University Hospital Southampton
NHS Foundation Trust

# Our quality account and quality report

2013/14

# Introduction

## Chief Executive Statement

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

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

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

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

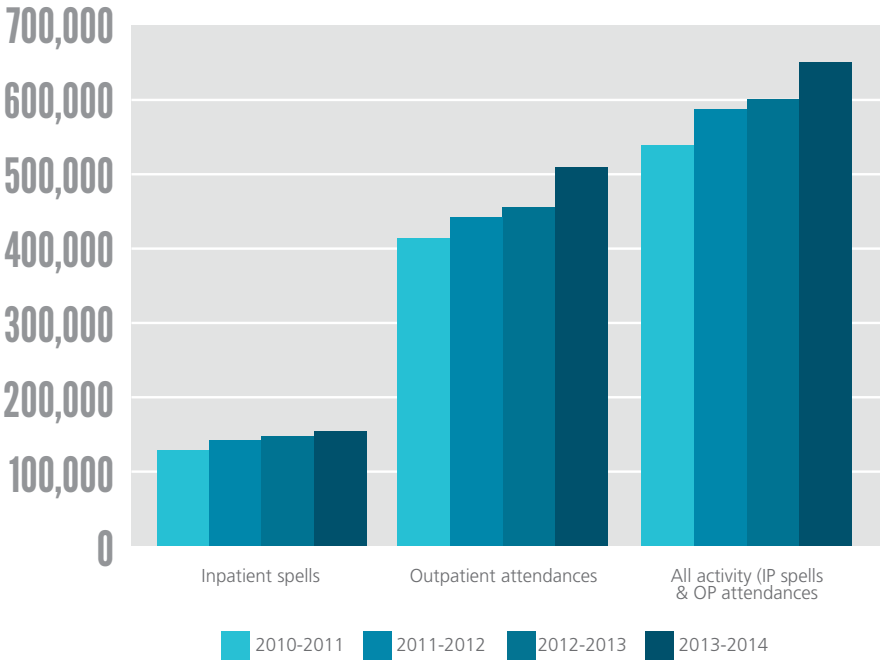
In 2013 we saw the publication of the Francis report and the Department of Health response. This was following the failings of Mid Staffordshire Hospital to its patients. We have undertaken listening exercises in our own response and have developed our own plan of action to ensure those failings do not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

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

**Fiona Dalton**
**Chief Executive Officer**

## Activity levels during 2013/14

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




## Strategy and leadership for high quality care

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

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

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

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

## University Hospital Southampton NHS Foundation Trust

### Provides
hospital services for people with acute health problems.

### Employs
around 10,000 staff

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

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

### Delivers
a regional specialist service for southern central England

major research programmes to develop the treatments of tomorrow

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

### Hospitals
Southampton General Hospital
Princess Anne Hospital

# Priorities for improving quality

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

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

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

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

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

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

# A review of our performance in 2013/14

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

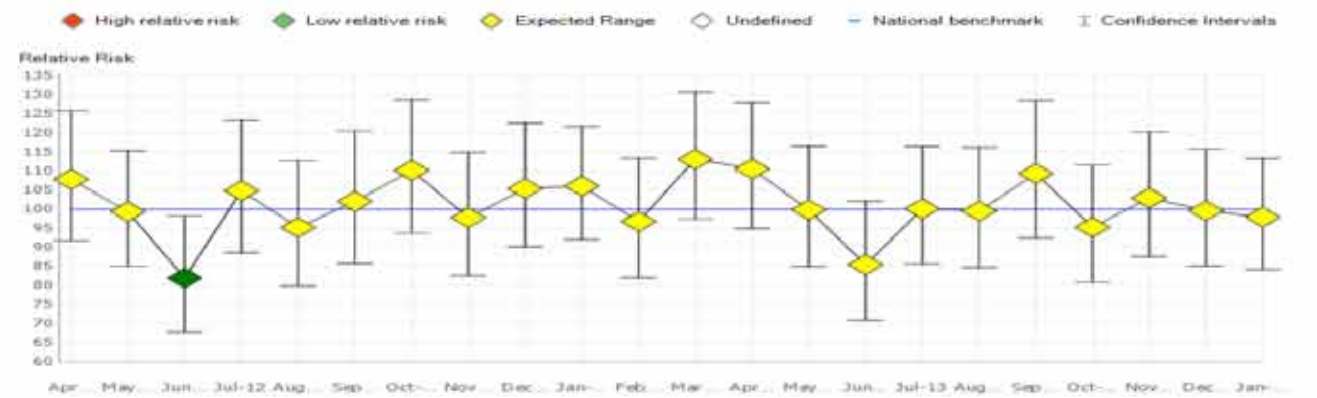
## Priorities for outcomes and clinical effectiveness

