APPENDIX 1

University Hospital Southampton NHS Foundation Trust

Our Quality Account & Quality Report 2012 13

DRAFT for comment

High quality care for our patients

Every patient should expect to receive high quality care in our hospitals.

Providing the most effective treatments, developing staff who are kind and respectful and keeping our services as safe as they can be are aspects of quality that we strive to improve year on year.

We are a busy hospital and provide care for the sickest patients in our region. Yet despite the fact that demand for our services is growing faster than our resources, our priority is to ensure that the quality of the care we provide is never compromised by the need to work more efficiently.

During 2012/13 more than half a million patients chose our Trust for their treatment and we are proud to report that in this time period, we achieved some notable improvements in the quality of care we provided including:

- 98% of all patients, and 99% of older patients, rating our care as good, very good or excellent
- Using the national Safety thermometer audit tool over 95% of our patients experienced new-harm free care across a range of measures.
- Mortality rates in the expected range
- A level 3 (the highest level) risk management standard rating for general acute services for our insurers (the NHS Litigation Authority) and
- A level 2 risk management standard rating for maternity services for our insurers, and aiming for Level 3 in our reassessment in September 2013
- Our lowest rates of C difficile infection, and achievement of our MRSA improvement target
- We are in the top 20% nationally for staff satisfaction at work

The Care Quality Commission undertook a responsive review of compliance at our Southampton General Hospital site in October 2012. They reported that patients and relatives were overwhelmingly positive about the staff and the care they had received. A small number of specific issues were observed, which we are addressing thoroughly, and this useful feedback has been included in our decisions about priorities for the coming year.
In December 2012, the Care Quality Commission also inspected the Princess Ann Hospital (PAH) and reported that mothers and partners were also very positive about the care they received and their consultation and involvement in decision making, with full compliance for the essential standards assessed.

The Trust fully supports the findings of the public inquiry into events at Mid Staffordshire NHS Foundation Trust (the Francis Inquiry) and the Department of Health's response 'Patients First and Foremost' the Trust. Many of the relevant recommendations are already firmly embedded in our practice. We understand that excellent patient experience, staff experience and clinical outcomes are inextricably connected and we work hard to ensure that we listen and take action to improve, at every opportunity.

This report provides detailed information about the quality of care we provided during the year and how this compares with what we wanted to achieve and how other hospitals are doing. It also sets out our goals for next year and describes how we have worked with patients and staff to decide what these should be.

We have worked closely with our local partners in commissioning and primary care with many joint approaches to safe care, the avoidance of admission to hospital and supporting earlier discharge. We look forward to continuing to develop this approach further in 2013/14.

I am grateful to all of you who have been involved in developing this document with us and I believe it will enable us to continue delivering the year on year improvement in quality we would expect to see in a world class hospital.

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

Mark Hackett
CEO

(sign and date)

<in a box> **About University Hospital Southampton NHS Foundation Trust:**

Provides: hospital services for people with acute health problems.

Serves: the local hospital for 650,000 people who live in Southampton, the New Forest, Eastleigh and the Test Valley
the residents of the Isle of Wight and the Channel Islands with specialist services.

Delivers: the regional specialist hospital services for central Southern England

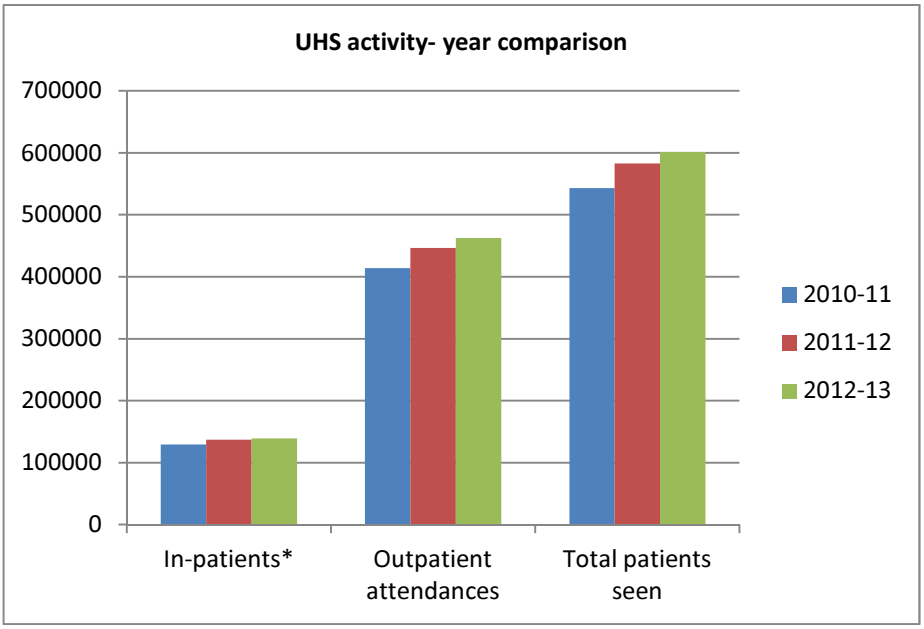
major research programmes to develop the treatments of tomorrow

training and education of the next generation of hospital staff

Hospitals: Southampton General Hospital, the Princess Anne Hospital, Countess Mountbatten House, New Forest Birth Centre.

<in a box> Activity levels during 2012/13

The graph below indicates the increase in demand for our services which has now been sustained over a three year period. This is reflected for inpatients (which includes those whose care does not require an overnight stay), outpatients and overall numbers. In summary, we have seen an increase of more than 10% from 2010/11 (543,200 patients) to more than 601,000 patients a year.



- Inpatients includes those whose care does not require an overnight stay

<in a box> Strategy and leadership for high quality care

We are a patient-focused hospital and our ambition is to excel in all aspects of acute health care delivery, for our local community and for our wider regional tertiary population.

Our quality governance strategy provides clear direction to the organisation on the whole-system approach we take to continuously improving standards. It includes a range of supporting strategies which define our priorities in more detail and our model is to deliver these through our patient improvement framework (PIF), which is reviewed and updated annually. The PIF is focused around four principal areas:

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

<Section heading> Our priorities for improving quality

Developing **our priorities for 2013/14**

Deciding which improvements we will prioritise for the coming year is a real team effort involving our patients, staff and wider public. The draft of this report has been shared widely with our staff, our commissioners, community partners and other key stakeholders.

Our patient improvement framework (PIF) continues to form the basis of our quality governance strategy and is designed to reflect a prioritised approach to quality. It is widely discussed by staff in our hospitals and is reviewed and updated on an ongoing basis.

As well as reflecting our patient and staff feedback , the PIF includes reference to national drivers, for example, the Department of Health Outcomes Framework for 2013/14.

We work closely with our community colleagues, and our priorities are linked to those of our local health economy set by our clinical commissioning groups (CCGs).

We also reflects our corporate risk register and assurance framework where this is relevant.

We began formally consulting with all our staff from November 2012 up to publication, and have integrated our priorities with our Members Council and Local LINKs groups feedback, as well as wider CCG quality priority setting jointly reflected in our contract arrangements. We have used this feedback to adjust our agreed priorities to reflect and support the views of the widest possible range of interested parties.

We assessed each potential improvement priority by asking;

- have our patients told us this is important?
- will this have a significant impact on improving quality?
- is this feasible given our resources and timeframe?
- does previous performance reflect potential for improvement?
- does this improvement tie in with national priorities or audits?

A review of our performance for clinical quality

The information below summarises our achievement for quality across all of the indicators chosen in our patient improvement framework since 2008/09. This is reported fully each month in our Trust Board performance reports.

Patient Safety						
Key targets	**2010/11**	**2011/12**	**2012/13**	**2012/13 Target**	**Met/ not met**	**Comment**
Serious Incidents Requiring Investigation (SIRI) Previously called Serious Untoward Incidents (SUIs)	84	159	127	**<=156**	✓	Prioritised for 2013 14 Note: from 2011 we also include grade 3&4 pressure ulcers, VTE and safeguarding adult alerts.
Never Events	2	3	2	**=0**	X	Included in our wider safety priorities for 2013 14. We have investigated these thoroughly for learning
Healthcare Associated Infection MRSA bacteraemia reduction	5	4	3	**<=4**	✓	**Achieved**
Healthcare Associated Infection MRSA screening ("Matched Census") (as average of monthly %)	393%	388%	375%	**>= 100%**	✓	**Achieved**
Healthcare Associated Infection Clostridium difficile reduction	89	66	40	**<=46**	✓	**Achieved**
Avoidable Hospital Acquired Grade III and IV Pressure Ulcers	78	33*	41	**<= 24**	X	Prioritised for 2013 14 We have improved our reporting of these. We review each in depth, for root cause and learning
Falls Avoidable Falls	-	13	5	*<8*		Prioritised for 2013 14 We have improved our reporting of these. We review each in depth, for root cause and learning
Falls % SIRFIT (UHS Falls risk assessment tool) Compliance (as average of monthly %)	94.3%	94.7%	94.5%	**>= 95%**		Prioritised for 2013 14 We are reviewing and improving our SIRFIT tool and will continue to re audit and learn.
Thromboprophylaxis (VTE) % Patients Assessed (CQUIN)	94%	91.21%*	95.31%	By Q4 year-end>= 95%	✓	**Achieved** And also prioritised for 2013 14
Thromboprophylaxis (VTE) % Patients receiving pharmacological prophylaxis (as average of monthly %)	81%	93.6%	96.16%	By Q4 year-end >= 95%	✓	**Achieved** And also prioritised for 2013 14
Achieve 24/7 safe emergency care (measured as bed moves)			18 (Jun-Mar2012)	Patients moved more than 4 times in a hospital stay <20	✓	
Childrens services: Reduction in unplanned admissions of full term babies ot neonatal unit One-to-one care in labour					tbc	These measures are currently being audited as part of the NHSLA assessment due in September. Results will be shared when available.
** This is the final number, and updates last years' quality account. This is because the thorough investigation*						

process we use meant that some cases were not confirmed by the time the report was published.

Clinical incidents

The occurrence of any adverse clinical event is taken seriously. Every incident form submitted is reviewed by a Patient Safety Advisor.

We encourage reporting, as a way of learning and improving our services. 11,070 incidents were reported (all categories, including those resulting in no harm). This is in line with NRLS data expectations.

All the moderate and severe harm incidents are individually validated. Of these, all high harm incidents, whether clinical or non clinical are robustly investigated and overseen by a trust level group.

Over the last year (2012/13), the Trust has reported 2 ‘Never events’. 'Never Events' are nationally defined and agreed as serious incidents that should not happen in a safe organization.

One 'Never Event' (wrong site surgery) is currently under investigation. The patient involved in the other Never Event, (retained swab) did not want to receive the investigation report, although he was robustly followed up and fully aware that an investigation was undertaken. The action plan for this event has been implemented and an audit structure is in place to ensure that organizational learning has occurred.

Patient Experience						
Key targets	**2010/11**	**2011/12**	**2012/13**	**2012/13 Targets**	**Met/not met**	**Comment**
Total Complaints	737	687	533	**<=720**	✓	**Achieved**
Percentage of complaints closed in target time (due this month) (as average of monthly %)	92.6	87%	92%	**>= 90%**	✓	**Achieved**
Monthly Picker Survey Overall satisfaction with care (as average of monthly %)	96%	97%	96.3%	**>= 90%**	✓	**Achieved** And also prioritised for 2013 14
Monthly Picker Survey Recommend hospital to family and friends (as average of monthly %)	96%	94.3%	94.3%	**>= 85%**	✓	**Achieved** And also prioritised for 2013 14
Monthly Picker Survey Have you ever shared a sleeping area with patients of the opposite sex during this stay in hospital? (Those who gave an answer, as average of monthly %)	6%	11.1%	7%	**<= 5%**	X	Further work is underway to understand and improve the mismatch between perceived and actual experience.
Same Sex Accommodation (Estates Compliance) (as average of monthly %)	99%	99%	99%	**>= 85%**	✓	**Achieved**
Same Sex Accommodation (Non Clinically Justified Breaches)	Not measured	85	10	**<= 360 (<=30 per month)**	✓	Improved to zero non clinically justified same sex accommodation breaches by year end.
Nutrition % Patients with MUST Screening in 24 hours (as average of monthly %)	Not measured	89.4%	91.9%	**>= 98%**	X	See review report for further Actions in place, detail
Deliver compassionate and fundamental care Patients feel they are treated with privacy & Dignity			92% (Feb)	**95%**	X	Further work is underway to improve this aspect of patient experience
Meeting the needs of older people: rating their care as good, - excellent.			98% (feb)	**95%**	X	**Achieved**

Outcomes						
Key targets	**2010/11**	**2011/12**	**2012/13**	**2012/13 Targets**	**Met/ not met**	**Comment**
Hospital Standardised Mortality Rate (HSMR) (as average of monthly rate) University Hospital Southampton NHS Foundation Trust	98	90.6	98	**<100**	✓	**Achieved** And also prioritised for 2013 14
Hospital Standardised Mortality Rate (HSMR) (as average of monthly rate) Southampton General Hospital	92.7	84.8	91.8	**<100**	✓	**Achieved** And also prioritised for 2013 14
Hospital Mortality (number of inpatient deaths excluding Countess Mountbatten House)	1698	1729	1902	**<1404**	X	Prioritised for 2013 14
Hospital Mortality (absolute number of inpatient deaths including Countess Mountbatten House)	2052	2047	2243	**<1404**	X	Prioritised for 2013 14
Hospital Mortality Rate (not standardised) (as average of monthly %)	1.6%	1.5%	1.6%	**<=1.5%**	X	Prioritised for 2013 14 Reviewed thoroughly throughout the Trust. Actions are in place, see review section of this report for detail
Emergency Re-admissions Within 28 days (as average of monthly %)	9.4%	9.3%	9.5%	**<=7.5%**	X	Prioritised for 2013 14 Actions are in place to reduce the number of patients readmitted. See our Board reports for more details
Emergency Re-admissions Within 30 days (as average of monthly %)	7.45%	7.2%	6.8%	**<=7.4%**	X	Prioritised for 2013 14 See above
Patient Reported outcome measures: PROMS Hip replacement data contributed Knee replacement data contributed			69% 97%	**80%** **80%**		
Improve outcomes from surgery at extremes of age Fractured neck of femur best practice tariff performance & actions (PIF) surgery in neonates (PIF)			87.7% Audit in progress	**90%**		NCEPOD: neonatal surgery issue: Necrotising enterocolitis. An audit is now mid-way through the data collection stage.

