Chief executive's welcome- pending

David French, Acting chief executive

Our approach to quality assurance

Our approach to quality

Always improving is a key value in our 'forward vision' along with patients first and working together. These are the Trust's underpinning values and delivering on them in relation to quality is the responsibility of the Trust Board. Derek Sandeman (medical director) and Gail Byrne (director of nursing and organisational development) are the lead executive directors for quality, while Jane Hayward (director of transformation) is responsible for quality improvement.

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

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

To embed quality and provide assurance at ward and department level the Trust has introduced a clinical accreditation scheme (CAS) - a process where wards and departments are required to demonstrate adherence to standards of care to become accredited. The wards gain this accreditation by submitting information on key quality performance indicators and patient feedback, complaints and compliments to a senior clinical panel. Patient representatives also undertake unannounced visits to the ward or department.

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

Clinical quality reviews (CQRs) of nominated services are conducted in each division based on the Care Quality Commission (CQC) inspections and their identified key lines of enquiry. The CQR provides an internal assurance process which is proportionate, risk based, professionally informed and linked to what matters to patients and staff. This information includes feedback around areas of good practice from the division, direct observation during the review and other information collected during the CQR which provides evidence for the overall judgement framework. A formal report and action plan is generated following the review.

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

Our commitment to safety

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

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

Duty of candour

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

We are committed to being open and transparent to patients and their families and have worked hard to ensure that our staff are aware of their obligations under the duty of candour, and have provided education and support to enable them to do this. We provide training to staff of all levels, both as part of their induction, education days and through rolling local programmes and cascade training.

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

We focus on a culture which allows staff to 'speak up, speak out' about practice which compromises patient safety as part of the Trust raising concerns (or whistle blowing) helpline. We have a Freedom to Speak Up policy and a Freedom to Speak up Guardian. Our staff survey shows that our staff consider UHS as above average in:

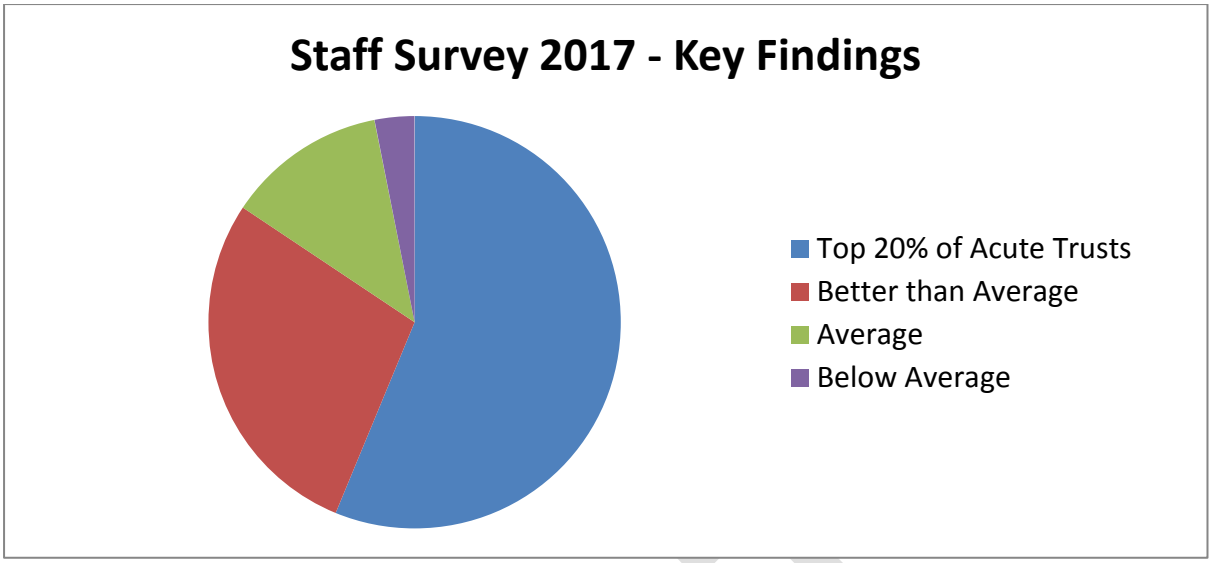
		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Fairness and effectiveness of procedures for reporting errors, near misses or incidents			
	% agreeing / strongly agreeing with the following statements:			
Q12a	"My organisation treats staff who are involved in an error, near miss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

Our commitment to staff

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

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

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



Our top five results were:

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

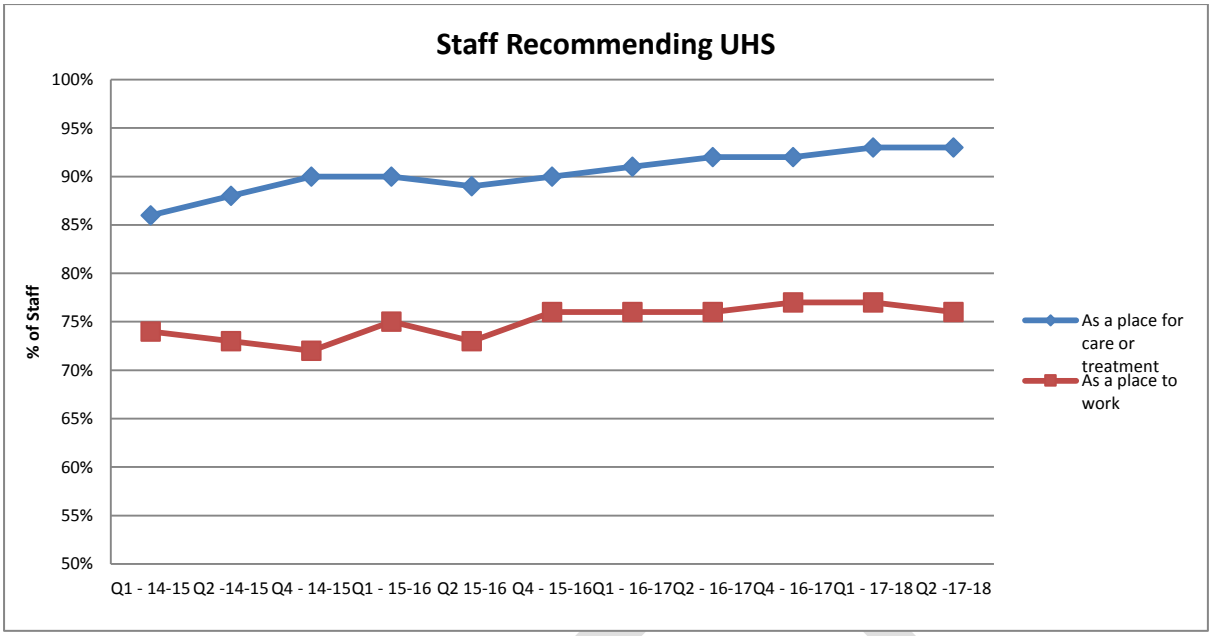
2. KF30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents – 3.87 against a national average for acute trusts of 3.73.

