progress.

Core audits in the Clinical Audit Schedule (undertaken within all areas) include: medicines management; documentation; information governance and security; emergency responses; the WHO Surgical Safety Checklist and safeguarding.

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 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).

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 audits 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 clear improvements in the quality, safety and clinical effectiveness of our services - with shared learning mechanisms used to maximise the benefits across whole service streams.

In April 2017 the North East London service was non-compliant with the WHO surgical safety checklist audit with a score of 94%. This was raised to 100% compliant by November. The improvements are the result of concerted efforts to ensure the highest standards of surgical safety in the centre.

The Emersons Green service was non-compliant with the VTE audit in June 2017 but through improving the documentation and evidence were able to report 100% compliance in December 2017.

Care UK's Emergency Scenario audit checks how prepared services are for medical emergencies such as cardiac arrests and major hemorrhages by assessing their response to a mock incident. The audit tool uses best practice guidance to ensure that the right people attend in a timely manner and deliver the correct care for the situation that presents itself.

In June 2017 both Peninsula and St Mary's were partially compliant with the audit and action plans were put in place. When re-audited in December 2017 both services reported 100% compliance, demonstrating that the action taken led to real improvement in this important area.

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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.

Local audit schedule

Audit title	Purpose of audit	Frequency	ISTC	CATS
Documentation (Clinical)	Supports best practice in patient documentation and guidance from professional bodies	6 monthly	✓	✓
Patient falls	Patient safety and compliance assessment tool	6 monthly and following a patient fall	✓	
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	Quarterly	✓	
Pain audit	Assess effectiveness of pain management protocols	6 monthly	✓	
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	Quarterly	✓	
Fluid balance audit	To assess fluid management in patients	6 monthly	✓	
Blood transfusion audit	Compliance with blood safety and national transfusion guidance	Annually and following an emergency transfusion	✓	
Traceability audit - endoscopy	Compliance to JAG standards and re-accreditation	Monthly	✓	✓
Endoscopy environmental audit	Compliance to JAG standards and re-accreditation	Monthly	✓	✓
Medicines management – deep dive	To monitor all aspects of medicines management across our clinical services	Annually	✓	✓
Controlled drugs documentation audit	A dedicated audit for pharmacists/meds management leads focusing on the documentation element of controlled drugs usage	Quarterly	✓	
Medicines reconciliation	A short audit to ensure compliance with NICE guidance focusing on reconciliation of medicines	Monthly	✓	
Omission of medication	A short audit to ensure compliance with NICE guidance focusing on medicine omissions	Monthly	✓	
Inpatient medication documentation	A short audit to ensure compliance with NICE guidance focusing on the documentation of medicines for inpatient services	Monthly	✓	
Anaesthetic observation audit	Assessment of compliance and quality of anaesthetic practice	6 monthly	✓	
Ward round (MDT) audit	Assessment of ward round practices and key team member involvement	Quarterly	✓	
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 and following use of agency/temp/locum staff	✓	✓
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	Annually and following an emergency response	✓	✓
Safeguarding audit	To ensure that safeguarding concerns are referred and logged, providing assurance that safeguarding responsibilities are discharged	Quarterly	✓	✓

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
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

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Name of national clinical audit	Care UK eligible to participate in	Care UK participation (Yes/No)	Comments
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
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

Name of national clinical audit	Care UK eligible to participate in	Care UK participation (Yes/No)	Comments
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

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.

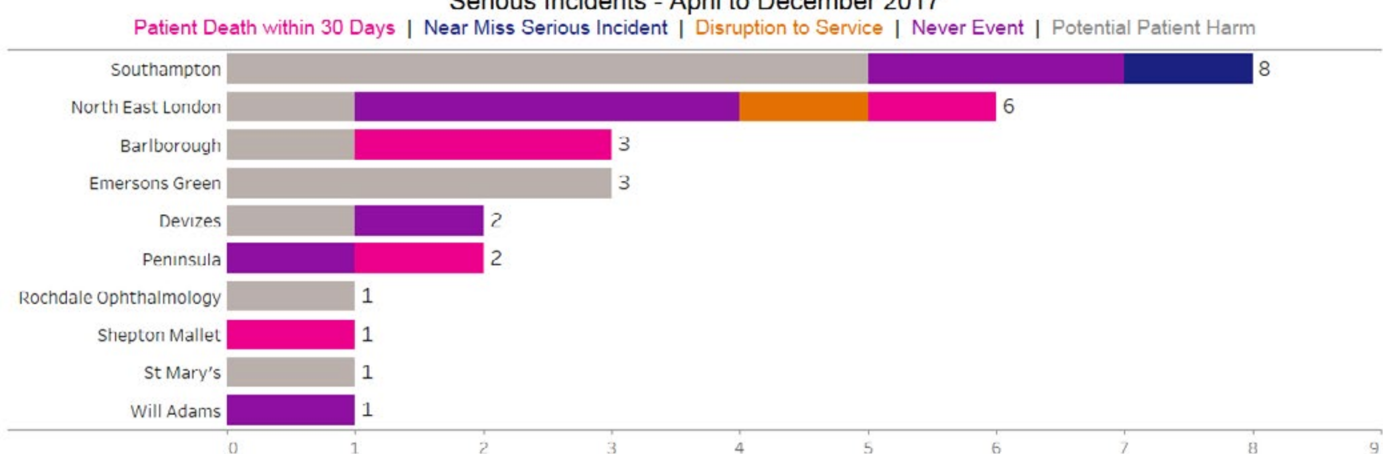
Following recommendations from an external review commissioned by Care UK, a revised incident reporting and investigation policy, was used in 2017/18 alongside new root cause analysis tools and methodology.

There were eight never events reported in 2017/18 across Secondary Care services. Three incidents related to wrong lens insertion.

A wrong tooth was extracted in Southampton and Devizes Treatment Centre and a piece of k-wire was retained in a patient's foot following surgery. There were two historic never events reported at North East London Treatment Centre when NJR completed a retrospective audit which highlighted two patients in 2009 and 2010 who had wrong side prosthesis implanted.

The processes at North East London and NJR have changed in the intervening period of time and as such similar incidents would not occur.

Site	Category
Devizes Treatment Centre	Wrong tooth extraction
North East London NHS Treatment Centre	K-wire retained post-surgery 2 Historic NJR wrong site prosthesis
Will Adams Treatment Centre	Wrong lens inserted
Peninsula Treatment Centre	Wrong lens inserted
Southampton NHS Treatment Centre	Wrong lens inserted Wrong tooth extraction



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 applied changes to practices, pathways and management, across all sites. Where indicated, we also review our policies and procedures to reflect these changes.

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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 however only one of which related to a patient safety incident. This is still under investigation and relates to a potential missed diagnosis of lung cancer.

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.

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 meeting convened by commissioners.

These meetings enable teams of experts, including both senior managers and clinical colleagues, 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.

Clinical coding
During 2017-18 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 14.1-505 and conducted in-line with the Clinical Classification Service's clinical coding methodology: version 11.
- The 2017-18 audit results demonstrated that the Care UK treatment centres were achieving the satisfactory percentage accuracy for Level 2 with the majority achieving the higher Level 3, in-line with the requirements of IG Toolkit 14.1-505. One treatment Centre did fall below the Level 2 requirement due to staffing issues where external clinical coders were used for a period.
- Care UK clinical coders receive ongoing training in-line with the Information Governance Toolkit 14.1-510 attainment Level 2.

Equality, diversity and inclusion
"Led and overseen by the Divisional Equality, Diversity, and Inclusion Steering Group our good work continued throughout 2017. Aside from maintaining and supplementing the existing communication channels and development resources the key in-year achievements of the Group were as follows;

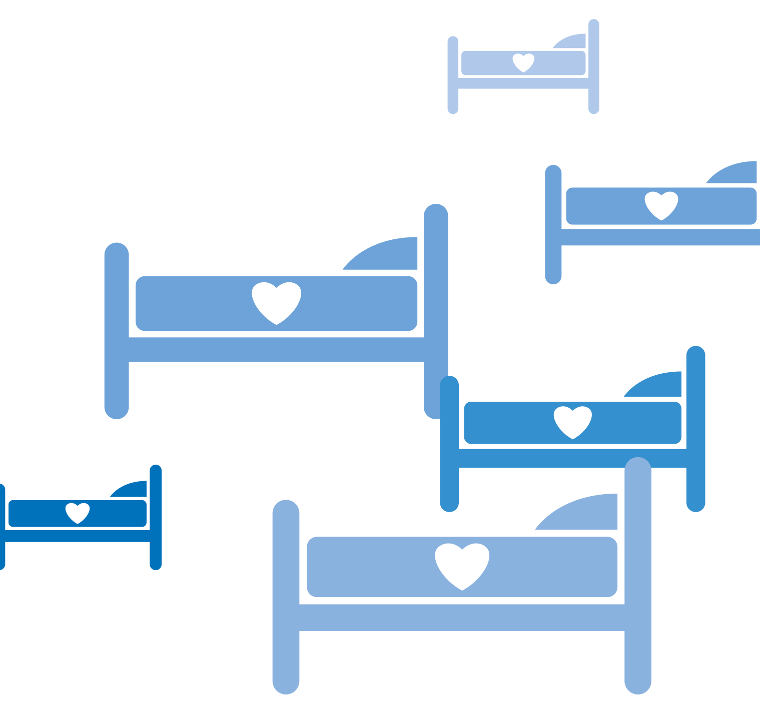
- Formal inclusion on the NHSE Equality and Diversity Partners Group (we believe we are the only independent provider to have achieved this membership)
- Inaugural generation and submission of the annual Workforce Race Equality Standards report to NHSE
- Inaugural generation and publication of the Health Care division Equality, Diversity, and Inclusion Annual report
- Successful completion of all CQC inspections with regard to the Equality, Diversity, and Inclusion aspects of the Well-Led framework

In addition, and pleasingly, the question that generated the most improved outcome across the whole workforce according to our annual divisional employee attitude survey "Over to you!" was "People where I work are treated fairly regardless of their race, ethnic origin, age, gender, sexual orientation, or disability".