Our priorities for 2013/14 – the patient improvement framework (PIF)

Our top priorities for 2013/14 are summarised below. We have included some further detail on how we plan to manage and measure our progress towards these aims. These will form the basis for our formal consultation with the public, staff and key stakeholders. **Safety priorities**

Priority 1
To improve the reporting of patient safety incidents and our mechanisms for learning from them

Why is this important
Incident reporting gives us an opportunity to learn from past events and to ensure that steps are taken to minimise recurrences. Evidence suggests that NHS organisations with a high level of incident reporting are more likely to learn and subsequently increase safety for their patients, staff and visitors.

The Trust reports approximately 9,000 actual and potential incidents per year, of which the majority are low harm and low risking rating. 69 were classed as serious incidents.

Our aims for 2013 14
To support and encourage reporting, we are moving from paper-based, to an electronic reporting system, The benefits of e-reporting include;
improving the time it takes to report an incident and the quality of incident information recorded to support learning and further improvement.

To maintain the number of incidents reported as serious incidents requiring investigation (SIRI) as 13 or less per month

Priority 2
To improve the trust's performance in the measures that are included in the national safety thermometer which is part of the strategy for harm free care

Why is this important
We are using an approach to patient safety that allows our frontline teams to think differently – measuring harm from the patients' perspective. The NHS Safety Thermometer is an audit tool that allows teams to measure harm and the proportion of patients that are 'harm free' from four of the most common and preventable causes. These are pressure ulcers (bedsores), patient falls, VTE (blood clot) and urinary infections due to catheters. In 2012 13 we focused on ensuring that we captured the information we need to measure the safety priorities included in this audit. We have achieved 100% audit results, so we now have a good understanding of our performance to set ourselves improvement targets.

Our aims for 2013 14
A 25% reduction in grade 3 and 4 hospital acquired pressure ulcers to 22 or less
A 25% reduction in high harm falls to 3 or less
95% of patients risk-assessed for avoidable blood clots by end of year and 98% prescribed appropriate treatment
A reduction in the number of inappropriate urinary catheter insertions

Priority 3
To improve the care of UHS patients with diabetes

Why is this important
Diabetes is a common life-long health condition. There are 3 million people diagnosed with diabetes in the UK and an estimated 850,000 people who have the condition but don't know it. Around 15% of all inpatients at University Hospital Southampton NHS Foundation Trust have diabetes.

The 2012 National Diabetes Inpatient Audit found 3,700 patients in hospitals across England and Wales experienced at least one medication error in one week. Those affected suffered double the number of severe hypoglycaemic episodes – a drop in blood sugar levels.

Although diabetes cannot yet be cured it can be managed very successfully. Because diabetes is a life long and common condition, many patients who visit us for other reasons, may also have diabetes. We aim to ensure we provide the best care and support for patients with diabetes who use any of our services.

Our aims for 2013 14
Zero incidents classified as "never events" in relation to prescription of insulin
20% reduction in incidents/errors relating to diabetes
Increasing the percentage of patients with a care bundle for diabetes
Reducing the number of patients admitted as emergencies due to diabetes

Patient experience priorities

Priority 1
To successfully implement and learn from the friends and family test (a national survey being implemented this year)

Why is this important
Seeking and acting on patient feedback is key to improving the quality of healthcare services. The Friends and Family Test gives hospital inpatients, and patients who attend the emergency department, the opportunity to give their views of the care or treatment they have received.
From April 2013, when patients leave hospital they will be invited to give their feedback by answering one simple question:

How likely are you to recommend your ward to friends and family if they need similar care or treatment?

This feedback, alongside other information, will be used to identify and tackle concerns at an early stage, improve the quality of care we provide, and celebrate our successes. The Friends and Family Test does not replace existing feedback methods at UHS|, with patients and visitors still able to pass on their compliments and complaints in the normal way.

Our aims for 2013 14
Deliver the roll-out plan for the survey
Increase the response rate in acute inpatient areas and the ED to at least 20% by the end of the year.
Increase the score for 2013/14 compared with the question asked in the 2012/13 national patient survey

Priority 2
To improve the experience women have of our maternity services

Why is this important
This national survey asked women to feedback what they thought about different aspects of the care they received during their pregnancy, labour and birth, and in the weeks following the birth of their baby. The results of the survey help us to identify areas where we can improve performance. We are classed as "about the same as the average" in the most recent national survey of maternity services

Our aims for 2013 14
To continue improving our performance in this survey
Measure important elements of experience including in antenatal, intrapartum (time of birth) and postnatal care.
Introduce real-time monitoring to capture immediate feedback on women's experiences.

Priority 3

To improve the continuity of care for patients when they move from one area of treatment to another and when they move between different organisations in the NHS. This includes improving handovers with comprehensive and accurate documentation.

Why it's important

To improve quality and standards of nursing documentation and handover. A holistic, problem solving approach to care, using the nursing process and an established nursing model is essential to address individual patient needs. Evidence demonstrates good documentation of nursing care and effective care planning ensures better continuity of care, patient outcomes, safety and experience. The clear communication of care rationale optimises decision making and a consistent approach to team working,

Our Aim 2013/2014

To implement the documentation of patient care policy (nursing)
Establish process for monitoring compliance and effectiveness of the documentation policy

Develop an education plan to support the implementation of the requirements of the documentation policy.
To develop the format for nursing documentation
Develop the electronic nurse's worklist as an adjunct to the doctor's worklist electronic initiative.
Meet compliance with Care Quality Commission (CQC) Quality Standards Outcome R20 for Records, NHSLA Health Record-Keeping Standards, Nursing & Midwifery Council (NMC) Guidance, Essence of Care Record Keeping standards and UHS Record Management policy.

Priorities for outcomes and clinical effectiveness

Priority 1
Making appropriate improvements in mortality rates and the way in which mortality is measured and evaluated

Why this is important
HSMR is a benchmarking ratio, of observed deaths / expected deaths (x100). It is used as an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect compared to the general population.

We can use information presented in this way to help us compare our performance fairly. National Summary Hospital level Mortality Indicator (SHMI) data is collected on all inpatients. In HSMR it is collected on approximately 85%.

We recognise that for some of our patients death is an inevitable outcome of their condition. We are fortunate to be able to provide a specialist palliative care team to ensure support to patients and their families in achieving as good and comfortable end of life care as possible.

Our aims for 2013 14
Continue to reduce avoidable deaths with a Hospital Standardised Mortality rate (HSMR) score of 100 or less when the next national adjustment takes place in 2013.

To improve coding accuracy.

Priority 2
Improve outcomes for deteriorating patients in hospital which contributes to mortality rate
Why this is important
In general, clinical signs of acute illness reflect failing respiratory, cardiovascular and neurological systems. These signs can be used to predict the occurrence of cardiac arrest. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report 'Time to Intervene' identified survival to discharge in patients suffering cardiac arrest is improved with close observation, earlier recognition of severity of illness and markers of risk; senior decision making and appropriate admission into a critical care environment all support better outcomes. We have improved our recognition and management of deterioration, and our patients outcomes are significantly better than the national average. However there is more we can do.

Our aims for 2013 14
To maintain levels of ward-based cardiac arrest at or below those achieved in 2012 13.
Achieve 90% compliance with the Trust's acuity audit in every month.

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

Why this is important
General hospital environments can be particularly confusing for people living with dementia. When treatment is required in a hospital setting, people with dementia need to have their dementia recognised so that appropriate care and treatment is delivered, irrespective of the reason for admission.
Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with dementia. Their length of stay is longer than people without dementia and they are often subject to delays on leaving hospital. Dementia affects an estimated 670,000 people in England, and the costs across health and social care and wider society are estimated to be £19 billion. Currently only around 42% of people with dementia in England have a formal diagnosis despite the fact that timely diagnosis can greatly improve the quality of life of the person with dementia by preventing crises (and thus care home and hospital emergency admission) and offering support to carers. In UHS we have screened 92.5% of patients at risk of dementia in 2012 13, and of these 100% were further assessed and referred to appropriate services.

It is estimated that 25% of general hospital beds in the NHS are occupied by people with dementia, rising to 40% or even higher in certain groups such as elderly care wards or in people with hip fractures, and so this remains a priority for us in 2013 14.

Our aims for 2013 14
Deliver high quality care for people with dementia and their carers
Identify more than 90% of relevant patients
Appropriate refer more than 90% of identified patients
Deliver appropriate training for staff
Ensure carers feel adequately supported

Statements of Assurance from the Trust Board

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

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

Review of Services:
During 2012/13 the University Hospital Southampton NHS Foundation Trust (UHS) provided and/or sub-contracted 109 relevant health services (from Total Trust activity by specialty cumulative 2012/13 contractual report). More information about these can be found on our website www.UHS.nhs.uk. UHS has reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2012/13 represents 100 % of the total income generated from the provision of NHS services by University Hospital Southampton NHS Foundation Trust for 2012/13.

Participation in clinical audits:

Clinical audit statements

During 2012/13 [TBC] national clinical audits and [6] national confidential enquiries covered NHS services that UHS provides.

During 2012/13 UHS participated in [XX% & Number TBC] national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

National confidential enquiries
The national clinical audits and national confidential enquiries that [UHS] was eligible to participate in during 2012/13 are as follows:
NCEPOD Bariatric Surgery (organisational element of study)
NCEPOD Cardiac Arrest Procedures
NCEPOD Alcohol related liver disease
NCEPOD Subarachnoid Haemorrhage
NCEPOD Tracheostomy (started in March 2013)
MBRRACE-UK- Perinatal mortality

The national clinical audits and national confidential enquiries that UHS participated in during 2012/13 are as follows:

NCEPOD Bariatric Surgery (organisational element of study)
NCEPOD Cardiac Arrest Procedures
NCEPOD Alcohol related liver disease
NCEPOD Subarachnoid Haemorrhage
NCEPOD Tracheostomy (started in March 2013)
MBRRACE-UK- Perinatal mortality

National Confidential Enquiry started February 2012
In addition to the above UHS has registered to participate in the National Review of Asthma Deaths (deaths from Asthma during the period: February 2012 to December 2012)

The national clinical audits and national confidential enquiries that UHS participated in, and for which data collection was completed during 2012/13, are listed below in Table A 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. (column 1 of Table A) and percentages (column 5 of Table A)

The reports of [0] national clinical audits were reviewed by the provider in 2012/13 and UHS intends to take the following actions to improve the quality of healthcare provided. See table C.

Table A: The national clinical audits and national confidential enquiries that UHS participated in

	Column 1	2	3	4	5
	Total number of NCAs UHS were eligible to complete (n=42)	Eligible (TBC)	Participated (TBC)	National audit reports reviewed (TBC)	% actual cases submitted / expected submissions
1	Acute coronary syndrome or Acute myocardial infarction MINAP National Institute for Cardiovascular Outcomes Research (NICOR)				100%
2	Adult Asthma (NICOR)				
3	Adult cardiac surgery audit ACS National Institute for Cardiovascular Outcomes Research (NICOR) CABG and valvular surgery				100%
4	Adult community acquired pneumonia				
5	Adult critical care (Case Mix Programme) Intensive Care National Audit and Research Centre (ICNARC)				100%
6	Bowel cancer NBOCAP - NHS IC				
7	Bronchiectasis The British Thoracic Society (BTS)				100%
8	Cardiac Arrest Audit NCAA - Intensive Care National Audit and Research Centre (ICNARC)				
9	Cardiac arrhythmia - National Institute for Cardiovascular Outcomes Research (NICOR)				
10	Carotid interventions audit (run by VSGBI through RCP)				100%
11	Comparative blood transfusion audit - Medical use of blood				
12	Congenital heart disease,(Paediatric cardiac surgery)- National Institute for Cardiovascular Outcomes Research (NICOR)				100%
13	Coronary angioplasty - National Institute for Cardiovascular Outcomes Research (NICOR)				57%
14	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) - NHS IC, Leeds				100%
15	Diabetes (Paediatric) PNDA - Royal College of Child Health and Paediatrics (RCPCH)				100%
16	Elective surgery (National PROMs Programme) NHS IC, Leeds - HIPS				75%
17	Elective surgery (National PROMs Programme) NHS IC, Leeds - KNEES				86%
18	Emergency use of oxygen The British Thoracic Society (BTS)				100%
19	Epilepsy 12 audit (Childhood Epilepsy) - Royal College of Child Health and Paediatrics (RCPCH)				

20	Fever in children CEM	☐	☐		100
21	Fractured neck of femur CEM	☐	☐		
22	Head and neck oncology - NHS IC	☐	☐		
23	Heart failure HF - National Institute for Cardiovascular Outcomes Research (NICOR	☐	☐		27%
24	Hip fracture database, national	☐	☐		100%
25	Adult - Inflammatory bowel disease IBD - Royal College of Physicians (RCP), CEEU – ***note: data collection continues into 2013/14***	☐	☐		***See note***
26	Child - Inflammatory bowel disease IBD - Royal College of Physicians (RCP), CEEU – ***note: data collection continues into 2013/14***	☐	☐		***See note***
27	Lung cancer NLCA - NHS IC, Leeds	☐	☐		Est.>54%
28	National audit of dementia audit NAD - Royal College of Psychiatrists (CCQI)	☐	☐		87.5%
29	NASH National audit of seizure management (epilepsy)	☐	☐		100%
30	National comparative audit of blood	☐	☐		TBC
31	National emergency laparotomy audit NELA	TBC	☐		TBC
32	National Joint Registry NJR	☐	☐		Est.>60%
33	National Vascular Registry NVR, including CIA and elements of NVD (data collected on index procedure: varicose veins / aneurism / lower limb / amputation)	☐	☐		AAA 100% , others 75%
34	Neonatal intensive and special care NNAP	☐	☐		100%
35	Non-invasive ventilation - adults - British Thoracic Society (BTS)	☐	☐		
36	Oesophago-gastric cancer - The Royal College of Surgeons of England (RCS) AUGIS	☐	☐		100%
37	Pain database	☐	☐		TBC
38	Paediatric asthma - The British Thoracic Society (BTS)		☐		100%
39	Paediatric intensive care PICANet - University of Leicester	☐	☐		100
40	Paediatric pneumonia - BTS	☐	☐		100%
41	Parkinson's UK	☐	☐		
42	Perinatal mortality - MBRRACE-UK	☐	☐		100%
43	Pulmonary hypertension - NHS IC, Leeds		☐		
44	Renal Colic CEM	☐	☐		100
45	Sentinel Stroke National Audit Programme (SSNAP), includes SINAP - Royal College of Physicians (RCP), CEEU	☐	☐		
46	Severe trauma (Trauma Audit & Research Network) TARN	☐	☐		100%

The reports of [53] local clinical audits were reviewed by the provider in 2012/13 and [UHS] intends to take the following actions to improve the quality of healthcare provided. See table B below.