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

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

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

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



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

Over the next 12 months we will continue to promote the NHS staff survey and encourage staff to participate. Any issues or concerns identified will be reported to the Board and a suitable action plan developed and implemented for every care group. We will use the feedback from the survey to support staff to improve the services we deliver and share our findings so that we can learn from our mistakes. This includes working with our Trade Union colleagues and networks to ensure views from all staffing groups are taken into account.

Some positive staff responses from the 2017 survey:

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

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

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

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

Our commitment to education and training

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

1. 'Learner reviews' (where learners in UHS meet with education leads to discuss their experience of learning during placements) are now fully embedded and being used to make changes in practice.
2. A number of 'trainer development master-classes' have been held and they are well attended and evaluated by participants.
3. Our in-house 'history taking and physical assessment' programme aimed at advancing practice in non-medical professions has been embedded.

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

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

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

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

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

Our commitment to technology to support quality

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our commitment to the Care Quality Commission (CQC)

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

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

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

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

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

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

The CQC saw areas of outstanding practice including:

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

background to view healthcare as a potential career option.

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

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

Review of quality performance

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

The tables in appendix two provide information against a number of national priorities and measures that, in conjunction with our stakeholders, form part of our key performance indicators which are reported monthly to Trust Board.

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

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

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

Clinical research

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

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

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

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

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

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

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

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

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

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

Review of services

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

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

CQUINS payment framework

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

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

A proportion of UHS income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between UHS and any person or body they entered a contract, agreement or arrangement with for the provisions of relevant health services, through the CQUIN framework.

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

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

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

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

Data quality

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

UHS submitted records between April 2017 - March 2018 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As at December 2017 (latest reporting month) the percentage of records in the published data:

Which included a valid NHS number was:

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

Which included a valid General Medical Practice Code was:

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

UHS Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation. UHS Information Governance Assessment Report overall score for V14 (2016/17) was 73%and was graded Satisfactory meaning the Trust met or exceeded the minimum required level of compliance assessment for all Information Quality and Records Management requirements of the toolkit for the reporting year.

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

Participation in national clinical audits and confidential enquiries

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

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

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

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

The national clinical audits that UHS participated in, and for which data collection was completed during 2017/18, are listed in appendix three alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

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

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

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

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

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

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

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

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

Learning from deaths

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

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

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

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

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

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

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

In relation to each quarter this consisted of:

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

**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Figures for 2016/17 period:

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

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

Progress against 2017/18 priorities

This section outlines how we have performed against the delivery of our 2017/18 quality priorities. Action plans and measures were developed for each of the priorities last year, and performance has been monitored throughout the year by clinical teams and UHS committees.

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

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

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

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

Patient experience

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

Our aims were:

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

2. Standard information to be provided for the patients at each stage of the process – templates to be used on the wards.

3. Clear process to be followed by the wards in conjunction with the Integrated Discharge Bureau.

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

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

Our achievements for 2017/18 were

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

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

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

Priority two: meeting patients' nutritional and hydration needs

Our aims were

1. To review the process for nutrition screening in adults and children, to ensure that patients at risk of malnutrition are identified and managed appropriately according to their individual needs.
2. To review and establish compliance with Protected Meals guidelines
3. To implement a hydration assessment chart to all adult inpatient areas
4. Work collaboratively with our new service provider to increase the percentage of patient satisfaction with food