Same sex accomodation
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.

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"



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.

Infection, prevention and control

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. We target these to ensure improvements are planned for, and actioned within a timely manner. Incidents 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 2017 - 2018
Healthcare Associated Infections (HCAIs):
Care UK had no reported cases of Clostridium difficile infection and no incidents of methicillin resistant or sensitive staphyloccus aureus bacteraemia attributable to their care during 2017.

This is our sixth consecutive year of zero HCAIs.

Health care associated infections (HCAI) 2011-2017

MRSA bacteraemias
0 infections

MSSA bacteraemias
0 infections

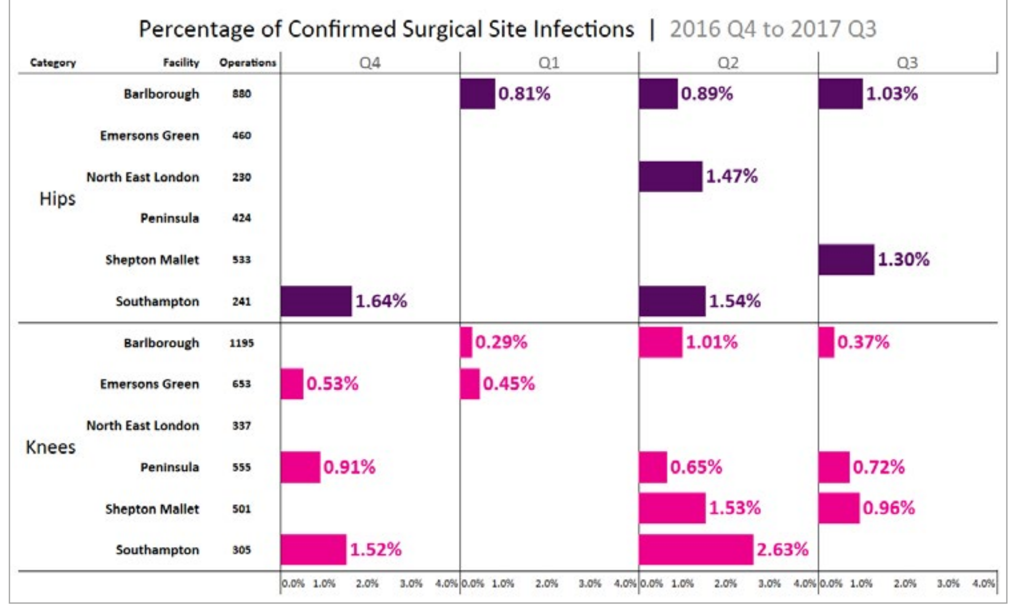
E.coli bacteraemias
0 infections

Clostridium difficile incidence
0 infections

Surgical site infection (SSI) rates (hip and knee replacement)
Care UK's Secondary Care services administer 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 NSSISS.



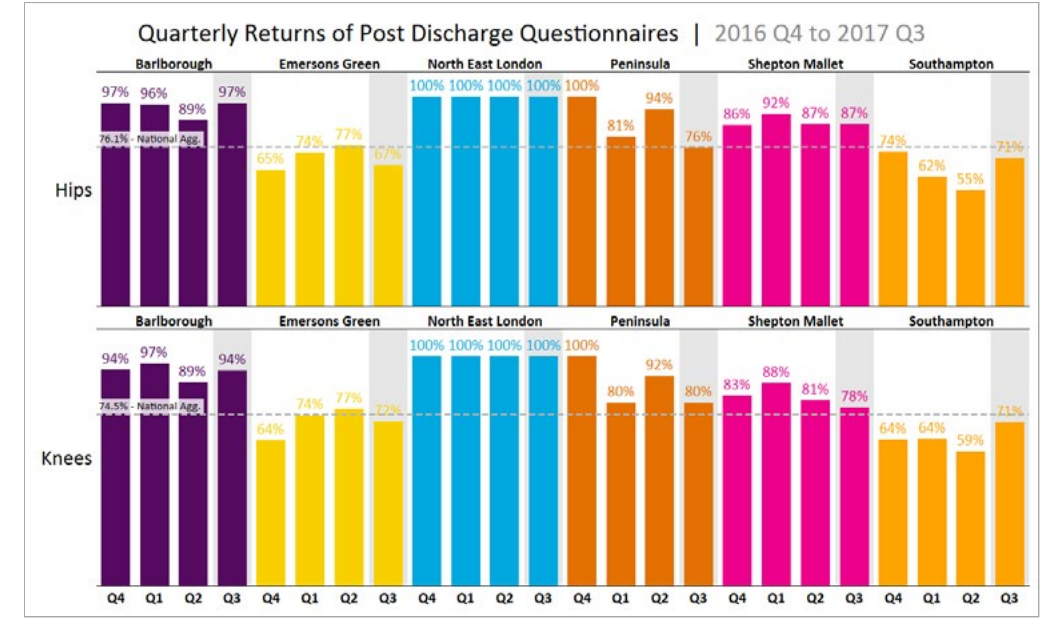
Care UK report incidences of surgical site infections on a monthly basis; this exceeds the national requirement of quarterly reporting.
This enhanced visibility of the post-discharge outcomes of our patients undergoing hip and knee replacement promotes transparency and confidence in the true values of our reported rates of infection.

Surgical site infection rates (hip and knee replacements)
In-line with national Public Health England guidance, Care UK monitors the patient experience once patients return home after surgery.

Questionnaires are given to patients following hip and knee replacement surgery and these are requested to be returned to us once the wound is healed.

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 patient experience 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.



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.

As a positive move towards seeing the world from our customers' point of view, we have introduced a new tool by which our patients are involved in assessing clinical staff compliance with hand hygiene.

This has proved a popular shift in stakeholder engagement with staff and patients responding well to opportunities for reflective practice.

The removal of observer bias in this style of auditing has highlighted units with consistently excellent practice and areas where improvements can be made in embedding infection prevention in routine practice.

The new tool allows patients to identify infection prevention performance against grades of staff which informs training improving the effectiveness of targeted action planning.

Cleanliness
Cleanliness remains a key priority for infection prevention and control action and is a specific audit within the clinical audit schedule undertaken by all treatment centres on a regular basis.

Scoring above 99% in Patient-Led Assessments of the Care Environments across the treatment centres evidences the high standards of cleanliness which are monitored by local infection prevention and control leads and heads of services as part of our internal quality management.

This year we have embedded the NPSA cleaning monitoring tool within our processes of cleaning supervision, placing control for the cleanliness of functional areas back with local and clinical site management.

Infection with Clostridium difficile

Indicator	Care UK overall data			
Rate of Clostridium difficile (number of infections/100,000 bed days)	Apr-Mar 2016-17	Aggregate 2008-17	Apr-Mar 2015-16	Apr-Mar 2016-17
All treatment centres	0	31.2	14.9	13.2
Data source:	Local data	PHE Annual Epidemiological Commentary, 2017. Ref: www.gov.uk/government/uploads/system/uploads/attachment_data/file/634675/Annual_epidemiological_commentary_2017.pdf		

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

- It is extracted from published verified local data that is submitted to Public Health England
- 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.

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).

Category	Name of national clinical audit	% of cases submitted Pre-op	% of cases submitted Post-op (of those who gave a Pre-op response)
Acute	National Joint Registry (NJR - 2017)	99%	
Other	Elective surgery (National PROMs Programme - 2016/17)	Varicose Veins 74% Groin Hernia 82%	Varicose Veins 52% Groin Hernia 67%

Patient 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 the Appendix. This also lists those we did not participate in, with a rationale i.e. we are not commissioned to provide the service being audited.

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.

National Joint Registry (NJR)

The NJR has, since 2003, monitored joint replacement surgery in terms of both its clinical effectiveness and the effectiveness of the surgical implants used.

The total number of procedures recorded in the NJR excedes 2.35 million, with 242,629 added during 2016/17 (14th Annual NJR Report, September 2017).

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.