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

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

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

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




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

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

## Priority 2: Improving outcomes for the deteriorating patient

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

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

**Cardiac arrests at ward level – performance 2013/14**

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

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

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

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

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

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

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

This was achieved through:

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

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

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

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

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

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

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

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

# Patient Experience

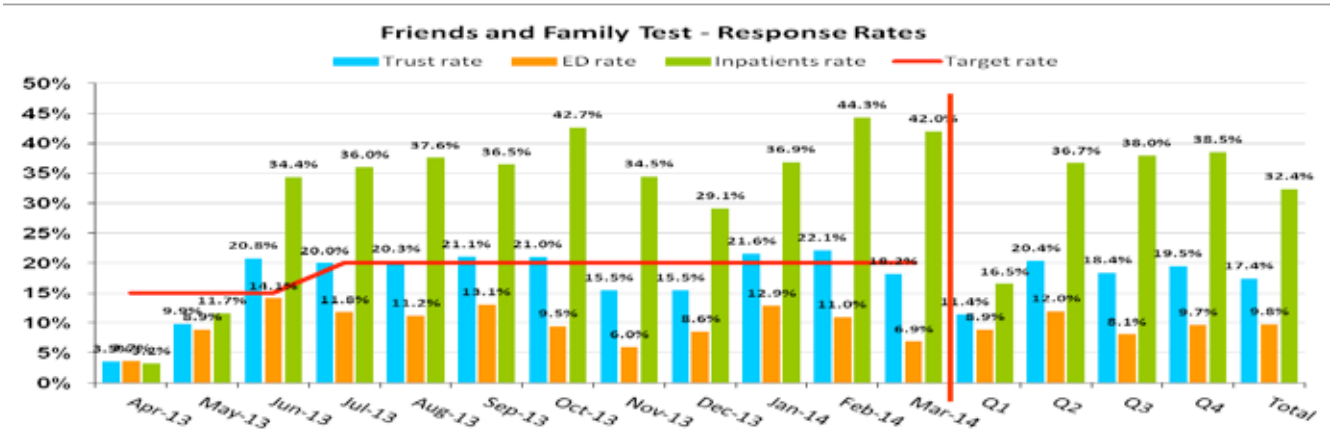
## Priority 1: To implement the national friends and family test

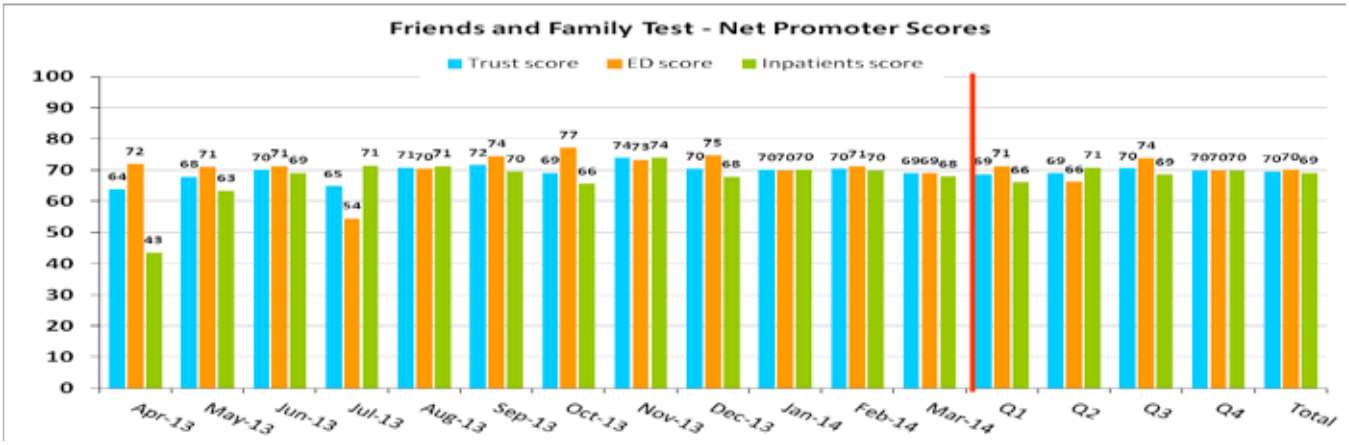
Seeking and acting on patient feedback is key to improving the quality of healthcare services. The national friends and family test (FFT) is a simple, comparable test which provides a mechanism to identify both good and poor performance across NHS organisations.