Table B: Local clinical audits, and actions

Audit Title	Actions
Re-audit - Pharmacy Record Keeping for Controlled Drugs	Remind staff that requisitions need to state exact quantities rather than simply "x number of boxes/bottles. The form of the drug must be stated on the requisition regardless of whether it is the only form available.
The proportion of cases of Hypertrophic Cardiomyopathy who are tested for fabry when age of onset	Production of a Fabry Disease Proforma
Re-audit of Physiotherapy intervention for total knee replacement	Liaise with team and gain consensus Adjust core standards in line with consensus if appropriate Provide IST on gait re-education
Completion of Guthrie/blood spot test in the admission paperwork	1. A poster has been placed on the ward staff rooms teaching and education board to raise awareness of the issue of the Guthrie and how to ensure it has been done, and where to then document this (see Appendix 3) 2. A poster has been placed in the doctor's room
Smoking and smoking cessation in acute medical inpatients	Documentation of smoking status Education, presentation at educational meetings Offering smoking cessation advice As above Offering NRT As above Documentation of smoking cessation advice AMU ward round pro forma
NICU Handover	Highlight results on AV system, Combination lock on office door
Baseline audit of testing phytanic acid levels in retinitis pigmentosa	Moderate priority. For discussion of Refsum disease diagnostic proforma at the departmental level followed by implementation of proforma.
An audit of documentation of endotracheal intubation on the Neonatal Unit	Developed intubation documentation proforma
Blood requests - acknowledgement of result	Presented at consultants meeting on 6/7/12. Shows that 14% of in-patient results not acknowledged at 48 hours after result available. Action: to emphasise importance of acknowledging results at induction of new FY doctors in August
An audit of the soft tissue mallets treated in RSH hand therapy against the soft tissue mallet protocol	Attach info sheet to mallet proforma as prompt to give to patients, remind all staff to use proforma sheet with all mallet patients. Update proforma to include: • Date of injury • Day 1 of complete DIPJ immobilisation in hyperextension Reinforce to staff
Non-diabetic retinopathy referrals from retinopathy screening service	Ensure all non-DR referrals are seen in the appropriate clinics All suspected CNV should be fastracked for assessment within current guideline Review of referrals by an ophthalmologist
An audit of the bony mallets in RSH hand therapy against the bont mallet protocol	Attach info sheet to mallet proforma as prompt to give to patients. Update proforma to include: • Date of injury • Day 1 of complete DIPJ immobilisation in hyperextension Reinforce to staff importance of accurate documentation on proforma. Reinforce to staff
Hospital acquired Pneumonia in Stoke	Follow up CXR formal reports for evidence of consolidation or not – education of medical staff Take into account of, and check SALT assessment when considering a diagnosis of aspiration pneumonia – education of medical staff.
Repeat audit of compliance with hypoglycaemia and hypothermia guidelines October 2012	Consultant to alert ward staff verbally re the stock-pile of previous versions of risk proforma still being used on wards and alert consultant midwife via emailActions implementation update received 10 January 2013:

	1. Replacement of old hypoglycaemia
Prevention and management of hypoglycaemia in neonates	Actions implementation update received 10 January 2013: 1. Replacement of old hypoglycaemia proformas which has taken place. 2. A survey of midwifery and nursery nurse knowledge was carried out at the end of November 2012 after which education sessions took place
Management of hypothermic newborns	Actions implementation update received 10 January 2013: 1. Replacement of old hypoglycaemia proformas which has taken place. 2. A survey of midwifery and nursery nurse knowledge was carried out at the end of November 2012 after which education sessions took place
Re-audit Microbiology culture audit of stem cell harvest (5)	Record all positive culture results and proposed treatment in the 'problems' section of the autologous transplant schedules.
Cardiothoracic documentation of ID check	Re inforce need for documentation of ID checks at monthly Staff meetings.
Audit of transthoracic echocardiogram aortic root measurements and reporting in marfan patients	Presentation of Data Clinical Governance in Cardiovascular Division to Training staff using HeartSuite Up-date a patients diagnosis on HeartSuite during an inpatient stay if inaccurate Pilot booking system Consider using HICSS
The concordance between the bone marrow aspirate and the bone marrow trephine findings	Immunophenotyping by flow cytometry will no longer be performed routinely on the lymphoma marrows (as per communications 28th December 2012). This has been communicated to the oncology team and is in place from January 2013.

The reports of [20/TBC] national clinical audits were reviewed by the provider in 2012/13 and [UHS] intends to take the following actions to improve the quality of healthcare provided [description of actions in Table C].

Table C

National audit title	Actions
Acute coronary syndrome or Acute myocardial infarction MINAP National Institute for Cardiovascular Outcomes Research (NICOR)	Quarterly meetings ongoing with primary/ secondary care providers reviewing data and development plans. Working with South Central Ambulance Service to provide seamless care.
Adult cardiac surgery audit ACS National Institute for Cardiovascular Outcomes Research (NICOR) CABG and valvular surgery	Based on the outcome data as demonstrated on the STCS website, UHS Adult Cardiac Surgery has the smallest mortality risk compared to the other Cardiac Surgery units in the UK. We intend to keep up with our current standards of maintaining excellent outcomes in Cardiac Surgical Cases performed by our Department
Adult critical care (Case Mix Programme) Intensive Care National Audit and Research Centre (ICNARC)	The data are submitted for patients approximately 3 months following their critical care admission so the data are always subject to a time lapse. This is true of all sites submitting data. Our standardised mortality rates are consistently excellent, our quality indicators of delayed discharges and night time discharges from critical care are consistently worse than the national average. A bed manager post was created to help to identify and actively manage day time discharges however the Black Alert status of the most recent months continue to have serious impact on ability to discharge in a timely fashion.
Cardiac Arrest Audit NCAA - Intensive Care National Audit and Research Centre (ICNARC)	Dissemination of information on timings and locations of cardiac arrests in the Trust. Training staff in management of cardiac arrest. Training in recognition of the deteriorating patient and preventing cardiac arrest.
Coronary angioplasty - National Institute for Cardiovascular Outcomes Research (NICOR)	Review of deaths from Primary PCI formally undertaken. No action found to be required.
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) - NHS IC, Leeds	Improve on areas flagged that need improvement in diabetes care for inpatient audit NDA audit is more reflective of primary care and cannot therefore be easily influenced by UHS, except through education and support in primary care, with need for increased resource
Diabetes (Paediatric) PNDA - Royal College of Child Health and Paediatrics (RCPCH)	Improve data collection & submission by using electronic patient care system HICCS to collect all clinical data on children with diabetes
Fever in children CEM	Increased presence of senior clinician (consultant) directly located within paediatric area. This includes a Paediatric Consultant who has joining the senior rota. This will enable earlier senior decision maker input. During the audit period there was no written advice (all ED advice cards had been removed as per Trust policy just prior to audit period). We now have a new re-written discharge advice card for children presenting with fever, printable from the Symphony system. Education regarding the "Traffic Light System" for all new doctors during induction. Continuing education regarding antibiotic usage in children during educational programme. Prominence of "Traffic Light System" guidelines within paediatric area emphasised.
Heart failure HF - National Institute for Cardiovascular Outcomes Research (NICOR	Unfortunately our data suggested an IT glitch. As such it was reported nationally that 0% of our patients were on an AVE-Inhibitor or a betablocker. We are meeting with IT to fix this problem.
Hip fracture database, national	Fragility Fracture Rehabilitation ward set up In March 2013 at Princess Ann Hospital.
Lung cancer NLCA - NHS IC, Leeds	Better than average 1 year survival at UHS compared to Nationally.
National audit of dementia audit NAD - Royal College of Psychiatrists (CCQI)	Report being reviewed at next consultant meeting and findings to be shared with organisation
NASH National audit of seizure	Only the organisational analysis was published in 2012 - actions relate to this. Liaison with

management (epilepsy)	neurology services to determine requirement for developing a pathway for onward referral of patients presenting with a (non-first) seizure.
National Joint Registry NJR	Report findings used in implant tender process
Neonatal intensive and special care NNAP	- all missing data points, including documentation of discussion with parents, to be identified by data entry clerk - where possible, data entry clerk to enter missing data from review of patient and maternal records - remaining missing data points to b
Paediatric asthma - The British Thoracic Society (BTS)	Continue with trainee education programme as established to minimise use of unecessary investigations - already half that of national averages. Need to maintain pressures to avoid over prescribing of antibipotics for acute asthma. Asthma nurse specialist engagement ongoing to maintain excellent outcomes around discharge planning.
Paediatric intensive care PICANet - University of Leicester	We have the lowest SMR of any large unit in the country on the basis of this data. We intend to maintain this high quality. We have started completing the PIC dashboard and we are now collecting PICANet transport data.
Paediatric pneumonia - BTS	Highlighted uncertainties around diagnosis of pneumonia coding. Further review of care pathway ongoing - Guidelines to be updated this year
Renal Colic CEM	Actions to improve timeliness and adequacy of analgesia provision: The Rapid Assessment and Triage (RAT) role has been formalised for the Consultant staff in the ED. This provides consultant RAT cover between 10:00-16:00 on weekdays (extending to 18:00 when four Consultants are present), resulting in a senior decision maker being present to assess the patient on arrival in the ED. Once an assessment of pain is made analgesia can be prescribed. Oral analgesia is now located directly within the assessment room, thereby removing unnecessary steps. Patient Group Directions (PGDs) will enable nurse prescribing of analgesia outside of RAT hours. Options including oramorph, intranasal diamorphine and intranasal fentanyl are being investigated. Education of all clinical staff in the importance of both initial assessment and re-assessment of analgesia stressed at departmental induction. Continuing development of the renal colic pathway to ensure timely diagnostic testing and fast-tracking of appropriate patients. Increase number of senior clinicians able to perform AAA scans within the Emergency Department (an in-house course will be organised for late 2013).
Severe trauma (Trauma Audit & Research Network) TARN	Regular M&M meetings across all specialties involved create actions and they are implemented with the support of the medical directors.

Research:

The number of patients receiving relevant health services provided or sub-contracted by University Hospital Southampton NHS Foundation Trust in 2012/2013 that were recruited during that period to participate in NIHR supported research approved by a research ethics committee was above 8,000.

Participation in clinical research demonstrates University Hospital Southampton NHS Foundation Trust's continued commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

University Hospital Southampton NHS Foundation Trust was involved in conducting 291 NIHR supported clinical research studies in a broad spectrum of medical specialties during 2012/2013.

There were over 1000 clinical staff participating in both National Institute for Health Research (NIHR) and non-NIHR supported research approved by a research ethics committee at University Hospital Southampton NHS Foundation Trust during this time.

Our goals agreed with the commissioners

A proportion of UHS income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between UHS and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

The monetary total for the amount of income in 2012/13 conditional upon achieving quality improvement and innovation goals was £10.26 M and a monetary total for the associated payment in 2012/13 was £9.86 M.

Further details of the agreed goals for 2012/13 and for the following 12-month period are available at www.uhs.nhs.uk

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

UHS; Our CQUIN priorities for 2012/13

Contract	Scheme	Type	Rate	Value £k
Specialist, SHIP & SW	VTE	National	0.125%	513
Specialist, SHIP & SW	Patient Experience	National	0.125%	513
Specialist, SHIP & SW	Dementia	National	0.125%	513
Specialist, SHIP & SW	Safety Thermometer	National	0.125%	513
SHIP & SW	High impact innovations	National	0.500%	1,356
SHIP & SW	Follow up of frequent attendees	Local	0.525%	1,423
SHIP & SW	Out of Hospital Care	Local	0.750%	2,034
SHIP & SW	Heath improvement assessment	Local	0.225%	610
SHIP & SW	Gateway	SHA		
Specialist	Clinical Dashboards	Local	0.200%	278
Specialist	Haemtrak	Local	0.200%	278
Specialist	Haemophilia Clinical Trials	Local	0.300%	417
Specialist	Haemophilia Trough Levels	Local	0.200%	278
Specialist	IVIG panel set up	Local	0.300%	417
Specialist	IVIG panel referrals	Local	0.200%	278
Specialist	IVIG Database	Local	0.200%	278
Specialist	Neonatal TPN	Local	0.200%	278
Specialist	Neonatal Discharge	Local	0.200%	278
	Total			10,257

The CQUIN targets set were challenging, however we have made significant progress. These areas remain part of our improvement focus for 2013/14.

What others say about University Hospital Southampton NHS Foundation Trust

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

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

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

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

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

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

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

University Hospital Southampton NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against University Hospital Southampton NHS Foundation Trust during 2012/13.

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

University Hospital Southampton NHS Foundation Trust participated in a child protection Serious Case Review (Southampton Child F) dated 18/06/2012.