Hospital	No. of procedures 2016/2017	NJR consent rate	Number of surgeons	Outliers – mortality rate	Outliers – hip revision rate	Outliers –knee revision rate
Barlborough NHS Treatment Centre	1,979	99.9%	10			
Emersons Green NHS Treatment Centre	1467	99.5%	6			
North East London NHS Treatment Centre	457	100.0%	7			2.00
Peninsula NHS Treatment Centre	868	95.4%	11			
Shepton Mallet NHS Treatment Centre	1028	100.0%	9			
Southampton NHS Treatment Centre	520	99.4%	7			

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

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)

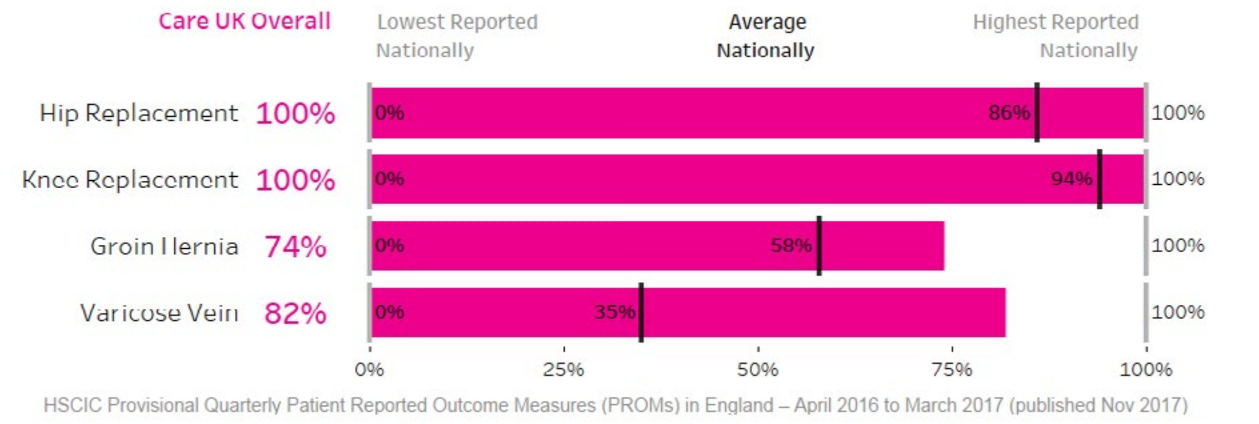
The NHS requires providers to ask patients having one of four specific procedures to complete questionnaires before and after their operation, to find out how much difference the operation has made to them. The four procedures are hip replacement, knee replacement, groin hernia surgery and varicose vein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

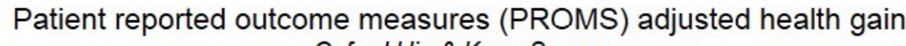
The tables below show how well we have done by comparing our achievements to the national average and to the best and worst performers.

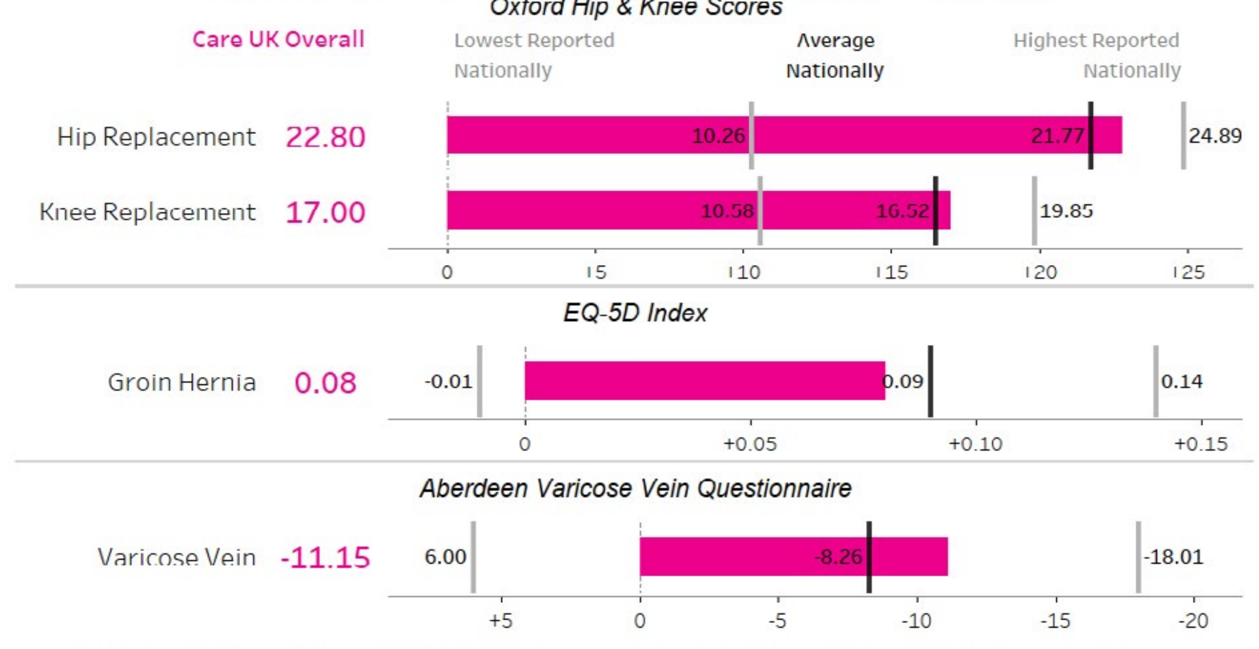
Indicator	Care UK overall data		Health and Social Care Information Centre (HSCIC) data - April 2016- June 2016		
Patient reported outcome measures (PROMS) participation rates	April 2015 - March 2016	April 2016 - June 2016	Highest reported nationally (best performing)	Lowest reported nationally (worst 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)					

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)					

Patient reported outcome measures (PROMS)







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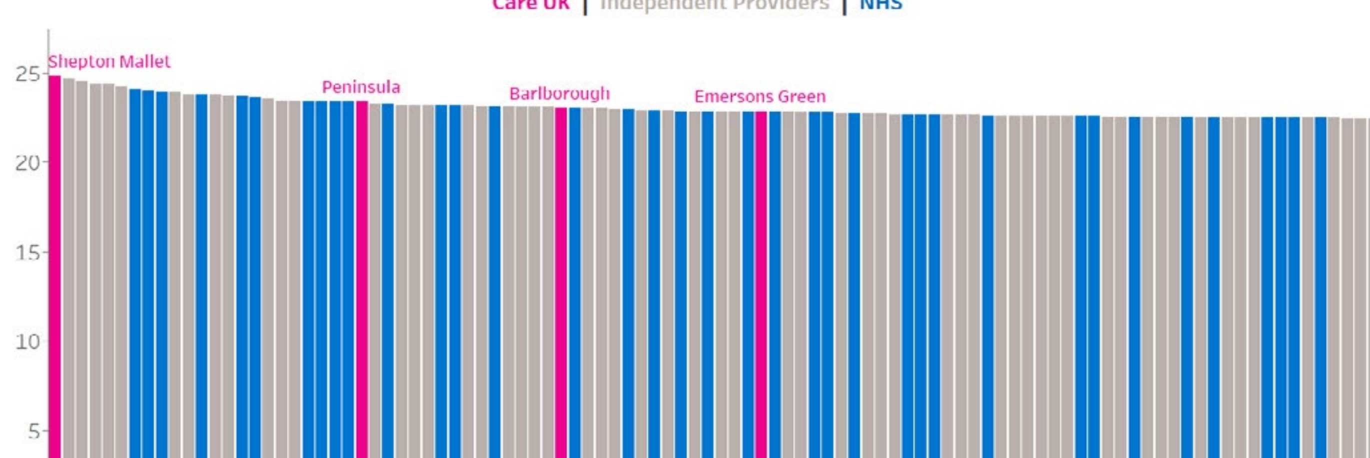
Care UK considers that these data are as described for the following reasons:

- 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.



Emergency readmission 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:	2017	Highest reported nationally (best performing)	Lowest reported nationally (worst performing)	National average
All treatment centres	0.21%	19.39%	1.42%	11.78%
Data source:	Local data	HSCIC/Indicator portal data set: '3b Emergency readmissions within 30 days of discharge from hospital'		

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

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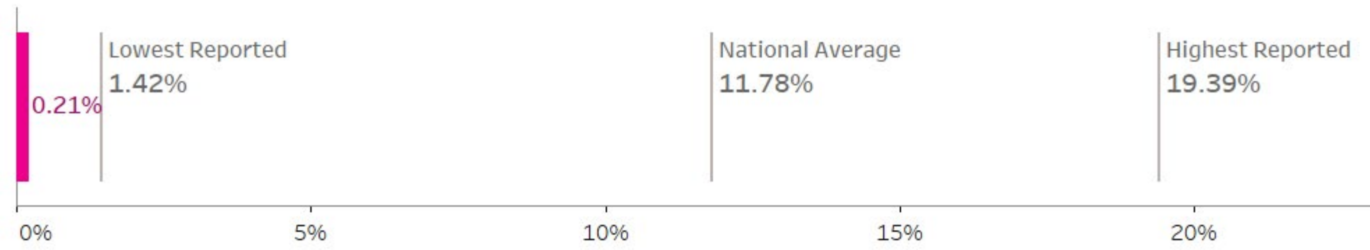
- It is taken from local data that is submitted to the Department of Health.
- Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:
- Emergency readmission rates are tracked monthly for each treatment centre and reported to the Senior 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 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	99.79%	100.00%	60.77%	95.53%
Data source:	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-201617			

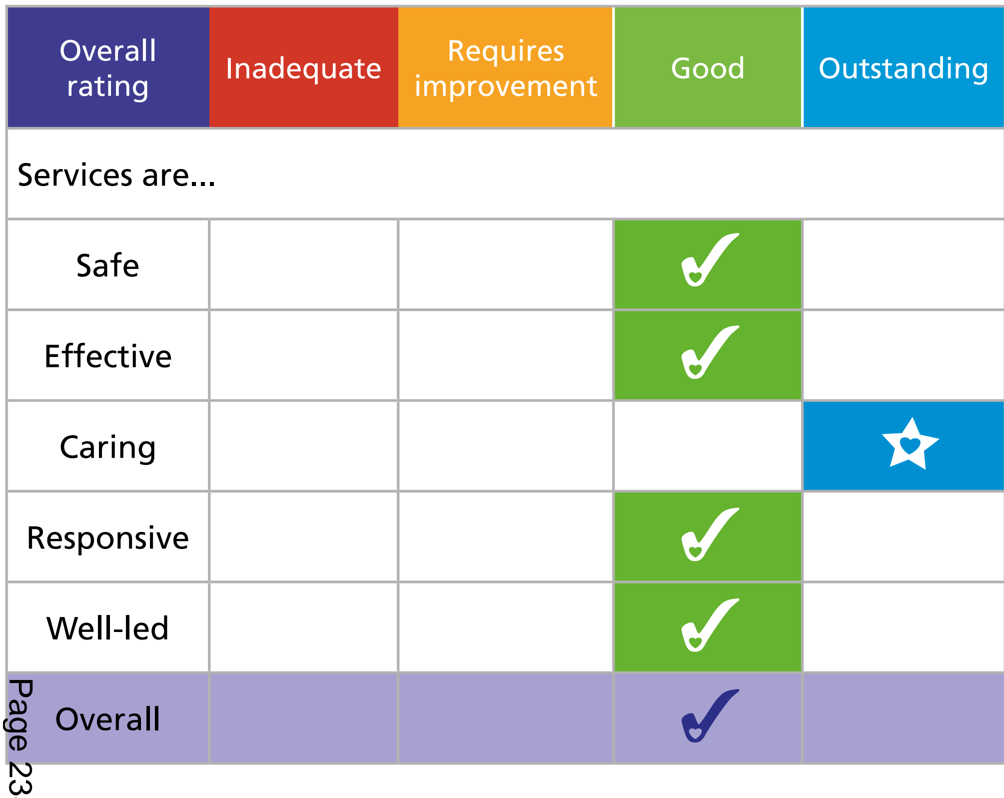
Care UK considers that these data are as described for the following reasons:

- 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.