Our achievements for 2017/18 were

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

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

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

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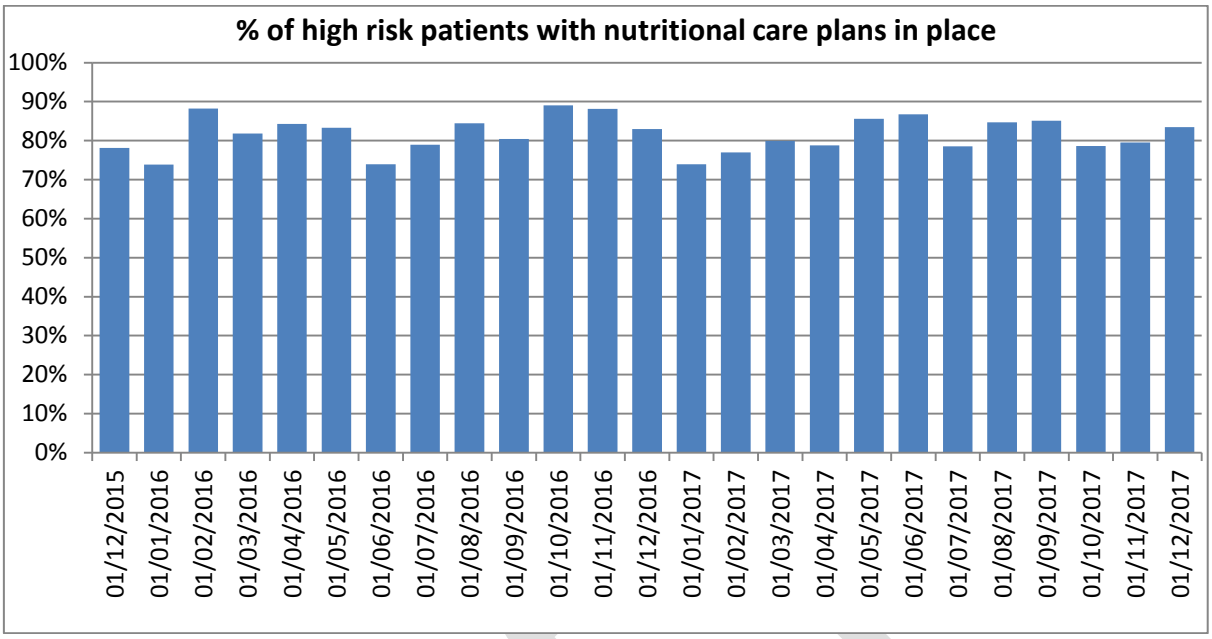
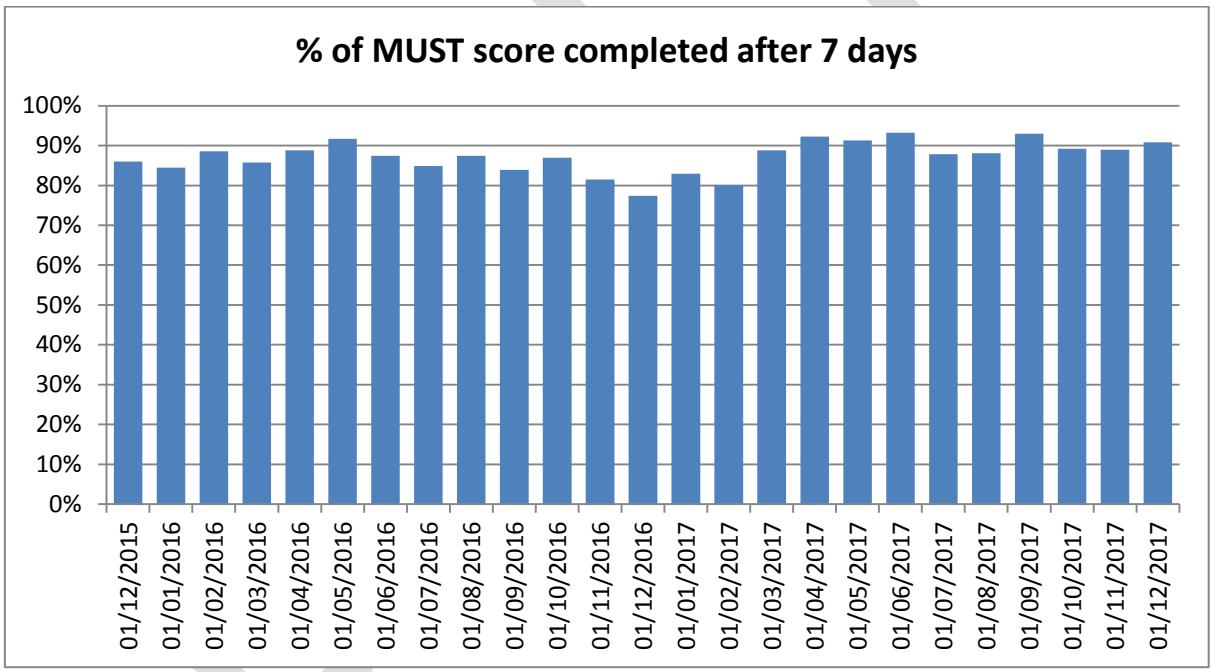




We have undertaken a review of compliance with Protected Meals guidelines, and generated a revised patient meal poster which has been issued to all wards. There is work underway to review mealtime co-ordinator roles and responsibilities in clinical areas to ensure collaborative working with catering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

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

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

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

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

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

Priority 3: Improving care for vulnerable adults

Our aims were

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

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

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

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

5. Focus on the autism agenda.

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

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

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

9. Introduce carers' passports.

10. Introduce the vulnerable adult champion role.

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

Our achievements for 2017/18 were

A Mental Health Board has been developed in order to scrutinise and improve the quality of the delivery of mental health care within UHS. Whilst the board is in its infancy, its role will include analysis of current service provision as well as a vision for the future provision. In addition, a recent internal mental health quality review was completed which will further inform the development of the mental health strategy. Early achievements include; terms of reference have been agreed and signed off, the board meet bimonthly, task and finish groups focus on key priorities and a mental health dashboard is being developed.

Furthermore, closer joint working across mental health teams and services is being facilitated by:

- The appointment of two mental health nurses with the overall aim of delivering the provision of specialist mental health nursing, practicing within the multidisciplinary team. They provide advice, education and support to patients, their carers and other health care professionals.
- UHS mental health nurses attend a weekly Older Person Mental Health (OPMH) and Acute Mental Health (AMH) allocation, and daily multi-disciplinary team (MDT) meetings to facilitate joint working and working across boundaries.
- UHS admiral nurses (dementia) attend a weekly G7 MDT on G7 Enhanced Care ward and patients from OPMH, admiral nursing and UHS wards are discussed to decide which would most benefit for transfer to OPMH.
- A part-time liaison 8b psychologist has been appointed (February 2018) to better integrate psychology provision in the liaison psychiatry (Adult Mental Health and OPMH) services and enable liaison psychiatry to offer brief psychological interventions and supervision.
- Health psychology continues to offer psychology in a number of specific areas where business cases have been successful in integrating psychology into medical and surgical teams.
- Division of preventative medicine (DOPM) offer a weekly one hour education programme which all nurses working in mental health in UHS and DOPM are welcome to attend.

- Health psychology offers a psychological supervision/reflective practice group for DOPM nurses to support working effectively with mental health patients.

Education and training achievements include;

- DOPM ran a UHS Mental Health Day with a whole day of speakers in 2017. This was open to all staff at UHS and SHFT locally and received excellent feedback. The intention is to repeat these annually in October on World Mental Health Day.

- DOPM (OPMH and AMH) staff offer bespoke training for clinical teams as requested on mental health topics as part of their commissioned service.

- UHS Dementia Working Group is currently liaising with the education team to monitor UHS staff compliance with mandatory dementia training on VLE, and this is a standing item on the group for oversight purposes.

- The Mental Health Board commissioned a workshop in October 2017 to scope the knowledge and skills of frontline staff around three key areas; mental capacity, absconding and patients detained and admitted under the Mental Health Act.