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

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

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






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

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

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

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

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

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

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

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

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

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

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

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

## Priority 3: Improving handovers, comprehensive and accurate documentation

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

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

### What we did

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

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

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

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

# Patient Safety

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

## Priority 1: Improving learning from patient safety incidents

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

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

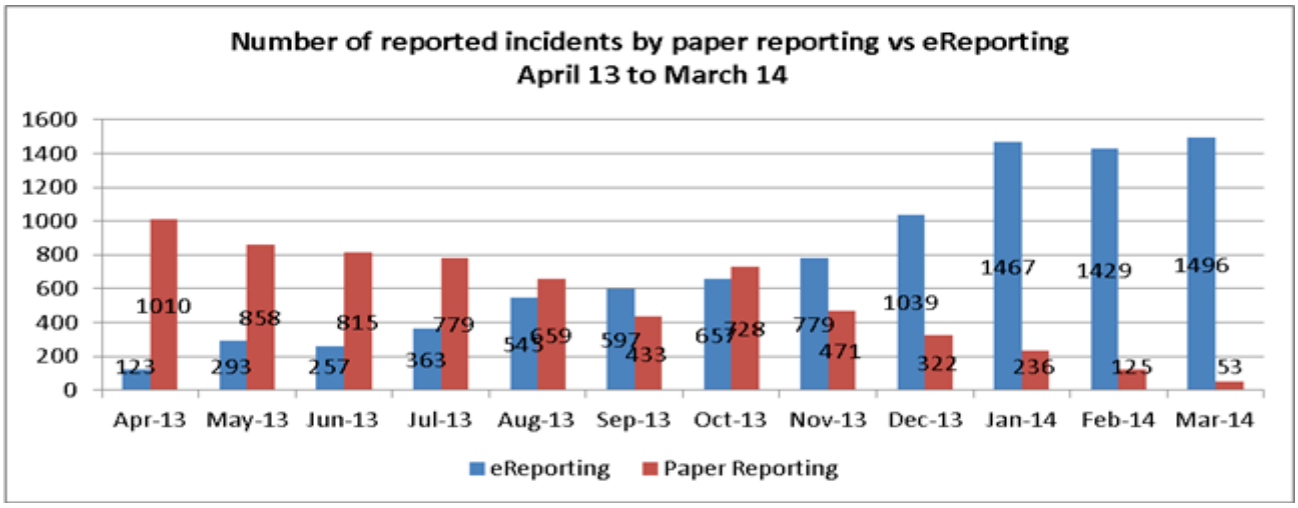
We have robust processes for the management of incidents and near misses where every incident is graded and analysed, and where required undergoes a root cause analysis report.