CQC inspection results

Barlborough Treatment Centre

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

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 Treatment Centre

2nd October 2015

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

"Staff treated patients with courtesy and respect, and patients were fully involved in decisions about their care."

"Staff took into account the needs of different people, for example, patients living with dementia, learning, or other disability conditions. And ensured they were seen as quickly as possible."

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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	

Will Adams Treatment Centre

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	

Emersons Green Treatment Centre

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."

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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 Treatment Centre

13th July 2016

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

"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."

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

Devizes Treatment Centre

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."

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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	

Shepton Mallet Treatment Centre

October 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 Treatment Centre

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."

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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	

St Mary's MIIU

2nd October 2015

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

"Services reflected the importance of flexibility, choice and continuity of care."

"Staff treated patients with courtesy and respect, and patients were fully involved in decisions about their care."

Royal South Hants MIU

29th March 2017

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

"The service had good facilities and was well equipped to treat patients and meet their needs."

"We saw that staff treated patients with kindness and respect, and maintained patient and information confidentiality."

Rochdale Ophthalmology CATS

November 2016

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

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"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	

Quality visit schedule

The CQC are currently under consultation to determine the revised inspection requirements for independent hospitals, to support the requirements and to provide assurance to the CQC a schedule of quality visits are being arranged internally within Care UK.

These visits will follow a regime of a team comprising heads of service will visit all Secondary Care services at least once in a 12 month period, will complete a quality visit and provide a report to support observations on the day with a series of recommendations.

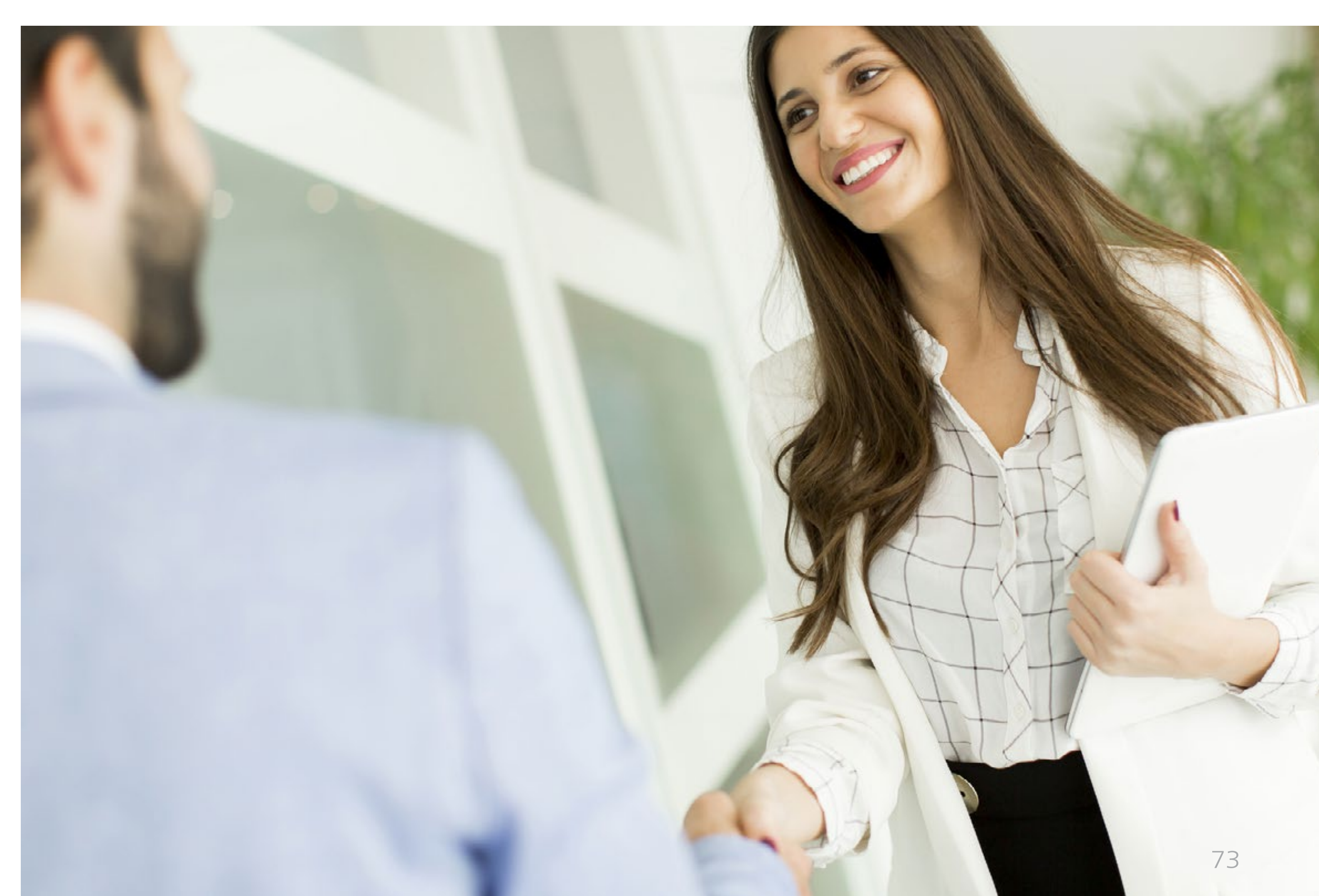
The quality visit will consist of observational visits to each department - following a set format aligned to NHS fifteen step challenge - to provide assurance of implementation of national and local procedure and process.

These recommendations will be monitored and managed via an action plan which will be reviewed as part of the monthly performance meetings chaired by the managing director.

The quality report will be provided within six weeks of the visit and shared with the senior leadership team locally in addition to the Medical Director for Secondary Care .

Any immediate concerns highlighted during the visit will be shared with the local sight at the feedback session at the end of the day.

The quality visit report will be able to provide assurance to both CCG and CQC of regular review of processes and procedures at a national level by the organisation.



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Appendices

Local updates

Key stakeholder feedback

Local updates

Shepton Mallet Treatment Centre

Details of current year (April 2017 – March 2018) local quality priorities

What we were trying to improve?

- Uptake of flu vaccinations for frontline staff in SMTC and SMCH
- Moving all referrals to our service to e-RS (electronic referral system) thus removing paper based referrals
- Introduction of Personalised Activation Measures (PAMs) to inpatients who are at high risk of falls

Why we were trying to improve?

- Comply with the guidance published by the World Health Organisation and advisory statements from the professional bodies, recognising our responsibility as a healthcare provider to contribute to the herd protection, in the event of a particularly virulent strain of a pandemic flu virus – protecting the otherwise well population.
- In-line with NHS digital guidance, to remove any reliance on paper based referrals by October 1st 2018
- Delivering personalised care and support planning to an identified cohort of patients with long-term chronic conditions

How we monitored progress

- Through a spreadsheet local data base, separating relevant staff groups, and recording compliance to the request for frontline staff having flu jabs – regular updates circulated to all staff groups, supported by posters etc.
- Dedicated work groups to move the four remaining services onto e-RS (ultrasound appointments, plain X-ray appointments, MRI appointments and flexible cystoscopy direct access GP referrals)
- Completion of online training modules, acquisition of 100 licenses through Somerset CCG – commencing of completion of questionnaires by February 1st. This is a two year local CQUIN.

Local priorities

CQUIN 2017-2018	Target
Improving the uptake of flu vaccinations for frontline staff within providers	70% frontline clinical staff
Ereferrals - enable all referrals into the provider through e-RS	Q1 a trajectory to reduce Appointment Slot Issues to a level of 4%, or less, over Q2, Q3 and Q4.Q2 80% of agreed speciality referrals to 1st O/P Services able to be received through e-RS. Q3 90% of agreed speciality referrals to 1st O/P Services able to be received through e-RS. Q4 100% of agreed speciality referrals to 1st O/P Services able to be received through e-RS. Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less in-line with the agreed trajectory set in Q1.
Supporting proactive and safe discharge	Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out protocols in partnership across local whole-systems. Develop and agree with commissioner a plan, baseline and trajectories which reflect impact of implementation of local initiatives to deliver the Part B indicator for year 1 and year 2. As part of this agree what proportion of the Part B indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers.
Personalised care planning for people with LTC	1. Community based providers would need to submit a plan via UNIFY (or alternative) outlining their approach to delivering personalised care and support planning to an identified cohort of patients and how they will record this activity in a format that can be aggregated at organisation level (ie local, operational collection can vary, but organisational submission to UNIFY must be consistent) following locally agreed sign off processes by the commissioner. 2. Providers would need to identify which patient populations would benefit from personalised care and support planning and should be prioritised, using the list of long-term conditions outlined in the GP Patient Survey and the Patient Activation Measure or GP patient survey criteria to assess their level of confidence and perceived support. Providers would need to identify relevant staff (as defined above) and record that they have undertaken training in personalised care and support planning (as defined above). To be submitted via UNIFY (or alternative) following locally agreed sign off processes by the commissioner.
Quality Accounts	
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.
Dignity champions will be implemented in each service.	All services have a dedicated dignity champion in role.
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.
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.
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.