Conflict resolution and breakaway training has been provided to emergency department (ED) staff and other high risk areas over nine days training in partnership with the UHS training and development team with further days to be arranged. Further key actions undertaken by ED to support staff and de-escalate behaviours include:

- Introducing a 'code green' approach for managing acute behavioural disturbance which prompts the involvement of senior nursing and medical staff, alongside security officers, to promote senior decision making.

- Working closely with commissioners and multi-agency partners to improve pre-hospital decision making and management of persons / patients detained under Section 136 of the Mental Health Act. UHS have been part of developing and agreeing S136 pathways for use across Hampshire and within ED at UHS.

- Secured funding for the build of two high risk assessment rooms in ED as a 'safe space' environment to de-escalate patients with acute behavioural disturbance.

- Introducing a new protocol for managing psychotic and manic episodes, with associated training.

- Introducing the role of Band 5 Registered Nurses (mental health) as part of the ED workforce to manage patients who present in mental health crisis. Once established in role, the team will provide training to ED healthcare assistants on providing enhanced support to patients in crisis.

There are a number of specialist teams across the Trust to support staff, patients and carers which include; learning disability liaison CNS's; admiral nurses; mental health CNS's; vulnerable adults support team (VAST); enhanced care and support team (ECST); and the department of psychological medicine (Southern Health NHS Foundation Trust service).

Positive progress has been made with the autism agenda. Funding has been secured from West Hampshire CCG to expand the learning disabilities team and this investment was used to develop a focused autism and transition post. The post holder has been appointed and is working closely with the wider learning disabilities team to scope the Trust's requirement around this agenda. The learning disabilities /autism working group will be the forum for developing and driving the strategy and this has been re-launched as part of the new safeguarding governance structure.

A new medicine for older people dementia lead has been appointed who is working closely with the admiral nurses and OPMH liaison to deliver a dementia service. The dementia working group has been re-launched with refreshed membership, the Dementia Champions programme is being re-invigorated ensuring all clinical teams have champions in their area, and development of the 2018-2021 strategy is ongoing. The Mental Health Board will offer scrutiny and oversight of the overall service.

In October 2017 the children's and adult's safeguarding teams were merged in order to facilitate a more holistic, effective and efficient approach to safeguarding within UHS – 'think family'. Whilst the change is in its early stages, the benefits have already been noted and well received, with partner agencies showing interest in developing similar models across Hampshire. A joint governance structure has been developed with the joint safeguarding governance steering group already being well established. This facilitates the learning for complaints, incidents and statutory reviews being shared. A monitoring and evaluation task and finish group has been established with the focus of identifying key performance indicators for safeguarding, development of a 'live' safeguarding dashboard, development of a formal reporting schedule and a formal annual effectiveness programme.

The learning disability, mental health and admiral nurse specialists are working with patient experience to re-launch all support available to carers across the Trust. This includes carer's passports, John's campaign, a carers' café / forum and signposting and support. This area of work is included within both the LD and Dementia strategies.

The vulnerable adults champion role is being reviewed following a change in structure of both the ECST and the safeguarding team.

Additionally, the adult safeguarding team have introduced a daily multi-agency safeguarding huddle with local authority partners to effectively and efficiently triage every referral and incident where a safeguarding concern has been identified.

A whole review of the current Mental Capacity Act and Deprivation of Liberty (DoLS) process has been undertaken following the appointment of a new named nurse for safeguarding adults. This review has highlighted the need for a number of changes to the current process, and we are therefore writing a new policy. Once this is completed and ratified, all training will be updated and modernised.

Patient safety

Priority four: recognition and management of the deteriorating patient

Our aims were

1. For the consultant body and acuity practice development matron to develop an annual action plan for acuity improvement which would inform training and education and feedback to clinical areas.

2. .To further improve on the recognition and deterioration of patients, with focus on progressing deterioration escalation on electronic systems (ePAMS).

3. Organisational review of Acute Kidney Injury (AKI) and sepsis outcomes.

Our achievements for 2017/18 were

An annual action plan has been successfully developed during 2017/18.

Part of that plan includes supporting the ROAR group who worked with the Academic Health Sciences Network (AHSN) to improve recognition and response to patient deterioration. The AHSN's present a unique opportunity to align education, clinical research, informatics, innovation, training and education and healthcare delivery.

We worked collaboratively with AHSN to speed up the adoption of innovation into practice to improve clinical outcomes and patient experience. During the year AHSN have helped support the development and roll-out of an electronic monitoring system, successfully introducing the mobile electronic observation system MetaVision Safe Track™.

Using mobile devices, nurses of all grades capture observations for their patients directly onto MetaVision Safe Track™, which calculates the MEWS and advises the next appropriate steps regarding escalation and monitoring. Clinicians can review the observational data from any UHS PC, laptop, iPad or iPod, as well as any personal device connected to the hospital Wi-Fi. MetaVision Safe Track™ is currently live on the trauma and orthopaedic, surgery and gynaecology wards (a total of 320 beds) and will next be implemented across medicine as part of the hospital-wide roll-out. Running in parallel is the implementation of the MetaVision PDMS into the intensive care and high dependency units. The major benefit of having both the MetaVision PDMS and MetaVision Safe Track™ is a single patient observation record across all clinical areas, ensuring a complete continuum of care across the Trust.

Other benefits include complete observations capture, accurate and safer MEWS score, ease of clinical handover of patients between MetaVision Safe Track™ wards, quick identification of deteriorating patients and those who are at risk, remote patient management for the out of hours teams, and viewable observations via the UHS Electronic Patient Portal (CHARTS).

Lorna Adams-Jones, Project Lead, said:

"MetaVision Safe Track is easily configurable and has been customised to support our clinical workflow. Our staff have embraced the system with minimal training and have been tremendous. We are excited to roll it out to the remaining wards across our hospital."

We have evaluated the introduction of the system in AMU and note 50% reduction in cardiac arrest and an increase in outreach calls evidences improved earlier recognition of deterioration. This outcome information has been shared with commissioners, AHSN, and partnership hospitals and we continue to monitor early warning escalation across the Trust and feedback findings each month to clinical areas for learning.