The Care Quality Commission undertook a responsive review of compliance at the Southampton General Hospital (SGH) site in October 2012 and reported that patients and relatives were overwhelmingly positive about the staff and the care they had received, and that the staff were incredibly hard working. Many of the wards CQC visited were compliant against the standards but in a small number, specific issues were observed that did not reflect our quality standards or our clinical policies and practices, which then contributed negatively to our final assessment as outlined below:

. **SGH - Standards Reviewed**	**CQC Judgement**
• Outcome 2 - Consent to treatment	Compliant
• Outcome 4 - Care and welfare of people who use services	Minor concerns
• Outcome 7 - Safeguarding people who use services from abuse	Compliant
• Outcome 9 - Management of medicines	Minor concerns
• Outcome 13 - Staffing	Moderate concerns
• Outcome 21 - Record management	Minor concerns

A comprehensive action plan was submitted to the CQC and the Trust Board are overseeing achievement of the plan through the Director of Nursing and a monthly Task and Finish Group, who will ensure delivery of the key actions to demonstrate full compliance to the CQC, the majority of which will be completed by the end of March 2013.

Ward staffing levels are reviewed annually, taking account of any staff increases needed linked to capacity changes and this review was completed in November 2012. We review staffing levels using recommendations included in the RCN guidance issued in 2010 and the Safer Nursing Care Acuity and Dependency tool. A number of further actions to add to our existing recruitment plans were agreed. These included an ongoing programme of overseas recruitment, increases to staff supported through the return to practice programme and a continued focus on encouraging the newly qualified nurses due to complete their training to work with us through the local universities, and career fairs. We have received very positive evaluations about the calibre, capability and compassion of both our overseas recruits and our newly qualified recruits.

In December CQC also undertook their first inspection of the Princess Ann Hospital (PAH) and reported that mothers and partners were very positive about the care they received and their consultation and involvement in decision making. The outcome of the PAH inspection was that the two outcomes reviewed were found to be fully compliant with the Essential Standards of Quality and Safety.

Our data quality:

University Hospital Southampton NHS Foundation Trust submitted records between April 2012 and March 2013 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics which are included in the latest published data. As at January 2013 (latest reporting month) the percentage of records in the published data:

— which included the patient's valid NHS number was:
97.4 % for admitted patient care;
98.5 % for outpatient care; and
95.3 % for accident and emergency care.

— which included a valid General Practitioner Registration Code was:
100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care.

Our scores were close to national achievement (NHS Number) or above reported national levels (Practice Code) for data quality.

University Hospital Southampton NHS Foundation Trust Information Governance Assessment Report overall score for 2012/13 was 72% and was graded red (Unsatisfactory). The Trust did not achieve a satisfactory level of compliance for one requirement in the assessment related to information governance training for staff. An action plan is being developed to improve compliance for this requirement during 2013/14.

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

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

UHS recognizes that good quality health services depend on the provision of high quality information. Continuing the work undertaken in 2011/12, UHS took the following actions to improve data quality:

- Introduction of a new UHS Data Quality Policy that details the expectations, processes and principles that support the collection and management of information to achieve high standards. It sets out the key stages for information management, outlines the principles to be followed and the main processes that support information quality assurance.

- Performance management of data quality via Trust and Divisional meetings, the Clinical Coding function, and the IM&T Information Team. These groups used key performance indicators on internal and external timeliness, validity and completion of patient data, including Dr Foster comparative analysis information. Areas of poor performance are identified, investigated and plans agreed for improvement.

- Continued work to reduce data quality problems at the point of data entry through improved system design, changes to software, and targeted support for system users.

- Working towards delivering real time admission, discharge and transfer recording across more ward areas, thereby supporting improved patient tracking and bed management.

- Supporting training and education programmes for all staff involved in data collection, including Information Governance training and the provision of information guidance.

- Maintaining a programme of regular internal audit, including data quality, record keeping, health records management, information governance and clinical coding audit.

- Continued to maintain and develop improved compliance with the Information Governance Toolkit standards.

University Hospital Southampton NHS Foundation Trust was subject to one Payment by Results clinical coding audit during the reporting period by the Audit Commission. This included Ophthalmology out-patients, General Medicine and Obstetrics

inpatients. This report is still in draft form and results and any actions required will be updated in the 2013/14 quality account. The results of the audit should not be extrapolated further than the actual sample audited.

Our standard core indicators of quality

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

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

a) the national average for the same; and

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

Our hospital mortality rating

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

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

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

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

The University Hospital Southampton NHS Foundation Trust has taken the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, see part 3 review of services

Below, our SHMI rating falls within the nationally expected range

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

	Reporting Period					
	P01571 - July 2011 - June 2012 uploaded Jan-13 next version due Apr-13		**P01533** - Apr 2011 - Mar 2012 uploaded Oct-12 next version due Jan-13		**P01106** - Apr 2010 - Mar 2011 uploaded Oct-11 next version due Jan-12	
	Value	OD_Banding	Value	OD_Banding	Value	OD_Banding
UHS	0.9079	2	0.9212	2	0.9634	2
National Ave	1.0022	2.04	1.0023	2.04	1.0013	2
Highest Trust Score	1.2559	1	1.2475	1	1.2141	1
Lowest Trust Score	0.7108	3	0.7102	3	0.6729	3

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

The figures below provide some context in understanding how the Countess Mountbatten House hospice care facility increases the number of patients at UHS overall, that come to us for palliative care.

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

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

	Reporting Period								
	P01573 - July 2011 - June 2012 uploaded Jan-13 next version due Apr-13			**P01535** - Apr 2011 - Mar 2012 uploaded Oct-12 next version due Jan-13			**P01404**- Apr 2010 - Mar 2011 uploaded Oct-11 next version due Jan-12		
	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate
UHS	12.8	26.3	27.6	13.4	27.2	28.6	15	21.6	22.4
National Ave	1.4	18.4	18.6	1.4	17.9	18.1	1.3	16.5	16.7

Highest Trust Score	17.9	46.3	46.3	19.7	44.2	44.2	25.9	38.9	38.9
Lowest Trust Score	0	0.3	0.3	0	0	0	0	0.1	0.1

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

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

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

	Reporting Period								
	P01572 - July 2011 - June 2012 uploaded Jan-13 next version due Apr-13			**P01534** - Apr 2011 - Mar 2012 uploaded Oct-12 next version due Jan-13			**P01403**- Apr 2010 - Mar 2011 uploaded Oct-11 next version due Jan-12		
	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate
UHS	0.5	1.2	1.3	0.6	1.2	1.2	0.6	0.9	0.9
National Ave	0.1	1.0	1.0	0.07	1.00	1.02	0.1	0.9	0.9
Highest Trust Score	1	3.3	3.3	1.1	3.3	3.3	1.4	2.9	2.9
Lowest Trust Score	0	0	0	0	0	0	0	0	0

Our Patient Reported Outcomes Measures (PROMS) following hip or knee replacement surgery
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's patient reported outcome measures scores for
(iii) hip replacement surgery, and
(iv) knee replacement surgery,
during the reporting period.

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

The University Hospital Southampton NHS Foundation Trust has taken actions to improve this percentage, and so the quality of its services, which are detailed in our Trust Board quarterly Outcomes report. See part 3 review of services

Below, our PROMS rating falls within the nationally expected range

PROMS (iii) hip replacement surgery

P01551	Reporting Period		
	Apr 2012 - Sep 2012 (Provisional - Feb13)	Apr 2011 - Mar 2012 (Provisional Feb13)	Apr 2010 - Mar 2011 (Finalised Aug12)
	Adjusted average health gain		
UHS	no uhs data	0.418	0.377
National Ave		0.414	0.405
Highest Trust Score		0.532	0.503
Lowest Trust Score		0.306	0.264

httpwww.hscic.gov.ukarticle2021Website-Searchproductid=10632&q=proms&sort=Relevance&size=10&page=1&area=both#top

http://www.hscic.gov.uk/article/2021/Website-Search?productid=10633&q=proms&sort=Relevance&size=10&page=1&area=both#top

http://www.hscic.gov.uk/article/2021/Website-Search?productid=8031&q=proms&sort=Relevance&size=10&page=2&area=both#top

PROMS (iv) knee replacement surgery

P01551	Reporting Period		
	Apr 2012 - Sep 2012 (Provisional - Feb13)	Apr 2011 - Mar 2012 (Provisional Feb13)	Apr 2010 - Mar 2011 (Finalised Aug12)
	Adjusted average health gain		
UHS	no data	0.289	0.327
National Ave		0.302	0.299
Highest Trust Score		0.385	0.407
Lowest Trust Score		0.18	0.176

Our readmissions rate for children and adults

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

(i) 0 to 14; and

(ii) 15 or over,

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

The University Hospital Southampton NHS Foundation Trust considers that these percentages are as described for the following reasons taken from national dataset using data provided.

The University Hospital Southampton NHS Foundation Trust has taken actions to improve this percentage, and so the quality of its services, which are detailed in our Trust Board quarterly Outcomes report.

Readmissions within 28 days <16

P00913	Reporting Period (all uploaded Dec-12 next Dec-13)		
	Apr 2010 - Mar 2011 standardised to persons 2006/07	Apr 2009 - Mar 2010 standardised to persons 2006/07	Apr 2008 - Mar 2009 standardised to persons 2006/07
	Indirectly age, sex, method of admission, diagnosis, procedure standardised percent		
UHS	10.44	10.52	10.48
National Ave	10.15	10.18	10.90
Highest Trust Score	25.8	31.4	22.73
Lowest Trust Score	0	0	0
Lowest Trust Score (non-zero)	3.53	3.7	3.32

Readmissions within 28 days 16+

P00913	Reporting Period (uploaded Dec-12 next Dec-13)		
	Apr 2010 - Mar 2011 standardised to persons 2006/07	Apr 2009 - Mar 2010 standardised to persons 2006/07	Apr 2008 - Mar 2009 standardised to persons 2006/07
	Indirectly age, sex, method of admission, diagnosis, procedure standardised percent		
UHS	11.33	11.09	11.08
National Ave	11.42	11.16	10.90
Highest Trust Score	22.93	22.09	29.42
Lowest Trust Score	0	0	0
Lowest Trust Score (non zero)	2.38	3.22	2.32

Our patient experience score for responsiveness to the personal needs of patients

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.

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

The University Hospital Southampton NHS Foundation Trust has taken actions to improve this percentage, and so the quality of its services, which are detailed in our Trust Board quarterly Outcomes report.

Present, in a table format, the data for at least the last two reporting periods.

Responsiveness to Personal Needs of patients

P01391	Reporting Period (all uploaded Mar13 next tbc)		
	2011/12	2010/11	2009/10
	Average Weighted Score		
UHS	64.2	64.8	64.6
National Ave	67.4	67.3	66.7
Highest Trust Score	85	82.6	81.9
Lowest Trust Score	56.5	56.7	58.3

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

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

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

The University Hospital Southampton NHS Foundation Trust has taken actions to improve this percentage, and so the quality of its services, which are detailed in our Trust Board quarterly patient experience report.

Percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends

P01554	Reporting Period (uploaded Dec12)
	2011
	Agreed or Strongly Agreed
UHS	67%
National Ave (All Trusts)	60%
National Ave (Acute Trusts)	65%
National Ave (Specialist Trusts)	86%
Highest Trust Score (All)	96%
Highest Trust Score (Acute)	89%
Lowest Trust Score (All)	21%
Lowest Trust Score (Acute)	33%

The percentage of our patients that were risk assessed for venous thromboembolism (VTE Blood clot)

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

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

The University Hospital Southampton NHS Foundation Trust has taken actions to improve this percentage, and so the quality of its services, which are detailed in our Trust Board quarterly report.

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

P01556	Reporting Period				
	2012/13 Q3	2012/13 Q2	2012/13 Q1	2011/12 Q4	2011/12 Q3
UHS	94.4%	92.6%	92.8%	92.3%	91.5%
National Ave (Acute Providers)	94.1%	93.8%	93.4%	92.5%	90.7%
Highest Trust Score (Acute Providers)	100.0%	100.0%	100.0%	100.0%	100.0%
Lowest Trust Score (Acute Providers)	84.6%	80.9%	80.8%	69.8%	32.4%

http://transparency.dh.gov.uk/2012/01/15/vte-information/

The rate per 100,000 bed days of cases of C.difficile infection in our Trust.

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.

The University Hospital Southampton NHS Foundation Trust considers that this rate is as described for the following reasons; taken from national dataset using data provided.
The University Hospital Southampton NHS Foundation Trust has taken actions to improve this percentage, and so the quality of its services, which are detailed in our Trust Board quarterly Outcomes report.

Rate per 100,000 bed days of cases of C.difficile infection reported within the trust among patients aged 2 or over (Trust apportioned cases)

	Reporting Period		
P01557	2011/12	2010/11	2009/10
UHS	17.7	24.2	33
National Ave	21.8	29.6	36.7
Highest Trust Score	51.6	71.8	85.2
Lowest Trust Score	0	0	0
Lowest Trust Score (non-zero)	1.9	3.2	2.4

The rate per 100 admissions, of patient safety incidents reported in our Trust.
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.
The University Hospital Southampton NHS Foundation Trust considers that this number and/or rate is as described for the following reasons; taken from national dataset using data provided.
The University Hospital Southampton NHS Foundation Trust has taken actions to improve this percentage, and so the quality of its services, which are detailed in our Trust Board quarterly Safety report.

Report the rate as per 100 patient admissions or per 1000 bed days, where data is available.