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Local outcomes

	Local results	National results
NJR	See table on page 57	
PROMS	Primary Knee Replacement – 1st – primary health care gain = 0.398 Primary Hip Replacement – 8th – primary health care again = 0.484	National report available – reflects local results
VTE	100%	95.6%
Complaints	7	
Incidents related to patient harm	0	

Details of next year's priorities - April 2018 – March 2019

What are we trying to improve?

- Introduction of consultant led specialty advice and guidance (in-line with local CCG and Trust initiatives)
- Increase uptake of flu vaccinations for frontline staff in SMTC and SMCH to 75%
- Continue to move all referrals to our service to e-RS (electronic referral system) thus removing paper based referrals (by October 1st 2018)
- Implementation and review of Personalised Activation Measures (PAMs) to inpatients who are at high risk of falls
- Preassessment of patients alcohol and tobacco consumption and offering alternatives – including signposting to appropriate service/support options
- Electronic Discharge Systems – improve ability to send discharge reports out of county – and when the referrer is not the GP.

How we will monitor progress

- Utilisation of advice and guidance clinics (published on e-RS)
- Increased percentage of flu jab take up to 75%
- Successful move to all services to e-RS
- Reports to the Referral Management Centre (managing the process on behalf of the CCG) and reduction of the patient's PAMs score as Primary Care will have intervened in terms of supporting the patient's ability to self-manage their long term conditions.
- Audit of relevant patients – and successful signposting into appropriate services
- Introduction of the required methodology to enable the sending of discharge reports out of area (required business systems assistance).

Patient Story

At age 55, Stephen Howarth, a manual and robotic welder from Crewkerne, is comparatively young to have had his left hip replaced, yet problems with osteoarthritis since his teens meant he had to have the operation sooner rather than later.

Now, thanks to hip surgery at Shepton Mallet NHS Treatment Centre, Stephen is fully mobile and back to having fun with his four grandchildren aged between 18 months and 10 years old.

Things came to a head for Stephen about a year ago. "Over the years I had got used to the pain, but the situation went downhill quickly over the past 12 months" he said.

"I was finding it hard to get about, I couldn't play with my grandchildren as I had done and I was having trouble sleeping."

He continued: "At first we thought it was a problem with my knees, yet when someone else said they had had similar symptoms and it turned out to be their hip, I asked my doctor to look into it and an x-ray showed my hip was really bad. There was a reluctance to replace the hip given my age, but when the surgeon examined me and manipulated the joint he said that I should have had surgery years ago and that I had probably had osteoarthritis since my teens."

Stephen was referred for surgery to Shepton Mallet NHS Treatment Centre. "I was five years old when I last stayed in hospital, and that was to have my tonsils out, and I was really worried about my treatment. I shouldn't have been – the treatment was amazing in a lovely hospital staffed by really friendly professionals, from the surgeon to the cleaners."

He added: "My surgery took place at about 2.00pm and my wife planned to visit me after work. She turned up at 6.00pm to find me sitting up in bed watching TV – neither of us expected me to be so awake. Nothing was too much trouble for the staff, and even when I felt a little sick as a result of the anaesthetic when I first starting getting about on a frame it was OK with everyone to let me continue at my own pace. I appreciated the time that I was given and the fact that, if I didn't feel up to it, that was alright."

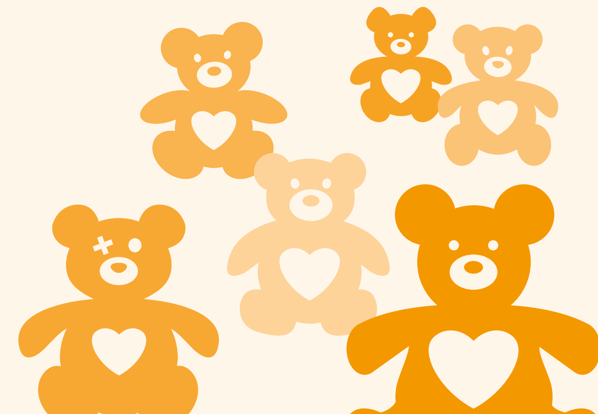
Stephen also praised the after care: "After I came home I was worried about something so I rang the hospital and I was put straight through to the doctor. She said that if I wanted to come in there and then I could and that they were there for me. I decided that we could probably leave it until the following morning and she provisionally booked an appointment for me first thing. In the end I didn't need it, but it was reassuring to know that the opportunity was there if I had required it and I was left even more impressed by the level of care."

"I would recommend Shepton Mallet NHS Treatment Centre to anyone who needs an operation. They are so professional and so caring. My operation has given me my life back, and I can now chase after a ball with my grandchildren whereas before I couldn't keep up with them at all."

Chester Barnes, Hospital Director at Shepton Mallet NHS Treatment Centre, commented: "We are really pleased to have made Stephen's first hospital stay in 50 years so positive for him, and we really appreciate his kind comments."

Shepton Mallet NHS Treatment Centre is part of the choice available to patients for NHS care. If a GP or other referring health professional agrees that a patient needs treatment, and it is for a procedure carried out at Shepton Mallet NHS Treatment Centre, then that patient can ask to be referred to the hospital for their care.

Waiting times are short and patients are guaranteed quality care – Shepton Mallet NHS Treatment Centre is the first hospital in England to have achieve a Care Quality Commission rating of 'Outstanding' across all criteria.



Peninsula Treatment Centre

Details of current year (April 2017 – March 2018) local quality priorities

What were we trying to improve?

- Service expansion
- The introduction of a third laminar air flow theatre
- Endoscopy unit, new service
- Fourth minor surgery theatre
- Introduction of trans-nasal approach gastroscopy service
- Anti-microbial stewardship program
- ISO accreditation for Information security management system - ISO 27001.

Why were we trying to improve and how we monitored progress

- Building work undertaken from December 2016 completed March 2017, introduction of state of the art third laminar air flow theatre for major arthroplasty patients. Review of all patient outcomes and increase in joint replacement surgery.
- Endoscopy unit opened, working towards JAG accreditation, registered with JAG, competency based assessments for all staff. Dedicated endoscopy and day surgery manager employed. Plus employed endoscopists and nurse endoscopist. Monitoring of patient outcomes monthly. Monthly MDT meetings to ensure the needs of the improving service is met and any risk areas have action plans that are regularly reviewed.
- Introduction of trans-nasal gastroscopy scopes, less invasive and more comfortable for the patient. Leading provider of trans-nasal scopes in the South west. Monitoring of patient outcomes, developed patient information leaflets and post procedure advice information.
- Monitoring and reducing the use of antibiotics to reduce antibiotic resistance- stewardship forum group developed meetings held quarterly, MDT involvement in all patients requiring antibiotic treatment based on microbiologist advice
- Information security management system ISO 27001 achieved with no non conformities.

Local outcomes

	Local results
NJR	100% submission in real time
PROMS	99.9% THR/TKR
VTE	99%
Complaints	15 formal 295 compliments and cards received
Incidents related to patient harm	1 patient incident, never event requiring corrective surgery, wrong lens implanted during cataract surgery

Details of next year's priorities - April 2018 – March 2019

What we were trying to improve?

- Achieving JAG accreditation
- Expansion of the ophthalmology services to meet local demand
- Improved working with the local NHS trust
- Reduction in the use of urinary catheters for knee arthroplasty patients
- Replacement of X-ray (C-arm) equipment
- Introduction of clinical scheduling to ensure smooth running of theatres and reduction in clinical cancellations on the day of operation.

What will success look like?

- Jag accreditation achieved
- Increase in cataract operations carried out, introduction of new ophthalmic surgeon and lead ophthalmology nurse
- Better choice for the patients within the South West region, positive outcomes and timely treatment
- Reduction in the requirement for catheterisation and reduction in catheter-related urinary tract infections
- New state of the art portable X-ray machine
- Reduction in clinical cancellation on the day of surgery by 50%.

How we will monitor progress

- Better choice for the patients within the South West region, positive outcomes and timely treatment
- Clinical outcome capturing all patients who develop catheter-related infections and working closely with the Infection prevention and control team
- Clinical outcome capturing of all patients that are cancelled on the day of surgery and seek plans to improve outcomes.

Patient Stories

Vicki's story

Just ten weeks after a hip replacement at Peninsula NHS Treatment Centre in Plymouth, Vicki, 67, from Looe in Cornwall has taken part in her first national swimming competition since her operation and won silver and bronze medals, as well as achieving some of her fastest times in three years.

Vicki took up swimming with the Masters Swimming Club 30 years ago when she took her children to their local pool in Norfolk and she noticed adults taking part too. "I'd never swum competitively before so I asked all about it and joined pretty much there and then – and the rest is history."

She has swum competitively since then, so when she started to suffer from genetic osteoarthritis and was told she needed a hip replacement, she was devastated. "I thought, 'why me?', especially as I have always kept fit and healthy, but it was in my genes and there was little I could do about it."

While the pain was alleviated when she was in the pool, outside of it, it became so bad that it kept her awake at night and made walking really difficult.