Sepsis and AKI assessments and alerting tools have continued to be developed, with full fluid balance charting functionality on the Metavision Safe Track™ system nearing completion. We aim to implement this later in the year.

AKI and sepsis outcomes have improved (see priority six) and it is the recognition of deterioration in both conditions that is key.

Training and development has been supported with the delivery of the new Senior ALARM course which targets senior nursing staff across UHS and focuses on simulation training on leadership and patient clinical deterioration. In addition, there is a much more robust process for thematic interrogation of incident reports and sharing of learning via the ROAR group and through governance groups across the Trust.

Priority five: National standards for safer invasive procedure (NatSSIPs - national safety standards for invasive procedures)

Our aims were

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

Our achievements for 2017/18 were

NatSSIPs have been developed and implemented in all theatres and areas carrying out invasive procedures under general anaesthetic or in catheter labs across the Trust over the last two years. They follow a standardised format, however, following the first round of implementation audits of specific areas (cardiac surgery, ophthalmology, obstetrics) it was found that major differences in practice consistently rendered parts of the standard NatSSIPs checklist irrelevant. Consequently staff have been permitted to modify the format to remove questions that are of no value and replace them with specific questions that enhance the safety of their practice.

Audit

A rolling audit programme has been introduced and refined within the main theatre areas. This has deliberately set the bar at a high level with a multiple point review of each stage of the process carried out by a small number of trained observers. The levels of complete compliance within each stage of the 2017 audit are outlined below.

SPECIALITY	OVERALL	TEAM BRIEF	SIGN IN	TIME OUT	SIGN OUT
ENT/OMF	79%	83%	94%	73%	74%
Thoracic	73%	94%	91%	59%	70%
Urology	76%	80%	100%	66%	63%
Paediatrics	81%	91%	91%	83%	69%
Orthopaedics	71%	79%	91%	62%	69%
Paeds Orthopaedics	66%	81%	87%	53%	64%
Neuro	75%	70%	98%	78%	63%
General/HPB/Upper G.I/CEPOD	82%	85%	95%	71%	85%
Vascular	94%	96%	100%	93%	88%
Average Score 2017	**77%**	**84%**	**94%**	**71%**	**72%**

The questionnaire includes subjective assessments of engagement, behaviour and communication as well as objective assessment of compliance with attendance, completion of checklists and tasks. The overall scores shown above reflect that, whilst our theatres consistently have a very good safety record, there are still significant areas for improvement in order to achieve ideal practice in all areas. It would have been easy to design an audit tool that simply addressed whether or not we completed checklists and which would have shown near 100% compliance in all areas, however this would have missed the point of the introduction of the safety standards which should serve to improve communication, benefit team working and change culture within the theatre environment.

In the first round of audit this observational tool did not involve early feedback to the teams, this has been addressed in the revised observational tool, which has increased engagement with the theatre team, allowing the observer to challenge practice and feedback where appropriate following each stage of the process. This then helps to facilitate discussion and learning. The revised audit tool being used in 2018 also identifies notable areas of positive practice for feedback, encouragement and wider dissemination.

Ongoing areas for development identified by our 2017 audit:

- Use of paper documentation during checks
- Clinician engagement in some areas
- Surgeon stating the operation without looking at the consent form during time out
- Surgical handover if the consultant leaves before the sign out phase.
- 'Timing' of 'Sign Out'
- Handover processes

The audit data has been fed back to each theatre and sub-specialty and presented during the educational half day programme.

Development of the debrief at the end of the theatre list has been the last major step in the introduction of NatSSIPs within the Trust. Whilst this has been established practice in some theatres, this has been a minority and the NatSSIPs steps are being formally revised in order to make this mandatory within all theatres from 1 April, 2018.

The second round of theatre audit has started and will also involve cascade training of additional observers to facilitate further audits as this evolves into an observational feedback tool that can be used outside of the formal annual audit process.

Cardiac theatres, eye theatres and Princess Anne theatres will all be included in the 2018 theatre audit, with minor alterations to the observational tool.

Interventional radiology, neurosciences and cardiac catheter labs all perform procedures under general anaesthetic in a catheter lab environment where NatSSIPs apply; these areas have developed a further modification to our NatSSIPs standard which is relevant to their way of working. An audit tool based upon the main theatres observational audit tool is being piloted by the cardiology team and will be used in other catheter lab areas.

LocSSIPs - local safety standards for invasive procedures

LocSSIPs are the more abbreviated set of stop points and checks prior to invasive procedures that are performed either by a solo practitioner or outside of a theatre environment.

A core three-step framework has been established for LocSSIPs:

- Sign in (team brief)
- Time out (knife to skin/procedure start)
- Sign out (completion of procedure)with a series of prompting questions to ensure:

- completion of consent/agreement to proceed
- confirmation of procedure and patient identity
- review of appropriateness of procedure, supervision and competencies
- preoperative, intraoperative and post-operative checks
- availability of equipment and monitoring
- escalation and recovery pathways
- post-procedure requirements

This three-step framework is backed up by procedure specific questions. The core questions and procedure specific questions are widely available in all areas carrying out invasive procedures as laminated cards as well as on MetaVision.

There has been a stepwise adoption and introduction of these across the hospital, with early uptake from endoscopy, surgery, intensive care, radiology, dermatology and the emergency department. They have also been developed and are in the process of being implemented in cancer care, neurosciences, AMU, medicine for people, specialist medicine, paediatrics, obstetrics and gynaecology.

All areas within the Trust are expected to be using LocSSIPs where appropriate by the end of Q4 2017/18. Implementation is overseen by the LocSSIPs working group with delegation to the divisional, care group and specialty leads as appropriate.

There are some minor invasive procedures (such as venous cannulation, adult bladder catheterisation) where it has been agreed that LocSSIPs do not apply. Each division has provided a list of those procedures where this is not required which has subsequently been assessed and agreed by the working group. Completion of LocSSIPs requires documentation in the notes, for speed and efficiency in some areas of the hospital this will be documented using a sticker that is completed and placed in the patient medical notes

Audit of LocSSIPs will predominantly be a notes based retrospective audit of documentation as to whether LocSSIPs were followed. This is because in many areas procedures are only being performed infrequently and therefore it is not practical for the use of an observational tool.