Number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

	Reporting Period					
P01558	Apr-12 to Sep-12			Apr-11 to Sep-11		
	Rates per 100 admissions	Severe and Death	Severe and Death (%)	Rates per 100 admissions	Severe and Death	Severe and Death (%)
UHS	6.42	22	0.5	6.14	47	1.2
National Ave (Acute teaching trusts)	7.03	28	0.5	6.6	28.63	0.6
Highest Trust Score (Acute teaching trusts)	12.12	86	1.6	9.22	110	2.3
Lowest Trust Score (Acute teaching trusts)	2.77	1	0	4.14	1	0
The latest data is available at:	incidents that occurred between 1/4/12 - 30/9/12 and reported to NRLS by 30/11/12			incidents that occurred between 1/4/11 - 30/9/11 and reported to NRLS by 30/11/11		

Where the necessary data is made available to the trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the trust with—
(a) the national average for the same; and
(b) with those National Health Service trusts and NHS foundation trusts with the highest and lowest of the same, for the reporting period.

Part 3 - Review of our services in 2012/13

This part of the Quality Report reviews the Trust's quality performance in the year 2012/13. There are two sections:

1. A brief report on the quality improvement priorities that were listed in the 2010/11 quality account for achievement in 2012/13.

2. A table of quality performance information that gives an overall view of the quality performance of the Trust in 2012/13.

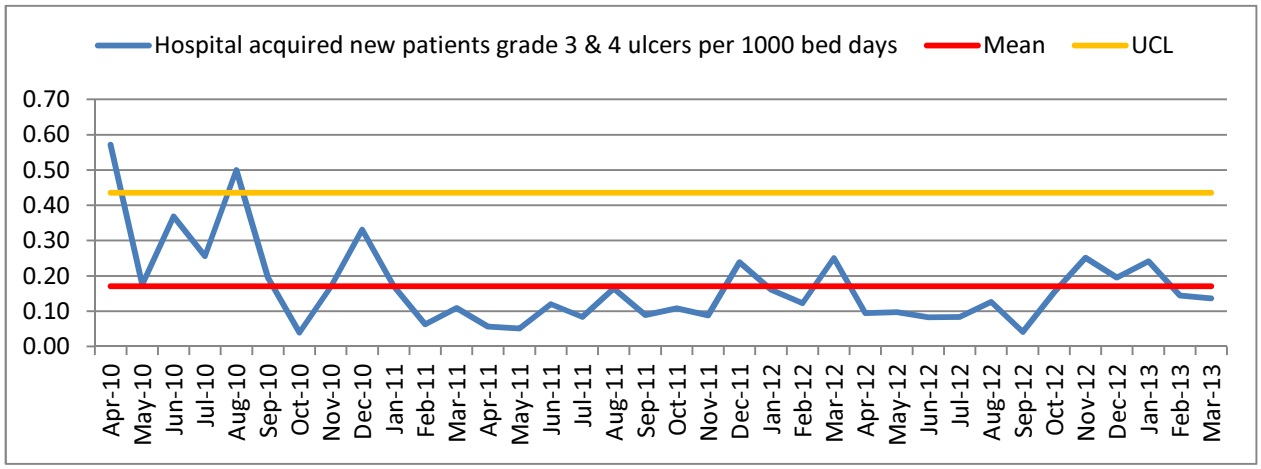
Patient safety priorities: Our 2012 13 progress

Pressure Ulcers

Our 2012/13 improvement target was to achieve a 25% reduction in grade 3&4's to a total of 24, and a 20% reduction in grade 2's to a total of 223.
Pressure ulcers are graded using the European guidance system from grade 1 to grade 4. Grade 4 is the most serious.

Our results for 2012 13 were:

The Trust has achieved a reduction with grade 2 pressure ulcers from 473 in 2010/11 to 291 in 2012 13, and a reduction for grade 3&4's from 78 in 2010/11 to 41 in 2012/13. However we didn't meet the challenging targets we set ourselves for this year. We have agreed that pressure ulcers will continue to be a priority for 2013 14.



What we did

Participation in the national safety thermometer Cquin programme that includes reduction of patient harm from pressure ulcers.

Full implementation of Nurse in charge ward rounds on every ward. This supports the turnaround process we implemented in 2011/12, through oversight of assessment and compliance.

We have noticed an increase in the number of frail elderly patients admitted, especially over the winter period. These patients are especially prone to developing a pressure ulcer. So our patient risk assessments for pressure ulcers, and wound care policies have been updated with an associated clinical standard of 100% compliance.

We have improved our communications for learning about pressure ulcers incidence, and provide regular reports to each ward matron about any of their patients that have a pressure ulcer.

Our root cause analysis panels have continued to enable in depth understanding and learning about reasons why pressure ulcers occur in our hospital, and actions we can take to learn from these and prevent them happening again.

We are increasing our training and supervision for pressure ulcer management, especially for new staff on our wards.

We are relaunching our Turnaround project, as this is proven to make a difference in reducing patient harms from pressure ulcers. We are linking this to our 'Safe Care in Our Hands Campaign. This brings together four projects:

Raising awareness of incident reporting including our new eReporting system. This will include a feedback process to ensure that we can learn more effectively from incidents reported)

The 'Speak up, Speak out' project , about how and when to raise concerns

Implementation of regular safety walkabouts

Reviewing how safety information is communicated.

To Improve Diabetes Care:

Our 2012/13 improvement target was to achieve: To have no insulin 'never events', and to achieve a 20 % reduction in incidents / errors relating to diabetes - setting a baseline for this in Q1 & 2. "Never events" are defined nationally as serious, largely preventable patient safety incidents that should not occur.

Our results for 2012 13 were:
UHS had no insulin Never Events for insulin in 2012/13.

What we did
We have improved the information for diabetes clinical management in the Trust to ensure we meet new national best practice. These are available both online, and on our new mobile phone app- DiAPPbetes:

Feb 2012 saw the launch of "DiAPPbetes".. This is the first smartphone application (APP) for Apple iPhone, iPod touch and iPad, designed to support the care of adult inpatients with diabetes. The APP acts as a decision support tool in helping non-specialists manage patients with diabetes.

Features include:
Touchscreen insulin dose calculator
Guide to manage hypoglycaemia for conscious, NBM and unconscious patients
Traffic light criteria for specialist referral (as per ThinkGlucose)
Top tips on safe use of insulin and safe prescribing (link to national NHS diabetes safe use of insulin included)

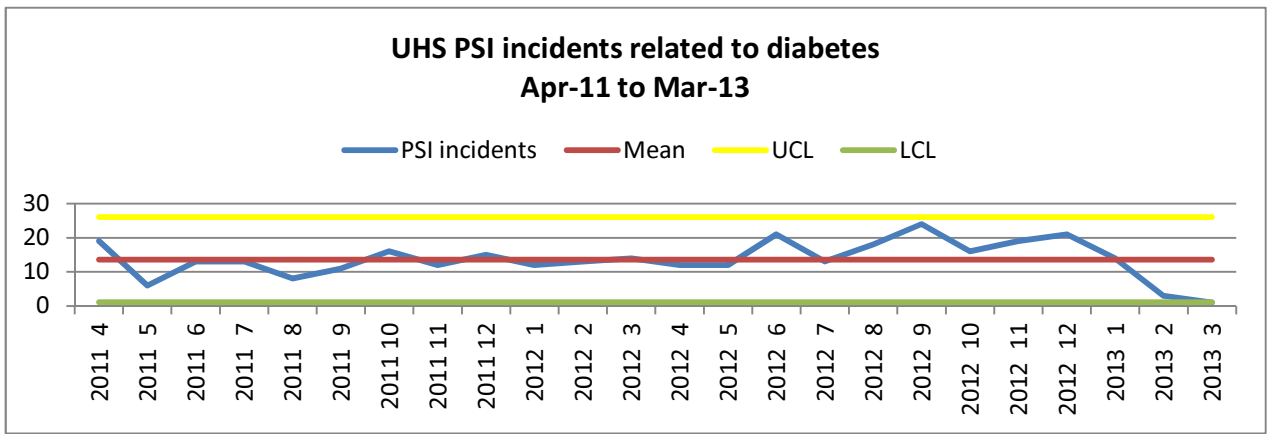
The application has had over 1300 downloads nationally and internationally from the Apple iPhone App Store since its launch, and is rated five stars in reviews.

Daily bedside clinics for patients with diabetes
In a three-month pilot project led by Dr Mayank Patel, lead consultant in diabetes, almost 400 cardiac, orthopaedic and vascular patients with the condition were seen in daily 'bedside clinics' by an inpatient diabetes team. Around 15% of all inpatients at University Hospital Southampton NHS Foundation Trust have diabetes. By switching the focus on to caring for patients' diabetes before they encounter problems and allowing us to dedicate time to them and the staff treating them, we have seen quite a radical transformation.

The diabetes team, made up of a consultant, two specialist nurses, a research dietitian and a pharmacist, completed full daily reviews, which included foot examinations, provided information materials to all patients and staff, offered bespoke teaching sessions to all wards and rectified any unsafe or incorrect prescribing.

In addition to preventing 45 potential diabetes-related medication errors, reducing readmission rates from 8.91% to 5% and reducing the length of inpatient stay– all patients surveyed said they were satisfied with their overall diabetes care, including the number of visits, clarity of information and monitoring of their condition.

Following the pilot, which was recently named one of the best inpatient care initiatives of the year at the Quality in Care Diabetes Awards, planning is underway to extend the scheme to the stroke unit and surgical wards.

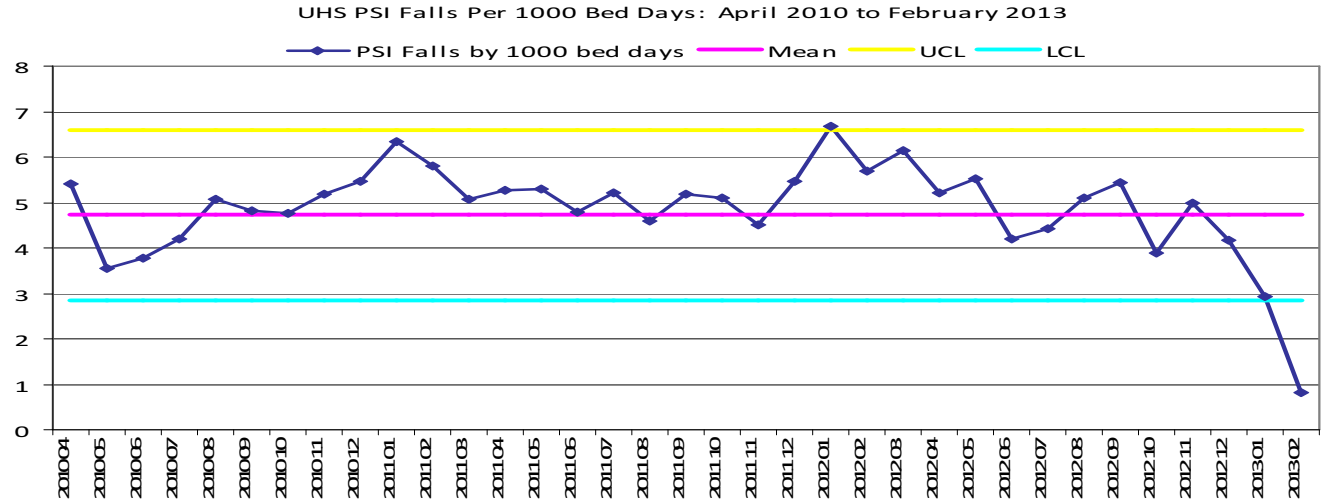


There has been an increase incident reporting related to diabetes however this should be seen as part of an improvement journey with the first step being to improve reporting and reliability of future measurement. The incidents are analysed and shared with ward teams to support understanding and learning.

Falls

Our 2012/13 improvement target was a 50% reduction of avoidable high harm falls i.e. 8 or less over the year.

Our results for 2012 13 were:
In 2012 13 we had 5 patients that suffered avoidable high harm falls. There are a further 5 cases awaiting validation.
We expect to meet this improvement target.



What we did

Over the past year our developments have included:
The FallSafe care bundle has been implemented through our falls assessment tool and resulting plan of care. We are including this in a streamlined nursing documentation pack to ensure it is readily available for all patients that need it.

We have piloted several types of falls prevention alarm (pressure pads). These have evaluated well and many wards, particularly those who have patients at risk from falls are keen to begin using the equipment more widely.

Our dementia specialist nurse is developing the current prevention strategies for preventing falls in patients to ensure they meet the needs of patients dementia or delirium as this group is at very high risk of falling.

Our therapies team has piloted an intervention program of structured education sessions and clinics for patients at risk of falls and their carers which has been extremely successful.

Occupational Therapy team patient falls improvement
As an orthopaedic therapy team we see the majority of fallers across the trust. We recognised that our service could be improved in terms of falls prevention. Some background research identified the key objectives that we should be meeting.

Over a period of 18 months, 3 audits were completed to monitor our adherence to these standards. Each audit showed a marked improvement.

Every patient is now screened for their risk of falls and those that are identified as high risk follow the 'falls pathway' which includes receiving written information about falls prevention, intervention for gait and balance issues and a referral to be seen in the community on discharge.

Feedback has been really positive and the changes to our practice are of huge benefit to both the trust and the patients themselves."

Our additional Patient Improvement priorities are summarised in the performance tables in section 1.