"I can walk from Looe to Polperro, about five miles, with no problem at all – but before my operation I could barely use the stairs and my posture was becoming very stooped."

Vicki had her hip replacement surgery at Peninsula NHS Treatment. After two weeks she was off her crutches and after six weeks was back in the pool – after taking advice from her surgeon, Tomasz Wudecki. Just ten weeks after her operation she was competing at the National Masters Swimming Club short course competition in Sheffield in the 65 to 69 age group – where she came away with a silver medal in the 100m backstroke, a bronze in the 50m backstroke, fourth in the 200m backstroke and fifth in the 100m freestyle.

"I was pleased with my performance, although I hate coming fourth!", said Vicki. "Some of my times were the fastest I've swum in three years. A lot of hard work has gone into achieving these results, but they could not have happened without my new hip from Peninsula NHS Treatment Centre and the support of my family and fellow members of Caradon Swimming Club."

Sunitkumar's story

73 yr old patient never knew he had a cataract but his vision was getting increasingly worse and he was unable to lead an active life. He went to the optician and had a thorough check and was informed he needed to have cataract surgery. He thought about this for some time and knew that his lifestyle would get worse if he did not do something positive, so decided to accept the referral from the optician and choose treatment at the Peninsula Treatment centre.

Referral to operation took three months and the patient had an excellent outcome. He no longer has to wear glasses and can see clearly. The patient was very impressed with the cleanliness of the treatment centre and commented that this inspired confidence.

He also commended the staff all working together and doing the jobs they were required to do with competence and efficiency.

The patient said, "The treatment was carried out so promptly, I can't even say time limit, within three months everything was over".

"For the last 45 years I've been wearing glasses, now I don't need glasses anymore. I can drive without glasses as well, and that is one of the biggest achievements I've ever made."

Southampton Treatment Centre

Details of current year (April 2017 – March 2018) local quality priorities

What we were trying to improve?

- Safety procedures for oral surgery pathway
- Groin hernia PROMs
- Acute kidney injury (AKI) prevention and provision of care if affected
- Implementation of multifactorial assessment to identify patient's individual risk factors for falls
- Sepsis pathway

How we monitored progress

- Local procedural teams were engaged to develop standard operating procedures for oral surgery pathways. These pathways were monitored for effectiveness and quality throughout the year using patient feedback and incident reporting.
- Ongoing monitoring process in place via PROMS database
- Training was provided to all relevant clinical staff to ensure that AKI was prevented (where possible) and treated appropriately and without delay (where necessary).
- Training was provided to reduce falls through risk assessments. Effectiveness was monitored through audit.
- Training was provided to all relevant clinical staff to ensure that Sepsis was prevented (where possible) and treated appropriately and without delay (where necessary). The pathway was reviewed to bring it in-line with the new NICE guidance.

What else did we achieve in 2017?

Organisational learning

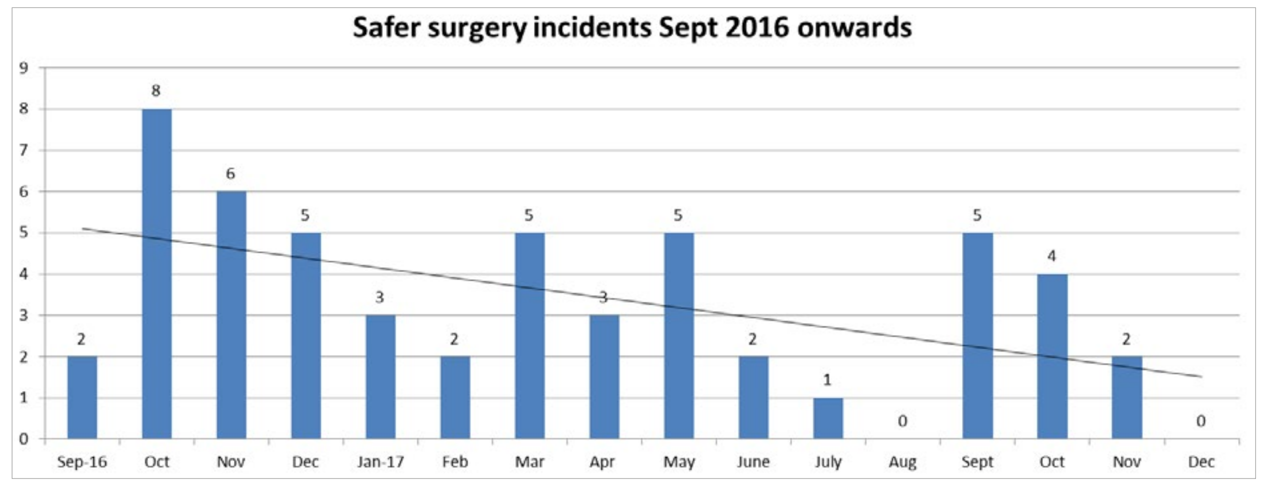
Southampton NHS Treatment Centre is committed to sharing learning within the treatment centre, across Care UK and with the wider healthcare community.

One of the key work-streams of this has been in making surgery as safe as possible. We have done this by reviewing and reducing minor documentation and process related errors to ensure that they do not follow through to more serious errors.

When incidents do occur that are more serious, a full root cause analysis is undertaken to determine what went wrong and how we can prevent it in the future.

Key themes from 2017 include:

- Record keeping and documentation
- The impact of medical abbreviations and understanding of them by non-medical staff members
- The transcribing of information from one document to another, where errors can be made in the process.



Local outcomes

	Local results
NJR	Revision rates are within the expected range for both hips and knees. The mortality ratio for hip and knee replacements is within the expected range.
PROMS	Pre-operative questionnaire response rate 90% (national rate of 75%). Post-operative questionnaire response rate 63% (national rate 66%).
VTE	2 VTEs in 2017 both unavoidable. Denominator in 2017 = 13591 therefore 0.01% of our activity.
Complaints	36 complaints in 2017. Denominator 2017 = 13591 therefore 0.3% of our activity.
Incidents related to patient harm	33 patient harm incidents in 2017. Denominator 2017 = 13591 therefore 0.2% of our activity.

Details of next year's priorities - April 2018 – March 2019

What are we were trying to improve?

- Flu immunisations
- Dignity audits
- Maintain 0% bacteraemia MRSA *C. difficile*
- Quality assurance review
- Patient reported hand hygiene responses
- Reducing face-to-face outpatient follow-up attendances
- Acute kidney injury (AKI) prevention and provision of care if affected
- Sepsis Management
- Local Safety Standards for Invasive Procedures (LocSSIP's)

What will success look like?

- 75% flu immunisation of frontline healthcare workers
- All areas will have completed all actions identified from dignity audits
- Overall improvement resulting in less QA recommendations
- 85% of healthcare workers will be seen decontaminating their hands as reported by patients
- 50% reduction in face-to-face outpatients attendance
- Correct management of patients and early identification of AKI risk factors
- Full Implementation with LocSSIP audit process in place.

How we will monitor progress

- Data and audit reviews will be carried out regularly
- Infection control data will be reviewed and actioned as necessary
- Quality and Assurance Governance process will be followed and reviewed.

Patient Stories

April 2017
A website enquiry received from a gentleman explaining that his wife desperately needed cataract surgery. He was very concerned that she may fall and hurt herself and wondered if we were able to offer her surgery sooner rather than later.

Due to a cancellation, the lady was seen in clinic in April 2017 and offered surgery dates of 20 April 2017 or 27 April 2017.

As the lady was due to be going on holiday to France on 30 April 2017, it was agreed that she would have her surgery on the earlier of the two dates. The surgery went well and the lady has not experienced any difficulties post–operatively.

The lady and her husband were thrilled with how quickly she was seen and treated. They were also both delighted with the quality of care received and confirmed they will sing the praises of our centre to all their friends and family. The GP practice was very impressed with the speed patients are seen and treated.

As the patient was treated ten days before her holiday, she felt reassured that she could access post-operative care if needed. She was also able to enjoy her holiday much more due to her improved vision.

September 2017
A gentleman with mild cognitive impairment who lived alone on the Isle of Wight had expressed a view that he did not want his gastroscopy procedure at his local hospital so was referred to our service.

Following discussions with the endoscopy unit manager, it was decided that the patient would be invited for an assessment of cognitive function. The patient relations facilitator (PRF) worked closely with the patient, sending an appointment confirmation letter providing step by step instructions about his travel arrangements from his home to the STC. (These were also confirmed verbally to the patient by telephone).

On the day of the assessment the PRF tracked the patient's journey by keeping in regular telephone contact with him. The PRF also liaised with both the Red Jet Service and the taxi company to ensure the patient's safe arrival for his assessment.

The assessment went ahead and the patient was passed for his procedure. The Endoscopy Team liaised with the Inpatient Ward Manager to arrange for the patient to be admitted the day before his procedure, so the staff on the ward could assist the patient prepare for the procedure.

The PRF once again assisted in making the travel arrangements to ensure the patient's safe arrival at the inpatient ward. The gastroscopy procedure was duly completed successfully without incident and the patient's son collected him at discharge.

By working together as a team, this patient was fully supported and was extremely grateful to all concerned.

The successful outcome achieved for this patient has changed the way referrals are triaged in relation to patients with special requirements, such as cognitive impairment. These referrals will now be reviewed on a case by case basis to determine whether - with some tailored support - treatment can successfully be provided.

The patient was successfully treated within a caring environment which made him feel calm and relaxed, reducing his anxiety levels. The patient found the entire experience a very positive one.

North East London Treatment Centre

Details of current year (April 2017 – March 2018) local quality priorities

What we were trying to improve?
- Over the last year we have tried to improve our Friends and Family response scores

Why we were trying to improve?
- Our patient feedback is important to us. It drives improvement and gives us a gauge for us to measure our effectiveness against.