Areas performing high numbers of procedures (such as radiology and endoscopy) will be possible to assess using an observer completing an observational audit tool.

Audits will commence in April 2018 in critical care, emergency department, endoscopy, neuroradiology and cardiac catheter labs.

Priority six: recognising and treating sepsis

Our aims were

Our aim throughout 2017/18 was to improve our recognition of patients at risk of sepsis and, as a consequence, allow the early management of septic patients recognising that if patients with sepsis are treated quickly mortality is reduced. We used the national sepsis CQUIN as a framework to drive improvement and worked towards a Trust-wide, systematic approach for the identification and appropriate treatment of life-threatening infections. At the same time we worked to reduce the chance of the development of strains of bacteria that are resistant to antibiotics. These priorities were discussed in depth with the UHS Quality Committee.

Through this we aimed to reduce death and morbidity related to sepsis in all areas of the hospital, reducing patient length of stay, critical care length of stay and thus improve patient experience and outcome.

Our achievements for 2017/18 were

The national sepsis CQUIN started in 2015 and continues until 2019. Over this time the CQUIN requirement has changed and enabled UHS to drive awareness amongst staff and service users as to the importance of recognising sepsis.

This year we have refined and embedded our sepsis screening tool. The roll out of the paper tool was phased over the year to ensure all areas received full education and support prior to its implementation. To support this the Trust ensured a clinical lead (consultant intensivist) oversaw the projects and created secondment roles for one band 7 sepsis nurse, one band 6 sepsis nurse and a band 4 data analyst. Alongside this the medical division recruited a substantive band 6 sepsis nurse within their education team and the pharmacy department recruited an antimicrobial resistance nurse.

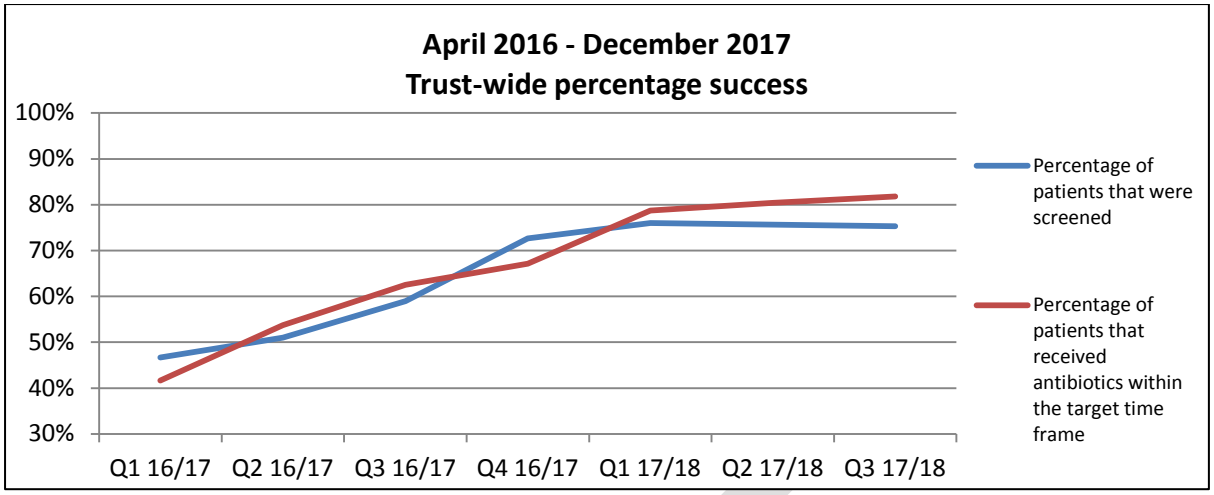
A sepsis working group was previously established which had excellent engagement from ward based nurses, medical consultants (ICU, AMU, surgery, paediatrics, ED and neurosciences), consultant pharmacist, consultant microbiologists, consultant infectious diseases, antimicrobial resistance nurse, critical care outreach team, and specialist nurses. This year the group has amalgamated into the Trust acuity group – ROAR (Recognise, Observe, Assess and React) as the work stream of sepsis cannot work in isolation but needs to be aligned with the deteriorating patient work stream.

All paper screening tools have gone through a number of PDSA cycles and the adult tool is now included in the escalation of clinical deterioration form with the aim to improve escalation and recognition of a deteriorating patient. The tool is now also included in the Trust's electronic Doctors Work List.

The Trust had previously developed sepsis electronic learning packages for both adult and child health patients in 2015. These are now well established. Antimicrobial resistance cards for staff have also now been developed. Sepsis boxes were trialled the acute admission areas –ED, AMU, ASU, and PAU and maternity, however the uptake in use of these boxes has not seen a significant increase in the management of sepsis and so has not been rolled out to the rest of the Trust.

The CQUIN time scale for delivery of antibiotics was reduced from 90 minutes to 60 minutes in April 2017, which for the Trust has since shown a slower increase in achievement for timely administration of antibiotics.

The graph below shows the overall Trust percentage for achievements for both sepsis screening and timely antibiotic delivery from April 2016.



CQUIN percentage achievements Q2 2015 – Q3 2017

	Emergency screening	Emergency antibiotics	Inpatient screening	Inpatient antibiotics
Q2 2015/16	24%	46%	-	-
Q3 2015/16	51%	61%	-	-
Q4 2015/16	90%	70%	-	-
Q1 2016/17	85%	36%	8%	47%
Q2 2016/17	90%	45%	12%	66%
Q3 2016/17	93%	56%	25%	73%
Q4 2016/17	94%	61%	51%	80%
Q1 2017/18	91%	78%	61%	79%
Q2 2017/18	93%	85%	58%	76%
Q3 2017/18	92%	76%	59%	89%

Text code - Green is full CQUIN target achieved, amber partial CQUIN target achieved

The CQUIN data will continue to show areas of achievement and areas for improvement. UHS has been recognised by NHS England's medical director for clinical effectiveness as being one of the Trusts which has seen the greatest improvements in sepsis recognition and treatment.