Patient Experience priorities: Our 2012 13 progress

Nutrition & Hydration

Our 2012/13 improvement target was: to understand and improve our patient feedback on quality of the food.
To ensure all wards manage a protected mealtimes for patients and those patients that require assistance receive it. To improve our nutritional screening (MUST) compliance to 98% of patients, and our nutritional care plan compliance to 95%

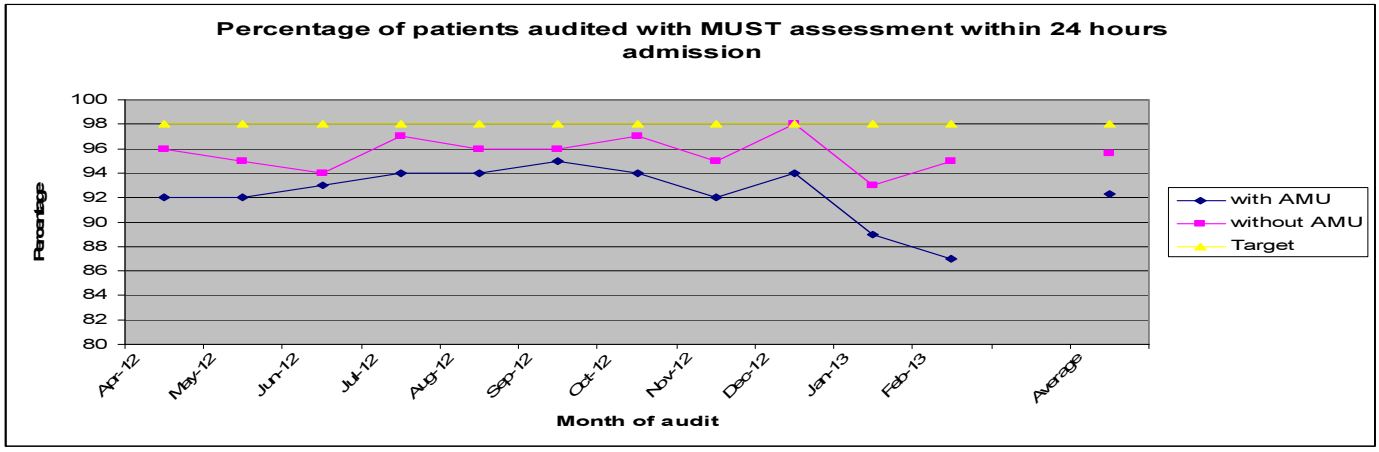
Our results for 2012 13 were:
Nearly 90% of wards now manage a protected mealtime for patients
Our MUST screening compliance is improved to 91.9%
86% of patients that need one, have a nutritional care plan

What we did
Catering and Hospital Food feedback
The upward trend in the food rating has continued a slow improvement. The average number of patients in who rated the food as poor has reduced over the year, from 17% in April to 14.94% by March 2013

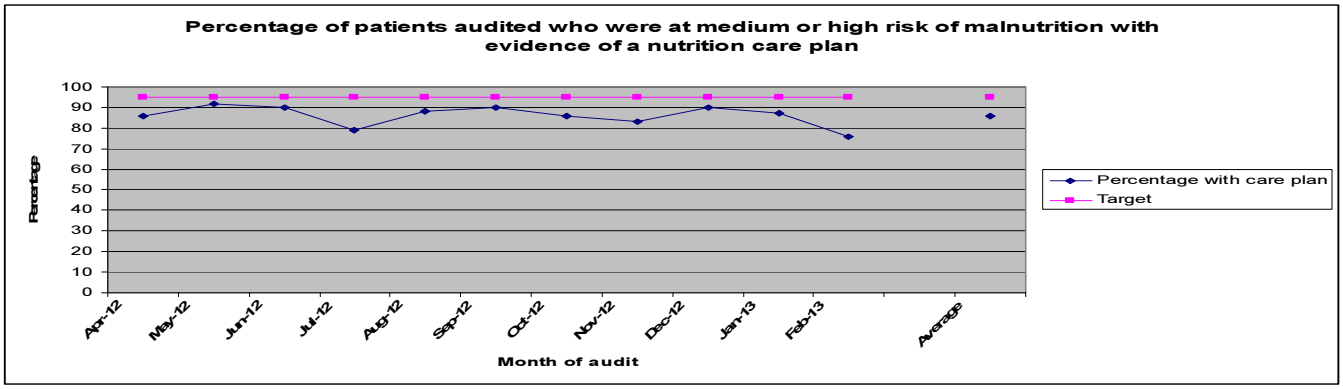
Protected mealtimes
We identified this as a priority issue for our patients through listening to patient feedback received in 2011 that only 60% of our wards were able to implement this.

A sustained approach has resulted in a rapid improvement to nearly 90% of wards implementing protected mealtimes by the end of 2012/13.

To improve our nutritional screening (MUST) compliance
We audited an average of 380 patients every month for MUST assessment within 24 hours of admission, and fed back results to support improvement. The average compliance for MUST assessment within 24 hours of admission was 92%. A large proportion of patients are admitted via AMU and this is a critical place for early identification and treatment of malnutrition risk.



Of those patients audited and identified as being at medium or high risk of malnutrition an average of 86% had evidence of a MUST care plan. The MUST care plans have now been redesigned in collaboration with nursing staff to make them easier to complete.



Improve Patient Communication: discharge planning and patient information

Our 2012/13 improvement target was: To keep patients, relatives and carers fully informed about their treatment plans and care, involving them in decision-making.
To improve the quality of patient discharge information provided to GPs, and increase the percentage of copies of GP letters that are shared with patients.

Communication and staff attitudes
Improving complaints received about **poor communication** (primary and secondary causes) by 20%.

Our results for 2012 13 were:
We have improved over the year, but not achieved our 2012/13 target, with 601 complaints received in 2012/13 against an overall improvement target of 467.

Improving complaints received about poor staff attitudes (primary and secondary causes) by 10%. We achieved our target, with 146 complaints received in 2012/13 against a target of 158 or less.

What we did
We have continued our focus on customer care training, with local customer care programmes being held with teams.
We are piloting a new approach to improving patient communications and address staff attitudes.
Our results: Patient Feedback Comment Cards and e-mails top themes

Month	Total No.	Top 5 themes				
		Praise	Delays/waiting times	Food	Communication	Attitude of staff
Apr	35	16	4	4	Not a 5 top theme	6
May	59	21	4	3	Not a 5 top theme	8
June	56	20	8	6	Not a 5 top theme	2
July	56	16	6	4	Not a 5 top theme	13
Aug	71	28	12	4	3	Not a top 5 theme
Sept	42	14	3	2	2	2
Oct	83	29	6	4	4	Not a top theme
Nov	43	16	8	2	Not a 5 top theme	4
Dec	46	21	3	3	3	3
Jan '13	25	14	1	1	1	1

Further detail about how we use our wider complaints feedback to prioritise improvement is included in the final section: 'How we monitor and report on quality'.

Discharge information
Our 2012/13 improvement target was: To increase the % of GP letters that are shared with patients.

Our results for 2012 13 were:
We improved the quality of our discharge information across a range of measures, and increased use of our comprehensive electronic discharge form to 96% of summaries written.

What we did
Discharge Summary audits are an essential aspect of measuring best practice with clinical record keeping. The NHS Litigation Authority has positioned discharge summary audits on its criteria for the assessment of risks.

Since it started, this clinical audit has led to improvements such as the introduction of an electronic discharge summary. The number of complaints relating to clarity and appropriate information, being given to the GP and patient, following discharge, has decreased over recent years.

Our results
The discharge summary audit is comprehensive and covers a range of measures, including:

Reason for admission and presenting complaints improved from 96% in 2010/11 to 100%,
Including clinical narrative improved from 87% in 2010/11 to 98% in November 2012.

Use of the comprehensive electronic discharge tool improved from 90% in 2010/11 to 96% in November 2012. This may have supported the wide range of further improvements made in addition to those highlighted above.

To increase the % of GP letters that are shared with patients
Our audit results for Information given to patient improved from 44% in 2010/11, to 56% in the November 2012 audit.

Patients concerns, expectations and wishes have been documented improved from 13% in 2010/11 to 78% in November 2012.
Address the Needs of vulnerable people:

Our 2012/13 improvement target was: To Implement a new Delirium and dementia pathway

Our results for 2012 13 were:
We have made many improvements to our care of patients who have dementia. In addition to meeting our Cquin ambitions of 90% of patient being screened for dementia, with further assessment and referral where relevant, we have made some changes to our ward environment to better meet the needs of these patients, as detailed below.

What we did

In a pioneering project, staff at Southampton General Hospital have created a 28-bed 'dementia-friendly' ward which was officially opened in September 2012, and introduced the UK's first hospital-based specialist nurse.

The development, led by matron Jill Young and her team in the medicine for older people unit, has been hailed a breakthrough moment for dementia patients and their families.

"We know dementia patients can be extremely confused in a hospital environment, particularly when they require medical treatment, and relatives are often concerned their dementia needs are neglected in the absence of carers or family," explained Jill.

Among the innovations are brightly coloured doors to help patients remember which bay they are staying in and images such as umbrellas, lighthouses and starfish instead of bed numbers to provide a visual memory aid.

Doors patients do not need to enter, such as cleaning stores and staff offices, blend in with surrounding walls, while the nurses' station has been lowered and renamed 'reception' to improve accessibility and ensure patients feel more comfortable to approach.

Additionally, paperwork is locked in cupboards out of sight to keep the area clutter-free and visiting time restrictions have been lifted to give access to carers and relatives at any time of the day or night.

Jill added: "We have worked hard to focus on the small things, like colour recognition, less clutter, better communication between staff and patients, to prevent further confusing patients and to give them and their families a sense of normality and we look forward to assessing the impact it has."

Until now, mental health nurses who specialise in dementia care, known as Admiral Nurses, have formed part of community nursing teams. In the newly-created hospital post, Jeni Bell, a former clinical lead Admiral Nurse in the community, will shadow clinical staff and oversee a training and development programme which will look at understanding patients' body language and how to handle those who do not interact verbally.

Barbara Stephens, chief executive of Dementia UK, said: "This project, particularly the introduction of the first Admiral Nurse specialist to be based in a large acute hospital, is a breakthrough moment in the care of dementia patients in hospital and a model of what we want – and need – to see across the country."

Our additional Patient Improvement priorities are summarised in the performance tables in section 1.

Patient Outcomes priorities: Our 2012 13 progress

Reducing the Trust's Hospital Standardised Mortality Rate

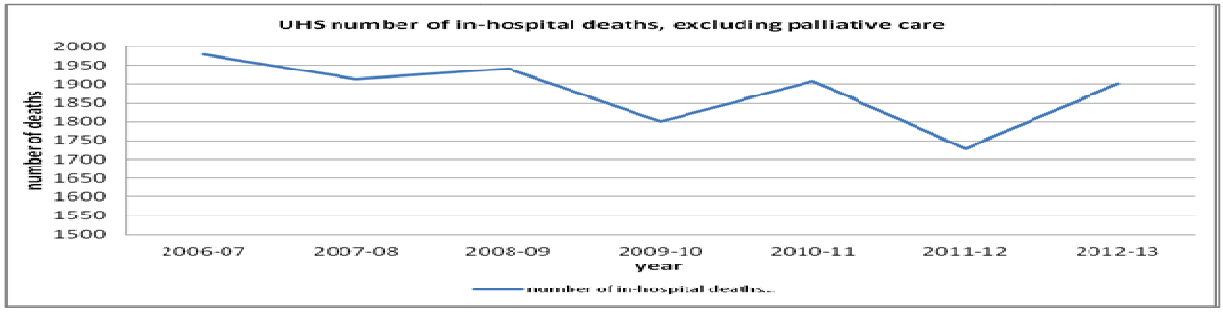
In 2012/13, our Aim was: To reduce the Trust's overall HSMR to 95 by the end of March 2013.

Our results for 2012 13 were:
Our most recent HSMR result is 97.7 (Better than nationally expected) for quarter 3. The national 'expected score' is 100
Our most recent SHMI is 90.8 (Better than nationally expected). The national 'expected score' is 100

HSMR is a benchmarking ratio, used as an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect compared to the general population. The results are collated nationally and are always published 3 months in arrears. It is reset each year to reflect the national performance in the summer. In 2012 the rebenchmarked value raised our predicted HSMR for year-end to above our internal target set. Because of this, we have maintained focus on HSMR as a priority for 2013/14, and graded ourselves as not achieved.

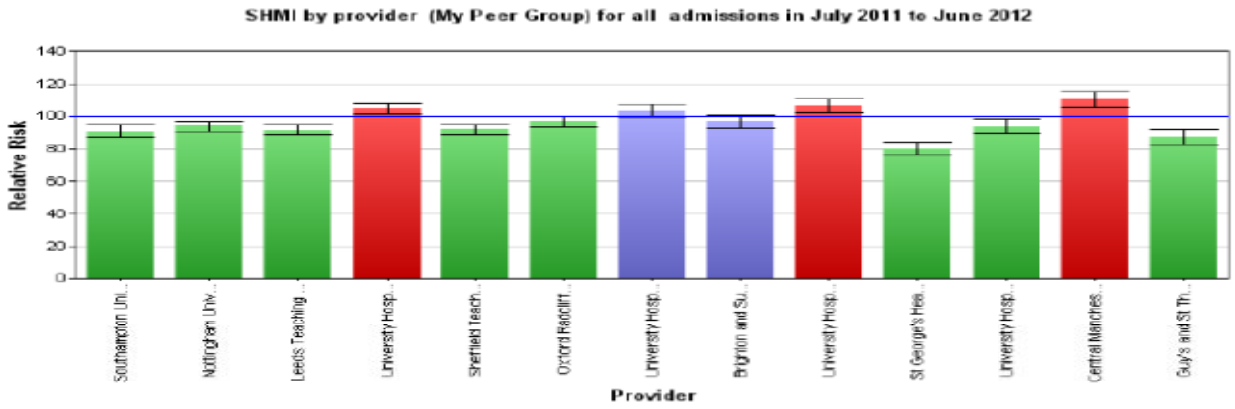
The number of patient deaths in the Trust has continued to fall gradually over the past 6 years. We track this as close to real-time as possible. Our areas of work to improve our mortality rates during last year focused on practical developments and on improving our communications and information systems that support patient care.

Our results
UHS in-hospital deaths, excluding palliative care 2006-2013

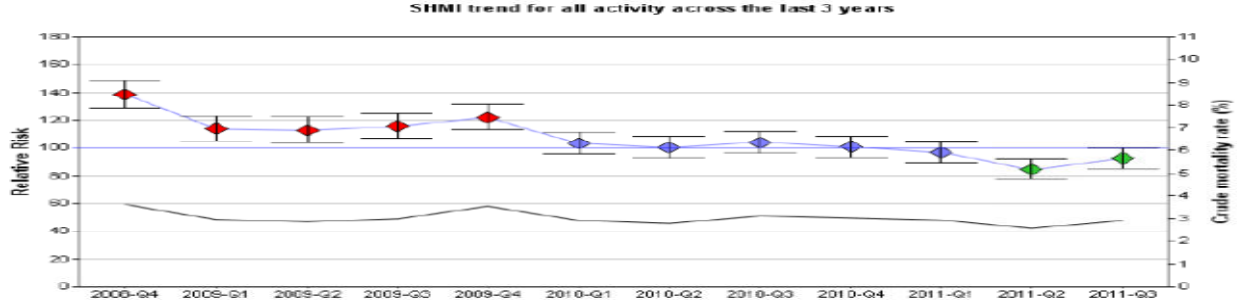


Our SHMI performance compared to other hospitals is demonstrated below (UHS on far left of graph).