How we monitored progress
- Monthly reports were obtained and feedback constantly given to the team with regards to their progress and successes.

Local outcomes

	Local results	National results
NJR	Total ops = 507 (hip = 200 and knee = 307) - Consent rate = 100%	NHS Total = 134,814 (hip = 62,611 and knee = 65,245) - Consent = 92% Independent total = 81,722 (hip = 37,557 and knee = 42,470) - Consent = 95%
PROMS	Hip Replacement Surgery – Oxford Hip Score: 20.098%	21.8%
	Knee Replacement Surgery – Oxford Knee Score: 15.802%	16.5%
	Varicose vein surgery – Aberdeen Score: -10.477%	-8.3%
	Groin Hernia Surgery – EQ-5D: 0.048%	0.087%
	Participation: Pre-op = 60.3% Post-op= 58.4%	75.4% 66.3%
VTE	99.779%	95.60%

Details of next year's priorities - April 2018 – March 2019

What are we trying to improve?

To eradicate avoidable cancellations of procedures and admissions by ensuring possible problems are identified early at pre-assessment and are addressed appropriately so that patients' procedures and treatments can take place as soon as possible.

What will success look like?

The delivery of a safe, effective, responsive and efficient service where patient care and treatment is planned, coordinated and managed throughout the patient's journey. Cancellations and delays will only occur if unavoidable and in the best interests of the patient.

How we will monitor progress

- Review the roles and responsibilities in pre-assessment / bookings departments.
- Investigate each event where a patient admission or treatment is delayed or cancelled to identify cause of delay or cancellation and feedback at local governance forums, departmental forums.

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Patient Stories

"It gives me great pleasure to be writing to you with regard to my recent inpatient stay at NELTC.

I was seen by the orthopaedic consultant, Mr A Pataki, on 16th October for a pre-assessment with a view to having a left total knee replacement.

The procedure was explained to me, and I agreed to have this surgery. I was admitted to KingFisher Ward (KFW) on 25th October.

During my stay, the treatment from every member of staff on the ward was excellent. The team (housekeeping, catering, physiotherapy, nurses, pharmacist, anaesthetist and doctors) was once again excellent.

On observation, the whole team worked so well together with the patients being the central focus of their attention and commitment.

Pre and post-operative information was sent or given to me, plus preparatory items i.e. antiseptic washing items and health drinks. The team were all welcoming, pleasant and aware of every detail of an individual's care needs.

This was done in a professional manner, with consultation and input from all members of the team, and administered to a high standard of care.

I have been in the nursing profession since 1978, within the private sector, NHS hospitals and in the community and have witnessed some decline in the standards of care in both sectors. So it was really positive and impressive to experience such high quality of care being provided on KFW.

I retired from nursing in 2007, but continue to be involved as a volunteer with NELFT and BHRUT and I am presently Vice Chair of the Integrated Patients Experience Partnership. I will impart my experience as an inpatient on KFW at the next meeting.

May I conclude by thanking all the staff on KFW for making my stay such a pleasant, positive experience, long may you continue to administer good quality medical and nursing care to everybody who needs this."

St Mary's Treatment Centre

Details of current year (April 2017 – March 2018) local quality priorities

What we were trying to improve?

- Introduction and continuation of transferred activity or additional specialties being provided at the centre

How we monitored progress

- 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.

What else did we achieve in 2017?

Investment and sign off business case for new endoscopy equipment – supporting efficiency and in-line with JAG guidelines. Delivery expected early 2018.

Referral trends to day surgery continue to increase month on month. This support business growth and is testament to the high standards of care and excellent reputation we have achieved with referrers.

There has been a revised structure implemented within day surgery creating a theatre/ward manager to ensure excellence in team working supported by deputy positions in both areas; thereby creating development opportunities for staff. There has also been the purchase of new anaesthetic machines for each of the three theatres.

A review of the emergency alarm system and installation of emergency call buzzers within each theatre – further supporting and optimizing patient safety.

The Care UK efficiency Pisces tool continues to provide support to the management of DSU and operations manager to ensure efficient lists are run throughout the three theatres. The tool can also be utilised to check any potential clinical concern and that procedures are being completed in an appropriate time frame.

High level positive patient feedback consistently received month on month. Trialed different concepts to improve patient flow - none totally successful, however, we will persevere with further ideas to consider.

Support to the local trust in managing their wait times for multiple specialties supporting timely care in our community.

Local outcomes

	Local results
NJR	NA
PROMS	93%
VTE	0 Known VTE 2017
Complaints	25 - 0.04% of activity 38 - 0.07% of activity
Incidents related to patient harm	10 - 0.02% of activity

Details of next year's priorities - April 2018 – March 2019

What are we were trying to improve?

- Flu immunisations
- Dignity audits
- Maintain 0% bacteraemia MRSA C. difficile
- Quality assurance review
- Patient reported hand hygiene responses
- Local Safety Standards for Invasive Procedures (LocSSIP's)

What will success look like?

- 75% immunisation of frontline healthcare workers
- All areas will have implemented actions identified from dignity audit
- Overall quality improvement resulting in less QA recommendations
- 85% of healthcare workers will be seen decontaminating their hands as reported by patients
- Full implementation with LocSSIP audit process in place.

How we will monitor progress

- Data and audit reviews will be carried out regularly
- Infection control data will be reviewed and actioned as necessary
- Quality and Assurance Governance process will be followed and reviewed.

Patient Story

Endoscopy

"I felt I must write and say a big thank you to your wonderful team of staff. I came to the centre on 15 November for a colonoscopy, a procedure I was not looking forward to, but your nurses and Dr Patel, were all so very caring and cheerful, **I felt relaxed and at ease straightaway.** My procedure went well with good results thankfully. Keep up the good work, having such cheerful and caring staff made all the difference."

Day surgery unit – general surgery

"I thought I would drop you a short note to express how grateful I am regarding my epidermal cyst removal surgery which you carried out on Wednesday the 8th.

Apart from a vasectomy operation which I had a few years ago, (done under a local), the last time I had a general anaesthetic was some 50 years ago and given the task at hand, I must tell you that I was pretty nervous to say the least! I guess for you it was another day at the office, but I have to say, **I was mightily impressed and put at great ease by your professionalism and manor.**

The surgery went well, was over in no time (I guess as I was asleep, I would say that), and I am already on the mend. My sincere gratitude to you Sir."

Barlborough Treatment Centre

Details of current year (April 2017 – March 2018) local quality priorities

What we were trying to improve?

- Reduce and prevent never events.
- Frailty screening of all patients 75 years old and over, attending pre-op assessment clinic.
- Provide all relevant staff with the toolkit to support patients with Dementia who are patients at the treatment centre.
- Raise the awareness of and support the uptake of the flu vaccination with all clinical staff.
- Health and wellbeing of all staff, supporting them to make healthier lifestyle choices both at home and at work.
- The recognition and management of a septic patient.

Why we are trying to improve

- Support staff with recognition and management of a never event. Ensure we are fully compliant with regards to reporting and escalating events in a timely manner both internally and externally.
- To ensure patients with Dementia are identified early and that they are then placed on a pathway to ensure they receive personalised care and support in-line with their current needs. Reducing the risk of `missed opportunities`.
- Influenza is a highly transmissible infection. Frontline healthcare workers are more likely to be exposed to the virus particularly during the winter months. Therefore, to protect both staff and patients we have provided drop-in flu clinics for staff within the treatment centre.
- To improve patient outcomes with the implementation of early warning sepsis indicators.

How we monitored progress

- Datix reports and monthly lessons learned reports showing zero never events have occured.
- The dementia friendly room on the inpatient ward is now completed and fit for purpose and is being utilised accordingly.
- Feedback from F&F test, cards, letters, the website and social media.
- We have captured the number of staff who received the vaccine at the treatment centre. We have also had staff informing if they had received the vaccine at their GP surgery and or any other place outside of the centre.
- Auditing number of patients identified and or confirmed as septic.

Local outcomes

	Local results
NJR	Number of ops - 1016. Consent rate 100%
VTE (%)	January 99.7 February 99.3 March 99.7 April 100 May 99.6 June 98 July 99.2 August 100

PROMS

Proceedure	Measure	Health Gain
HR-PRIMARY	EQ5D	0.415
HR-PRIMARY	VAS	7.590
HR-PRIMARY	OXFORD HIP	22.658
KR-PRIMARY	EQ5D	0.281
KR-PRIMARY	VAS	1.150
KR-PRIMARY	OXFORD KNEE	16.365
KR-PRIMARY	OXFORD KNEE	17.125

Details of next year's priorities - April 2018 – March 2019

What are we trying to improve?

We are continuing to focus on Sepsis and the health and wellbeing of staff in 2018. We have also added two new priorities, dignity and autism.

Dignity

With regards to dignity we want staff both clinical and non-clinical to recruit as dignity champions who will sign up to the dignity pledge and create a culture which embraces the dignity values.

How we will monitor progress

Meeting agendas, minutes and action plans will evidence how well we have implemented this priority, as will feedback from patients and visitors to the treatment centre.

Autism

We aim to raise awareness of the autistic spectrum, create an environment conducive to supporting all patients with autism, provide training to staff in order to gain an understanding of the multi-faceted condition which affects many people in many ways and in severity.

How we will monitor progress

Uptake of training and feedback from patients, carers and relatives will provide some evidence of how well we are doing with this priority.

Patient Stories

December 2017
The ward received a phone call from the daughter of a patient that was on the ward... The patient's husband had arrived a little early to pick his wife up following surgery so decided to take their dog "Oleg" for a walk.