The data that is collected for the CQUIN is only a small part of the data we collect for each patient where we look at time of observations, time of sepsis tool completion, time of review by medical team, sepsis biomarkers, outreach review, sepsis six care bundle delivery, antibiotics started, three day antibiotic review, etc. This data enables a wider data set that is shared internally to divisions and care groups to identify where recognition and management of patients can be improved. This information is also shared with the Trust acuity group (ROAR), Patient Safety Steering Group, Quality Governance Steering Group and Trust Board to enable escalation of concerns and support for required developments.

Sepsis has been added as a separate cause code onto the electronic adverse event reporting system which enables sepsis incidents to be easily identified and reviewed. All patients who have sepsis as a

cause of death that have been through the IMEG process (Internal Medical Examiners Group) are reviewed by the sepsis clinical nurses and investigated as required.

Favourable Event Reporting Forms (FERF) is written for staff, teams or wards that have provided excellent recognition, care and management to a patient.

The Trust is in the process of rolling out an electronic observation system to all wards. The sepsis screening tool will be included on this system thus providing a mandatory screening tool which should improve compliance similar to that seen within the ED.

We can demonstrate that mortality and length of stay has decreased – data pending April 2018

Clinical outcomes

Priority seven: report outcome measures in every speciality across the hospital

Our aims were

To continue developing the work streams across all clinical specialities and to establish an outcomes group to provide a greater level of scrutiny and assurance.

That every speciality would identify outcomes that are specific to their clinical service – these can be nationally reported or locally developed outcomes.

Each care group would be able to present their outcomes to a newly established outcomes scrutiny group on an annual basis, demonstrating progress against the identified outcomes.

Our achievements for 2017/18 were

An outcomes group was established with a rolling programme which ensures that all care groups attend on an annual basis to present their outcomes. This group reports into the quality committee.

More specialities are identifying outcomes each quarter. This remains work in progress.

All care groups have presented their outcomes to the scrutiny group during 2017/18 and the programme for 2018/19 ensures that this will continue. This will allow care groups to update their progress against identified outcomes since being presented in 2017/18.

Priority eight: Improve care for patients at the end of life

Our aims were

Eight priorities were set in the 2015/16 UHS Quality Account for End of Life Care.

1. Deliver our new five year UHS End of Life Care Strategy so that education and training in care of the dying are delivered for clinical and front-line non-clinical staff caring for dying patients. The scope and level will vary according to staff group and the frequency that they are involved with care of dying patients and their families.

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

3. Enhancing our pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met.

4. Facilitating discussions with patients and families about their wishes relating to their preferred place of care whilst dying. This will include discussion about what is safe and feasible. This will enable increased numbers of dying patients to be discharged home or be transferred to an alternative place of their choice in a timely manner.

5. Working with relatives and carers to hear their voice about their experiences of end of life care and their ideas for improvement.

6. Continue to participate in and inform the national work stream around the emergency care and treatment plan, working alongside Wessex CLAHRC into the use of treatment escalation plans (TEP).

7. Replicating the National Care of the Dying Audit locally in 2017 ahead of the anticipated next national audit round.

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

Our achievements for 2017/18 were

There has been progress in all domains. The Trust Board have acknowledged that end of life care is a field which requires continuous quality improvement.

We have started delivering our new five year UHS End of Life Care Strategy which includes:

- Role specific mandatory training has been agreed for all staff groups from April 2018.
- We are providing increased education on end of life care including: all FY1 and FY2 Doctors, weeklong situational and more formal teaching on a ward by ward basis.
- In November 2017 we held our fifth annual End of Life Care conference for UHS staff which was both well attended and positively evaluated.
- The Hospital Palliative Care Team clinical activity continues to rise year on year (1912 new referrals in 2014/15, 2094 in 2015/16 and 2230 in 2016/17) providing even more opportunities for the team to teach situationally and influence the care of far more people than they see.
- An enhanced proactive palliative care team service for the UHS cystic fibrosis service commenced in January 2018.

We have progressed our intention to discuss with the patient, if well enough and appropriate, with family, carers or other advocates that they are approaching the end of life:

- Our most recent comparison of UHS Dying in Hospital Audits of the care of patients who died in June 2015 and in September 2016 (repeating previous National Audit) shows improvement from 81% to 91% in the recognition of dying exceeding the national target of 83%.
- The percentage of notes in which there was documented evidence of discussion with the patient that they would probably die in the coming hours or days was 29% in both audits against the national target of 20%. A large percentage of patients were deemed too ill to have such a discussion.
- The percentage when this was discussed with a nominated person important to the patient increased from 80% in 2015 to 87 % in 2016 against a national target of 79%.

We have enhanced our pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met. In 2018, the Spiritual Care Team diversified its service; employing Christian chaplains of varying denominations, the team now also employs those of other faiths and none. Specifically, Muslim and Hindu Assistant Chaplains have been appointed as well as a Humanist Pastoral Carer. Whilst all chaplaincy includes generic care, Muslim, Hindu and the non-religious now have dedicated spiritual care staff available should they require this.

Facilitating discussions with patients and families about their wishes relating to their preferred place of care whilst dying has been an area of focus in 2017/18. Whilst we believe there are more discussions initiated about individuals' preferences at the end of life, there is no single system to record these preferences and, in any case, those discussions are usually best placed to occur in the community. Of those patients from UHS 2016 Dying in Hospital Audit, only one out of 77 patients was admitted from the community with an advance care plan (ACP).

We are concerned about the number of patients who are unable to be discharged home when approaching the very end of their life due to social care constraints and are interrogating the data to identify the root causes of this. The number of adult patients dying in the Trust is increasing. In 2015/16 there were 2,111 adult deaths of whom 364 died in Countess Mountbatten House (CMH), in 2016/17 2,341 with 415 deaths at CMH. The proportion of patients referred to and followed up by the Hospital Palliative Care Team (HPCT) who die in hospital has increased; 541 (25.8%) and 634 (28.4%) of HPCT referrals died in SGH in 2015/16 and 2016/17 respectively. The number and percentage have continued to rise 590 deaths (30.6 %) of HPCT referrals in the first 10 months of 2017/18.