SHMI by provider (My Peer Group) for all admissions in July 2011 to June 2012



SHMI trend for all activity across the last 3 years



What we did

A summary of three of the supporting practical developments to achieve this are included below:

Emergency pathway
In 2012/13, our Aim was: To improve the effectiveness of our Accident and Emergency performance. Five areas were chosen to work with in 2012/13.

Our results for 2012 13 were:
Unplanned re-attendances
Clinical advice is that a range between 1% and 5% suggests optimal care. As a Trust, unplanned re-attendances are 7.3% for Qtr 3.

T**otal time spent in the A&E department**
We aimed to improve the time taken, and monitoring of care to ensure patients do not have excessive waits in A&E before leaving the department. We aimed for 95% of our patients to wait 4 hours or less. Over the year, we achieved 95 percent of our patients waited 4 hrs 58 minutes, or less.

Left without being seen
We aimed to improve patient experience and reduce the clinical risk to patients who leave A&E before receiving the care they need. The 'left without being seen' target rate was below 5%. Our rates ranged from 4% to 2.9% over the year. Regular reporting has now been set up to review any patient left without being seen and returning within 48 hours.

Time to initial assessment
Our aim was to reduce clinical risk associated with the time the patient spends un-assessed in A&E with 95 percent of our patients waiting for assessment less than15 minutes. A new agreed pathway within majors was developed that is both consistent with the ethos and principles of initiating a 'meaningful assessment' and meets the time requirements of both SCAS and ED. Our performance is improved to 3 minutes to assessment.
This is a reflection of the commencement during November of implementing a new system for patients that arrive via ambulance to be immediately assessed by a consultant.

Time to Treatment
We aimed to reduce the clinical risk and discomfort associated with the time the patient spends before their treatment begins in A&E to a median of 60 mins or less, from arrival to seeing a decision-making clinician across all patients. Our median is now improved to 1 hr 09 minutes.

Emergency Pathway: Childrens Air Ambulance
The country's first dedicated air ambulance for children has made its first landing at UHS. The Children's Air Ambulance (TCAA), launched as part of a new national emergency air transfer service, will fly critically ill babies and children from district hospitals to specialist centres in England and Wales.

Since December, TCAA has completed three successful missions and is in the process of visiting the country's five lead paediatric intensive care units – including Southampton General Hospital – for familiarisation.

Although it will operate under national charity The Air Ambulance Service (TAAS), it will not attend rescues like other air ambulances but will solely undertake emergency transfers of children already in hospital.

Around 6,000 babies and children suffering from severe illnesses or injuries, such as meningitis, heart conditions or major trauma, need urgent specialist treatment every year and, with TCAA, transfer times will be reduced from hours to minutes compared with the same journeys by road.

Dr Iain Macintosh|, director of the paediatric intensive care unit| at UHS, said: "Once we have this vital service up and running, it will provide an incredible safety net for the whole country.

"Hundreds of children who would have been at risk from longer travelling times will no longer be at risk and that is a major development in the care of critically ill children."

Out of hours and hospital at night
In 2012/13, our Aim was: To develop a service model for 24/7 safe care for adults and children during 2012/13.

Our results for 2012 13 were:
We have developed a 3 part plan to strengthen this covering:

Leadership and Culture to develop service model team including PAH and RSH;

Education and training To include staff that only work nights

Developing the service models for adult, and for child health.

What we did
Our Hospital at Night programme is clinically driven, using teams with skills crossing professions and specialties. The hospital at night approach adds support to medical training and service delivery and aims to achieve safer care by having staff with a full range of skills and competencies to meet the immediate needs of patients.

Improving Night Time Safety

The Emergency department assault data team play a key role in a city-wide initiative to improve the safety and enjoyment of the night-time economy for Southampton residents and visitors.

They provide a weekly report of anonymous data to Southampton's community safety team about emergency department (ED) attendances following assault. This provides valuable information to the police and council staff who are then able to use it to plan interventions to reduce crime and disorder at night within the city centre.

This has included the ICE (in case of emergency) bus, street pastors, taxi marshals and a yellow card scheme.

This multiagency approach began in 2006 and has dramatically reduced violent crime (down by 67%) and admissions to ED (down by 22%).

In December 2011 this initiative was the overall winner at the national Home Office's Tilley Awards for Problem Orientated Partnerships.
The team was runner up at the UHS NHS FT Hospital Heroes 2012 awards held on Thursday, 7 March 2013.

Identifying deteriorating patients more quickly, to improve outcomes

In 2012/13, our Aim was: reduce on-ward cardiac arrests, particularly those due to 'pulseless electrical activity' (PEA)
improve early recognition and management of patient deterioration

Our results for 2012 13 were:
We have reduced the number of cardiac arrests due to pulseless electrical activity by 28% this year.
We have achieved 94% of completed observation of acuity scores.

What we did
We have improved our processes for the escalation of care for patients showing deterioration, by increased training for the nursing and medical staff. This includes using the modified early warning monitoring system (MEWS) tool.

Although the number of MEWS activations has stayed about the same, there has been a slight decrease in admissions with a marked improvement overall in delays in admission >1hr. The number of patients receiving assessment continues to improve, with fewer patient triggering MEWS more than one time. These results demonstrate improved recognition and management prior to admission into GICU.

The national average for return of spontaneous circulation (ROSC) is 35 – 40%. Less than 20% patients survive to discharge. Our hospital's outcomes are much better than this and our results at UHS are: **51%** achieve ROSC and **29%** of these patients are discharged home.

Intensive Care outcomes for Children

Children being treated in intensive care at Southampton's university hospitals have a better chance of surviving the most serious illnesses and injuries.

The latest Paediatric Intensive Care Audit Network (PICAnet) report, coordinated by the universities of Leeds and Leicester, shows the paediatric intensive care unit (PICU) at Southampton General Hospital is the sixth largest by admissions and has the best recovery rate in the country.

As part of the audit, each hospital receives a score based on how ill patients were and how many survive, known as the standardised mortality ratio, with hospitals expected to meet the average of 1.0. University Hospital Southampton NHS Foundation Trust's score is 33% lower at 0.67.

The unit, which has 12 beds and a 24-hour retrieval team, covers Hampshire, Wiltshire, Dorset, Surrey, West Sussex, the Isle of Wight, the Channel Islands and other parts of the UK and last year admitted 971 patients, from birth to 18 years of age.

In addition, since 2006, staff in PICU have performed advanced extracoporeal membrane oxygenation (ECMO) treatment for critically ill heart patients.

National figures suggest two out of every 100 heart surgery patients might require the system, which acts as an artificial heart and lung by removing blood from the body, passing it through a pump which acts as the patient's heart, adding oxygen and returning the blood back to the patient.

The latest figures show 62% of those who need ECMO after heart surgery in Southampton survive compared to an international average of less than 50%.

"I am immensely proud of the staff on PICU in Southampton for having the passion, drive and determination to develop this unit into a centre of excellence for patients not just in the south but across the country," said Dr Michael Marsh|, medical director at UHS and a consultant in PICU.

"From staff on the unit, to the retrieval team and the ECMO service, we have staff at the very top of their field and there is no greater feeling than knowing families feel comforted that their children are receiving the best treatment possible with the best chance of surviving and recovering well."

Our additional Patient Improvement priorities are summarised in the performance tables in section 1.

Further Information about our Trust

How we monitor and report on quality:
The patient improvement framework (PIF) focuses on patient safety, patient experience and patient clinical outcomes and the Trust sets improvement targets on the PIF quality priorities each year. The framework development includes our key local or national priorities, and any areas of concern or needing further improvement, identified from our quality management systems and feedback. We work closely with our PCT commissioning colleagues to reflect joint priorities in our quality contract agreements which also support the patient improvement framework development and delivery of CQUIN targets.

These common PIF themes are also mirrored in the Trust's committee structures and high level reporting practices. An integrated approach ensures that staff understanding of quality is embedded throughout the organisation and reflected in the Trust's quality dashboards and key performance indicators.

Our feedback cycle approach to the management and improvement of quality informs how we agree our priorities for the following year:

We review the implementation status of all National Institute for Clinical Excellence (NICE) guidance, and National Confidential Enquiries (NCE) to risk assess any development areas at UHS and take action to implement recommendations.

We continue to support the use of clinical outcome data to assess and improve services with participation in national audit, the patient reported outcome measures programme (PROMS), as well as undertaking local audits to continue our cycle of quality improvement.

Our annual clinical effectiveness conference was held in November 2012, celebrating audits that have led to improved patient outcomes, safety and experience, with Dr Sophie Staniszewska, Senior Research Fellow and Director of Graduate Studies, Patient and Public Involvement and Patient Experience at the RCN Research Institute, University of Warwick as keynote speaker.

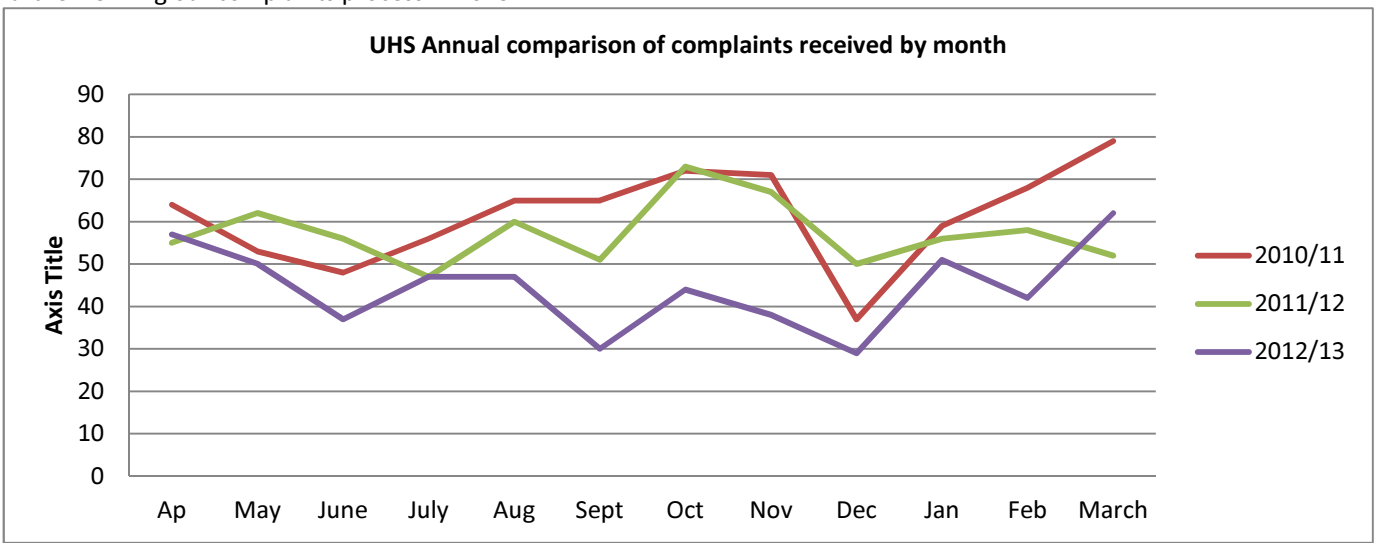
Patient feedback
Patients and visitors are able to give us feedback on the care we provide via our website, email, comment cards, enquiries through our patient support service/PALS and the NHS Choices website. We have used this feedback to help inform the priorities we have set for quality and to engage our staff in reviewing and improving services.

From the feedback received from our comment cards in 2012/13, the top five themes were:

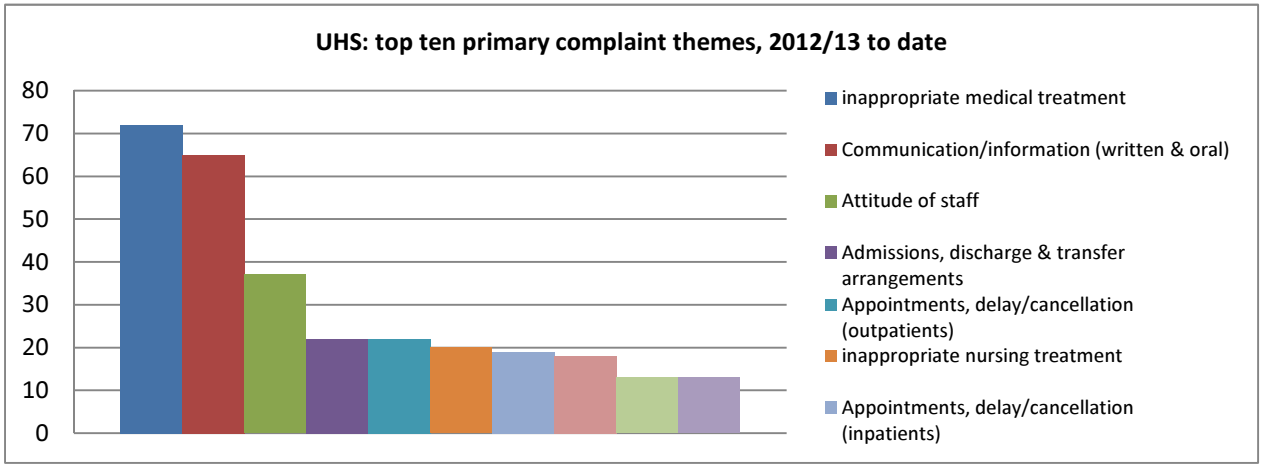
40% praise for services and/or staff
12% delays or waiting times
9% facilities
8% attitude of staff
7% food

Complaints

With over 600,000 patients seen a year, our complaint rate is very low, at less than 0.5%. During the last 3 years the Trust has worked hard to improve the early resolution of concerns and complaints. We are also working much more closely with our complainants at an early stage in the process, focusing on early resolution of complaints where we can. As a result, we have reduced the number of complaints investigated via formal process. In light of the reduction in the number of complaints, we are further refining our complaints process in 2013 14



The primary theme of all complaints received by the Trust is recorded. The graph below shows the top ten themes of complaints received 2012/13.