It was during this walk around the lake next to Barlborough that the gentleman took a tumble down the embankment and injured his leg. He had no idea where he was but told his daughter on the telephone that he could see the hospital.

Staff on the ward decided to have a look out of the window to see if they could see anything but couldn't see anything. So Claire and the team Gemma Hunt, Bev Allison, Mandy Gascoigne, Jane McFarlane and Karen Carter went in search of the injured husband.

After a short while of searching and a few trips and stumbles of their own and a little muddier than what they started off, they found the injured man.

Staff took care of the dog and walked him back to the hospital to his other owner and the staff wrapped the gentleman in blankets and called the ambulance.

The ambulance took one and half hours to arrive from the initial phone call, Mandy helped by flagging them down. By this point the patient was shivering and very, very cold.

The patient's daughter came to collect her and the gentleman was transferred to Chesterfield Royal where he has fractured his ankle in 3 places and is still in Chesterfield Royal Hospital. So far he has had his operation cancelled twice.

His family are working on getting him transferred to Lincoln County so he is closer to home and hopefully gets the operation done this side of Christmas.

December 2017
"I want to say a huge thank you to all the staff at the Barlborough NHS Treatment Centre for the fantastic care that I received there in the week leading up to Christmas.

I live alone and I have been told that I can be a little grumpy and I do not tolerate fools gladly. As a result I do not have a huge group of friends and I do feel isolated at times.

I went into Barlborough for a hip replacement that was quite complex with a well-known surgeon at the centre following years of pain.

Despite initially being my usual grumpy self the staff was so helpful and constantly happy. Their smiles made me, dare I say it, happy too.

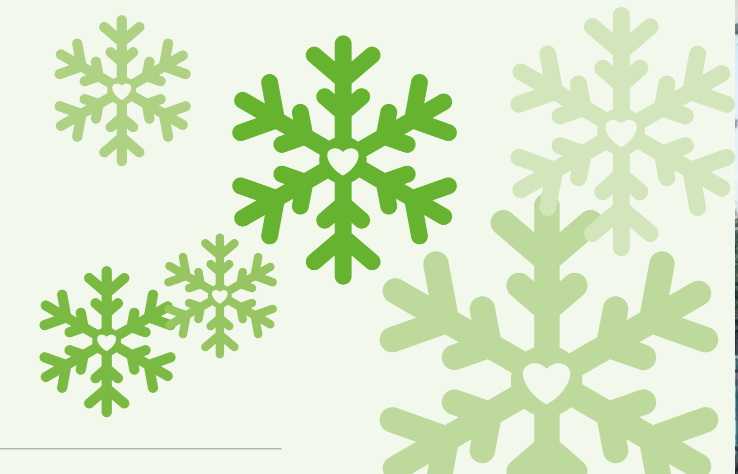
I thought that perhaps it was the Christmas spirit but I was told by another patient who had visited Barlborough before that this was the usual kind, caring, happy band of people that delivered high-quality care.

I was so upset when it was time for me to be discharged and I really did not want to leave and go back to my isolated self.

However the staff helped me form a friendship with another patient that had been admitted for the same procedure and we have stayed in touch. He has visited me whilst at home and we speak to each other every day. I have been introduced to other people that have undergone replacement surgery and so I do not feel lonely any more.

I feel as though the clocks have been turned back and I am so pleased that I can now say that I am without pain and I feel as though I have a life.

Thank you to all the Barlborough team. You are all unique and I have been so lucky to have been treated in your hospital."



Will Adams Treatment Centre

Details of current year (April 2017 – March 2018) local quality priorities

What we were trying to improve?
- The past year we focused on our Family and Friends response rates.

Why we are trying to improve
- As we continually strive to improve our patients' experience as well as gauging our effectiveness. Although our Patient Satisfaction is raging between 98 and 100% our response rates fluctuates and we would like to capture the highest possible percentage of visiting patients.

How we monitored progress
- Monthly reports via the devices. Results are discussed, with the teams to highlight areas requiring improvement and celebrating successes, at various meetings

Details of next year's priorities - April 2018 – March 2019

What are we trying to improve?
- Reduce avoidable cancellations

Why we are trying to improve
- By reducing cancellations, the patients' experience is improved and an effective and efficient service is provided and ensuring optimal use of the resources.
- Maintaining an above 98% patient satisfaction rate, minimised verbal complaints and patient feedback regarding waiting and/cancellation of procedures.

How we monitored progress
- Monthly monitoring and reporting of cancellation rate KPI.

Local outcomes

	Local results
NJR	NA
PROMS	
VTE	98%
Complaints	14
Incidents related to patient harm	13

Patient Story

A patient was seen at Will Adams, NHS Treatment Centre and diagnosed.

Unfortunately the required treatment was not offered at Will Adams, however, it could be done at North East London Treatment Centre, should he wish to travel.

The patient agreed to the offered treatment plan.

The patient said, 'I had significant arthritis in my knee that had developed over the years after falls that are just a part of horse riding," he said. "The pain and the lack of flexibility got worse and worse and, in the end, I could no longer ride."

He came to Will Adams and saw Mr Ahad. Diagnostic imaging revealed that Mr D needed to have a complete knee replacement, a procedure we don't carry out.

He was then told by Mr Ahad he could have his surgery at the centre's sister service in Ilford, if he didn't mind travelling.

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He said, "I was very impressed with Mr Ahad and so wanted to keep him as my surgeon. I like working with people who are good at their job and he was not at all arrogant. Travelling also meant shorter waiting times for surgery and I was keen to be back riding."

The surgery went well, under a spinal anaesthesia and an enhanced recovery pathway that sees patients up on their feet and working with physiotherapists within hours of surgery.

"I was walking properly within three weeks and back on my horses, in Hoo, within three months. I had not tried it before that as I was under very strict instructions from my wife and daughter, who would follow me to the field to ensure I wasn't taking a sneaky ride."

Mr D. takes part in horse archery, where riders gallop down a strip while firing at targets as they go.

He said, "I had been doing archery with my son, but target archery got a bit dull so I found horse archery, that combines two of my interests. Now my knee is better I am back in the saddle and have also taken up field archery that involves shooting at animal model targets in a rough, countryside course."

St Mary's MIIU, Royal South Hants MIU and Havant Diagnostics

Details of current year (April 2017 – March 2018) local quality priorities

Priorities and areas for improvement	What are we trying to improve?	Why are we trying to improve?	How we monitored progress
St Mary's MIU – embedding of the navigation system – this system improved patient accessibility by ensuring that the patient was safe to wait and wasn't waiting if they were in the wrong environment to get care.	This system ensured that every patient had an assessment within 20 mins of arrival and was either seen with the department or directed to the appropriate service.	This was to improve the initial assessment of all patients seen within 20 mins.	20 minute KPI and redirection forms were reviewed on a weekly basis and the daily KPI monitored and saw a great improvement.
MIU both – Development of a deputy lead role within the MIU's.	Senior support and advise within both MIU's for staff and patients at all times.	Staff reported that they had no access to senior support working clinically at both sites as the lead nurse was unable to be at both sites as much as staff required the support.	Staff feedback, patient experience feedback, improved moral in both departments.
MIU both – Introduction of an orthopaedic lead.	Improve the service to patients and staff to advice on orthopedics within the MIU's.	Service delivery and patient care and reduction of cost of consultant lead fracture clinic.	Patient Feedback, reduction in cost, staff feedback – reduction in diagnostic errors.
Diagnostics – Implementation of new equipment.	To lower radiation dosage to patient and improve quality of images.	Improvement of healthcare delivery and to improve image quality.	Improvement of image quality and reduction of recorded exposure dose.

Local outcomes

	Local results
Complaints: SMTC MIU RSH MIU SMTC Diagnostics Havant Diagnostics	 14 – 0.03% of activity 26 – 0.05% of activity 11 – 0.05% of activity 7 – 0.04% of activity
Incidents related to patient harm: SMTC MIU RSH MIU SMTC Diagnostics / Havant Diagnostics	 5 – 0.01% 11 – 0.02% 12 – 0.05%

Details of next year's local quality priorities

Priorities and areas for improvement	What are we trying to improve?	Why are we trying to improve?	How we monitored progress
MIU –Initial Assessment – this system is replacing our navigation system to ensure that every patient is seen within 20 mins and has an assessment and offered health promotion activities and receives the most appropriate care.	Initial Assessment – we are trying to improve the patient pathway by ensuring that they receive the most appropriate care that is required whether this is within the MIU or other services and gets appropriate health promotion advice if required.	All patients will have access to health promotion at the initial assessment and will not have to wait in the department if care is unable to be provided.	Patient feedback surveys about the initial assessment, referrals to health promotion unit and data from re-directions to other services.
Diagnostics – To explore the reporting radiographer role within X-ray.	Turnaround time for reports and accuracy and support for MIU practitioners and development opportunity for radiographers.	A radiographer will be successful in completing the Appendicular Reporting Course at University and this will ultimately reduce the current contract cost for X-ray reporting.	Reduction in reporting errors, and reduction in cost and feedback from clients and X-ray and MIU staff.

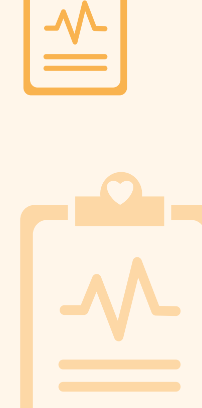
Patient Story

St Marys MIU

A patient was seen initially and then had a cardiac arrest whilst in the department and had to be resuscitated.

The patient was transferred to the local general hospital.

The patient had initial immediate attention and returned to the department after 10 days to thank all the staff for saving their life and for immediate skills that everyone used.



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