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

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

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

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



## Priority 2: Implementing the safety thermometer bundle

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

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

**No harms 2013-2014**

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

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

## Priority 3: Improving care for patients with diabetes

**What have we achieved?**

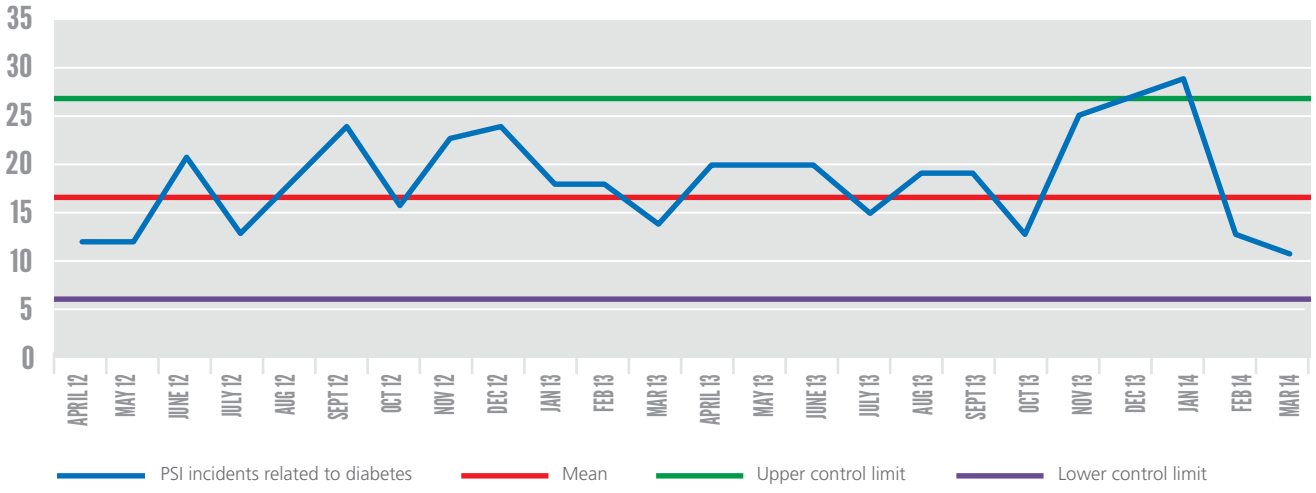
Our aim for 2013/14 was to have zero incidents classified as "never events" in relation to the prescription of insulin. This has been achieved through close monitoring of patients' prescriptions.

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

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

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

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



# Our quality priorities for 2014/15

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

## Priorities for clinical outcomes

### Priority 1
### Every clinical speciality will identify an outcome measure

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

**Our aim**

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

### Priority 2
### Improving Hospital Standardised Mortality Rattios (HSMR)

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

**Our aim**

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

### Priority 3
### Improving Hospital Standardised Mortality Rattios (HSMR)

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

**Our aim**

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

## Priorities for patient experience

### Priority 1
### Improving care and safeguarding vulnerable adults

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

**Our aim**

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

## Priority 2
## Improve the patient experience at mealtimes

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

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

**Our aim**

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

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

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

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

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

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

**Our aim**

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

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

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

# Priorities for patient safety

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

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

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

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

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

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

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

Actions to achieve the aims include:

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

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

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

**Our aim**

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

Actions to achieve the aims include:

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

## Participation in national clinical audit and confidential inquiries

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

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

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

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

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

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

**Table A: National Clinical Audits**

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

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

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

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

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

**Table B: Actions from National Clinical Audits**

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

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

## Participation in Trustwide and local Clinical Audit

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

**Table C Actions from Local Clinical Audits**

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

## Participation in Clinical Research

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

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

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

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

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

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

## Data quality

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

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

which included a valid NHS number was:

- 98.3% for admitted patient care;
- 98.8% for outpatient care; and
- 97.3% for accident and emergency care.

which included a valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

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

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

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

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

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

## Review of services

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

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

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

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

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

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

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

## Our CQUIN priorities for 2013/14

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

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

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

# Registration with the Care Quality Commission

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Our standard core indicators of quality

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

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

a) the national average for the same; and

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

## Our hospital mortality rating

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

a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period is included to give context

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

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

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

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

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

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

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

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

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

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

### Adjusted health gain

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

### Participation rates

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

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

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

### Our readmission rate for children and adults

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged:
(i) 0 to 15
(ii) 16 or over

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

### Readmissions within 28 days <16

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

### Readmissions within 28 days 16+

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

Note: This is the most recent data available.

**The Trusts responsiveness to the personal needs of its patients during the reporting period.**
Unsure what this relates to?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Outcomes, experience and safety performance indicators

These are both national and local mandated indicators of quality

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

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

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

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

# Conclusion

# Statement of Directors' responsibilities in respect of the quality report

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

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

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

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

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

old statement

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

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

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By order of the Board

**Date: xx/05/2014**

**Chairman**

**Date: xx/05/2014**

**Chief Executive**

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

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

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

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

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

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

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

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

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

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

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

**Awaiting Confirmation of Signatories**

# Response to the Quality Account from our Council of Governors

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

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

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

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

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

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

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

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

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

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

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

**Margaret Wheatcroft**

**Lead Governor**

# Response to the Quality Account from Southampton Healthwatch

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

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

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

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

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

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

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

**Harry Dymond**

# Statement of directors' responsibilities for the quality report

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

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

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

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

**By order of the Board**

**Date: xx/05/2014**

**Chairman**

**Date: xx/05/2014**

**Chief Executive**

## For more information contact:

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**www.uhs.nhs.uk**

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