We review and share complaints received to ensure that we learn from them Trust wide. Complaints and actions are shared via governance groups, quarterly reports to divisions and patient experience report to Trust Board. These themes have influenced the priorities we have chosen for quality improvement in 2013/14.

How our staff values and culture drive improvement in quality for our patients

Following the publishing of the public inquiry into events at Mid Staffordshire NHS Foundation Trust (the Francis Inquiry) and the Department of Health's response 'Patients First and Foremost' the Trust has undertaken a scoping exercise to asses its position in relation to the 290 recommendations made.

The results of this suggest that the majority of the relevant recommendations are already firmly embedded in practice across the organisation or are already part of established work streams. However in order to follow up the key issue within the report, which highlights the negative impact culture and behaviours can have on the quality of care, the Chief Executive has commenced a series of listening exercises with staff across the trust. Further work on this issue and regular reports to the trust board will be taken forward in the coming year.

In 2011 we launched our People Strategy to:
Increase levels of employee well-being and engagement
Build a high performing culture
Create an employer brand where UHS is recognised as a great place to work

Progress is measured through a range of measures, including the results of the annual staff attitude survey. This includes questions on how our staff rate the Trust as a place to work year on year and the pride which they take in working here.

Last year the results of the staff attitude survey also encouraged the Trust to prioritise action on increasing the take-up of equality and diversity training. The 2011 survey shows we have improved to reach the top 20% of NHS employers for this measure, improving both patient experience and staff experience.

The survey results are set out as 41 key findings. We are above average for two thirds of findings and below average for 5 findings. Our staff report that they work longer hours than they should. In 12/13 we will continue to reduce pressures on our staff encouraging the planning and taking of their holidays, maintaining low levels of overtime and completing the rollout of e-rostering to non ward based staff.

On staff engagement, our staff tell us we are above average. We are in the top 20% of employers for staff participation in the survey as this year returns increased from 54% to 61%. We have also rated as an above average NHS employer as a place to work or receive treatment.

68% of staff responded that they agreed or strongly agreed to the question "if a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust" The national median for Acute Trust is 62%. Even though we are above average we are determined to increase our percentage further.

Over the last two years the Trust has consulted and developed a new set of values. We aim to make these values 'what we do' – to inspire, develop and support every one of us to live our values; every patient, every colleague, every day. These values are about us all helping each other to deliver great patient experience more consistently – involving people who use our services, their families, carers, staff and partners in continuing to improve the experience people have using and delivering our services. They were created by a full staff engagement exercise following one-to-ones and small group interviews with over 150 staff members.

Our values are:
Patients First: Patients, carers and families lie at the heart of everything we do. Their experience of the hospital and their perception of the Trust, are our measures of success.

Working Together: Our clinical, technical and support staff are all crucial to providing successful services. We work together for maximum effect, and collaborate to make internal boundaries invisible to patients.

Fresh Thinking: We incorporate new ideas, technologies and greater efficiencies in the services we provide. We value research and education as drivers of future innovation and development, and also recognise our individual responsibility for improvement.

The values are being embedded in the Trust in many different ways, for example.
We regularly review our communication in the way we talk and write, both with each other and also with our patients. Our values will be included in our recruitment and selection processes, as well as our staff appraisals.
Our training and induction courses ensure our values are identified in the new skills learned.
Hospital Heroes, our staff recognition scheme, is judged including our values as the criteria. That way, the values and behaviours we set store by are always at the forefront.

Assurance and compliance
The Trust Board is accountable for the systems of assurance, internal control and risk management and monitors these on a quarterly basis. The Chief Executive is responsible for ensuring the delivery of a high quality service to patients and for the delivery of and compliance with assurance, quality and performance targets.
For operational delivery, this responsibility is delegated to the Medical Director and the Director of Nursing for governance and quality and to the Chief Operating Officer for performance targets. To achieve this we have clear systems and processes in place. Our quality governance strategy has been developed to ensure that Quality Governance is an integral part of Trust business and is at the heart of our clinical practice and service provision. It includes further details about the practical steps we have taken to support assurance and compliance for clinical quality improvement.

Board engagement
Over the last year, the Trust Board has actively embedded the key components of quality into its approach and work programme development, for example through Board development seminars; undertaking visits to the clinical divisions; talking to frontline staff and patients, and ensuring the Trust is compliant with the Clinical Quality Commission's (CQC) 'Essential Standards of Quality and Safety'. The Trust Board has also reviewed the recommendations of nationally relevant external reports and publications for quality, and taken forward actions as appropriate.

The Board uses its 'quality pyramid' early alerts tool, integrating financial and quality high level performance. This assures that effective management of financial resources does not have a negative impact on the delivery of a high quality service.

The Quality Governance Steering Group (QGSG) ensures that there is an annual comprehensive programme of quality improvement for the care of patients, and reports to the Trust Board. The Committee also ensures that clear lines of accountability exist within the Trust for the overall quality of clinical care.

The Trust's Patient Improvement Framework (PIF), forms the basis of the Quality Governance Framework. Monitoring of quality is undertaken through quarterly Patient Safety, Patient Experience, Clinical Outcomes & Effectiveness and Regulatory Assurance Reports as well as ward accreditation, clinical dashboards and other performance indicators.

The Board also undertakes Divisional Performance Reviews and regular visits to Divisions to review delivery of the quality agenda.

Regulation
In October 2012 the CQC undertook an inspection visit to the SGH site. It reported that patients and relatives were overwhelmingly positive about the staff and the care they had received, and that the staff were incredibly hard working.

Many of the wards CQC visited were compliant against the standards but in a small number, specific issues were observed that did not reflect our quality standards or our clinical policies and practices. As a result of this CQC found minor concerns related to three outcomes and moderate concerns with the staffing related outcome.

A comprehensive action plan was submitted to the CQC and the Trust Board are overseeing achievement of the plan through the Director of Nursing and a monthly Task and Finish Group, who will ensure delivery of the key actions to demonstrate full compliance to the CQC, the majority of which were completed by the end of March 2013.

In December CQC also undertook their first inspection of the Princess Ann Hospital (PAH) and reported that mothers and partners were very positive about the care they received and their consultation and involvement in decision making. The outcome of the PAH inspection was that the two outcomes reviewed were found to be fully compliant with the Essential Standards of Quality and Safety.

Clinical standards accreditation
The National Health Service Litigation Authority (NHSLA) is a national body which works to improve risk management practices in the NHS and attainment of NHSLA Risk Management Standards, which provide assurance that risk management and safety are embedded into practice, is an important achievement for the Trust.

We met Level 2 requirements in Maternity Services in September 2010 and Level 3 requirements - the highest level of assurance - for our Acute Services in December 2011. Our maternity services will undergo reassessment in September 2013 when we aim to achieve Level 3 compliance.

Overview of the quality of care offered by University Hospital Southampton NHS Foundation Trust

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

Key Performance Indicators					
Key targets	**2010/ 11**	**2011/ 12**	**2012/ 13 March 13 YTD**	**2012/13 Targets**	**Comments**
A&E patients, % admitted, transferred or discharged < 4 hours (UHS & Partners)	97%	95.1%	94.3%	>= 95%	**Achieved 1 quarter out of 4.** Actions are in place to improve this measure. See our Board reports for more details
18 weeks – Admitted patients treated within 18 weeks	87.2%	90.0%	>= 90%	Maintain >= 90%	**Achieved all 4 quarters**
18 weeks – Non admitted patients treated within 18 weeks	95.3%	95.0%	>= 95	Maintain >= 95%	**Achieved all 4 quarters**
18 weeks - Patients currently waiting on an 18 week pathway within 18 weeks (Incomplete pathways)	Not measu red	Not measu red	>= 92% in quarte rs 2 & 3	Maintain >= 92%	**Achieved 2 quarters out of 4** Actions are in place to improve this measure. See our Board reports for more details
6 weeks - Maximum waiting times for 15 key diagnostics tests: % waiting >6 weeks	31 pts	0.07%	0.06%	<1%	**Achieved all 4 quarters**
Cancers: 2 week wait (Urgent GP/ GDP referral) to first hospital assessment	96%	95.8%	95.3%	>= 93%	**Achieved all 4 quarters**
All breast symptoms: referral to first hospital assessment	95.8%	98.5%	97.0%	>= 93%	**Achieved all 4 quarters**
Cancers: 31 days (Decision to treat) to first treatment	97.2%	97.7%	98.5%	>= 96%	**Achieved all 4 quarters**
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (drugs)	99.8%	99.9%	99.8%	>= 98%	**Achieved all 4 quarters**
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (surgery)	95.6%	96.5%	97.9%	>= 94%	**Achieved all 4 quarters**
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (radiotherapy)	97%	98.9%	99.0%	>= 94%	**Achieved all 4 quarters**
Cancers: 62 days Urgent GP referral to treatment	87%	88.2%	89.5%	>= 85%	**Achieved all 4 quarters**
Cancers: 62 days NHS Cancer Screening Service to treatment	99.6%	93.6%	97.7%	>= 90%	**Achieved all 4 quarters**
Cancers: 62 days Consultant upgraded referral to treatment	89.9%	93%	95.1%	>= 85%	**Achieved all 4 quarters**
Last minute cancellations: % of elective admissions	0.9%	0.98%	1.21%	<= 0.8%	Actions are in place to improve this measure. See our Board reports for more details
Last minute cancellations not rescheduled < 28 days	5.8%	9.11%	10.58 %	<= 5.0%	Actions are in place to improve this measure. See our Board reports for more details
MRSA Bacteraemia	5 cases	4 cases	3 cases	<= 4	**Achieved**
C.Difficile	89 cases	66 cases	36 cases	<= 46	**Achieved**
Stroke pathways 80% of people with stroke spend at least 90% of their time on a stroke unit			84.9%	80%	**Achieved**

2012/13 has again seen sustained performance in many areas across the Trust, however demand for emergency services (ED attendances and direct admissions) have continued to increase from last year's high levels leading to significant pressure on the Trust's capacity. This has impacted on the Trust's ED and 18 week performance. As well as continuing with the actions from 2011/12, the Trust has supported achievement of patient access targets by developing improved patient pathways. Examples of this include working with GPs to develop a map of medicine for more streamlined patient care from primary to secondary care and back again, and working with local private providers to ensure additional capacity is available when appropriate to reduce patient waiting times.

We work closely with our local partners in commissioning and in primary care, to develop community-wide reforms to ensure patients are seen by the most appropriate provider, and unnecessary attendances at UHS are reduced. South West Hampshire System consists of:

- NHS Southampton
- NHS Hampshire
- UHS
- South Central Ambulance Service
- Social Services
- Solent Healthcare
- Southampton City Council

The joint system management board is attended by executive directors from all organisations, and is currently working on specific, detailed schemes, linked to national and international best practice. This collaborative working continues with the new clinical commissioning groups in 2013/14.

In Collaboration with the wider health system, UHS is also working to improve patient flow and ensure a high level of patient experience by reducing delays in discharging patients when there is no longer a need to be in an acute setting.

Please visit our website www.uhs.nhs.uk. Here you will find useful further information, including:

Clinical effectiveness blog (website www.uhs.nhs.uk), explaining some of our clinical developments in more detail

Annual reports explain how we link our broader financial responsibilities to providing quality patient care

The Statement of Internal control/Annual Governance Statement, explaining how our audit and assurance processes are arranged.

Conclusion

We are proud of the advances we have made in the quality of services we provide. However we are not complacent and know that we are still on a journey to achieve excellence in all areas.

The Quality Report enables us to qualify our progress comprehensively and agree the priorities for 2013/14. Future reports will therefore present a quantitative delivery against a forecast.

We see this as an essential vehicle for us to work closely with our Council of Governors, our commissioners and the local and wider community on our future quality agenda as well as celebrating our successes and progress. Working with all our key stakeholders including patients we are determined to continue improving to achieve high quality performance in all services.
As part of our annual quality review we will be producing a summary leaflet of our progress and new quality priorities. This will also include patient stories.

Statement of Directors' responsibilities in respect of the quality report

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

We have a proactive and rigorous approach to achievement, using our Patient Improvement Framework (PIF) to prioritise and drive excellence in the Trust.

We take our part in supporting health priorities community-wide, working closely with our commissioners to develop and achieve the 'Commissioning for Quality and Innovation (CQUIN) programme for local and national quality improvement goals.

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

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

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

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 2012 to June 2013

Papers relating to Quality reported to the Board over the period April 2012 to June 2013

Feedback from the commissioners dated XX/XX/20XX

Feedback from governors dated XX/XX/20XX

Feedback from Local Healthwatch organisations dated XX/XX/20XX

The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17/07/2012

The [latest] national patient survey 16/04/2013

The [latest] national staff survey 28/02/2013

The Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX

CQC quality and risk profiles dated 31/03/2013

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

The performance information reported in the Quality Report is reliable and accurate;

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

.....Date.....Chairman

.....Date.....Chief Executive

Annex - statements from primary care trusts, local involvement networks and overview and scrutiny committees.

This section will include the formal feedback on our Quality Report from:

- our lead commissioners- NHS Southampton City
- our lead LINKs- Southampton
- the Overview and Scrutiny committee for Southampton
- our Members' Council

NHS Commissioning Board Statement (1 page)

Southampton LINKs final support statement: (1 page)

UHS Members Council final statement (1 page)

Head of Internal Audit's annual opinion (2 pages)