The HPCT was directly involved in the care of 86 of the 215 (40%) adult patients who died in SGH/PAH as inpatients in December 2017.

In order to improve our working relationships with relatives and carers we conducted a survey of bereaved relatives. 160 questionnaires were handed out during February 2017, with a response rate of over 50%. Over 90% of respondents rated their relative's care as good or very good for the majority of the questions. Feedback about specific ward areas was sent to relevant clinical leaders so they could learn from both the accolades and any negative comments. In addition we ensured the feedback was shared across all the clinical areas to improve practice.

In July 2017 we also held the second of the UHS CEO patient lunches for bereaved relatives, which is held on a three yearly cycle. Relatives were given the opportunity to discuss directly with the CEO

their experience of the care for both the dying person and themselves. Where necessary the CEO asked for some of those who were involved to communicate with families and to harness their ideas about improvement. One family is now working with us to improve the 'Coping with Dying' information for relatives.

In 2017/18 we committed to continue to participate in and inform the national work stream around the emergency care and treatment plan, working alongside Wessex CLAHRC into the use of treatment escalation plans (TEP). We have actively been part of the local, regional and national work streams for TEP throughout the year.

During 2017/18 we replicated the National Care of the Dying Audit locally i ahead of the anticipated next national audit round. We carried out this audit using data from the notes of 77 adult patients who had died in September 2016. On the whole the results showed an improvement compared to the audit of those who died in June 2015, and in some domains we exceeded the national targets. Where the results suggested a need for improvement this has been incorporated into our End of Life Care Action Plan

In order to assess the use of the individualised end of life care plan we have carried out a baseline audit of staff knowledge and experience of the UHS End of Life Care Plan to establish standards for practice. We have developed an education programme which we are implementing and will then re - audit and use the results to inform continuing improvement in the care of the dying.

Priority nine: reduce the impact of deconditioning and immobilisation on the frail elderly

Our aims were

1. Increasing ambulatory care at the front door.

2. Increasing the identification and better understanding of frailty.

3. Initiatives to positively encourage mobilisation on the wards including Implementation of the 'Eat Drink, Move and End Pyjama Paralysis' initiative in AMU and MOP wards. This is an initiative to encourage patients to dress in their own clothes to promote self-reliance in the frail elderly which has been shown to improve their independence, wellbeing, and reduce their length of stay.

Our achievements for 2017/18 were

During 2017/18 we re-launched our present ambulatory pathways aimed at increasing ambulatory care (AEC) at the front door. We rolled out AEC clinics seven days a week and reviewed the headache pathway with ED colleagues and looked at diabetes and superficial thrombophlebitis.

Our biggest success in 2017/18 is the introduction of the Eat, Drink, Move initiative. This is part of a national initiative linked to #endpjparalysis and #last1000days looking at how we can value every moment of our patient's time while they are in hospital. The initiative is headed up nationwide by Professor Brian Dolan and has taken on great momentum over recent months. It is important because 65% of patients admitted to hospital are 65 or older , and a person over 80 who spends 10 days in a hospital bed will lose 10% of muscle mass. This could be the difference between going

home and going to a home. UHS has taken on this concept and following permission from the Heart of England NHS Trust have used their 'Eat, Drink, Move' campaign focussing on the importance of eating and drinking well while in hospital. We are working closely with the dieticians and Serco to ensure this is happening.

The initiative also links to the Red to Green days and SAFER ward rounds, ensuring that a patient's hospital journey is moving forward at all times. SAFER is a bundle of interventions to ensure better discharge, including all patients having a daily senior review in the morning; all patients being given an expected discharge date and clinical criteria for discharge; efficient patient flow ensuring patients are in the right place at the right time; patients are sent home when it is safe and timely to do so; and any patients in for extended lengths of stay are reviewed by a senior multidisciplinary team to work to get them home.

Linked in to this, in 2017 the Trust became one of five pilot sites for the Helpforce initiative. This is a national company which is developing the invaluable role volunteer's play in hospitals to enhance patient experience. At UHS we already have an established, extensive volunteer service that undertakes a huge variety of roles. In 2016/17 we participated in the SOMOVE study, looking at the feasibility of training volunteers to encourage patients to mobilise and prompt them to complete bed and chair exercise programmes. This study was highly successful and demonstrated a significant increase in the activity levels of those patients involved.

Priorities for improvement 2018/19

In order to determine our priorities for improvement we have consulted with a number of stakeholders including our Trust quality committee, our Trust Board, our Trust executive committee, commissioners and patient representatives (through our Healthwatch group), and our governors. The quality committee on behalf of the board approved the priorities and there will be regular reports on progress to the committee throughout the year.

We have developed this year's Quality Improvement Framework (appendix one) to ensure that our quality priorities are aligned with feedback from patient surveys and complaints, as well as incidents. We have used our progress against last year's priorities to help decide which priorities need continuing focus in 2018/19. Priorities are built around our ambitions and intention to deliver well-led, safe, reliable and compassionate care in a transparent and measurable manner.

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

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

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

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

This section outlines the following 2018/19 quality priorities.

Patient experience

Priority one: Improving the experience of discharge

Why we have chosen this priority

Getting discharge right is a challenge facing most acute providers. The multi-agency and multi-faceted nature of the discharge process combines to cause delayed transfers of care, avoidable hold ups, and other process issues that keep patients from going home, keep beds filled when there is no longer a clinical need for the patient to be in them, and ultimately impacts on a patient's overall experience of care.

Many of the problems are outside of our control, with the lack of availability of ongoing community and residential care the biggest factor in delayed transfers of care at UHS. But there are things within the Trust that we know we can continue to improve.

We know from our patients that our discharge experience requires improvement. In the latest National Inpatient Survey results, published in 2017, the Trust underperformed when compared to other Trusts. In particular, patients reported concerns about:

- Discharges being delayed due to a wait for medicines and / or patient transport
- Information given to patients about their medication and side effects to watch out for
- Patients reporting that they knew what to expect regarding their care after leaving hospital
- Family members or carers being given the appropriate amount of information about a patient's condition and ongoing care needs

We also know that sometimes we do not work as effectively with our care and nursing home colleagues as we could. This has an impact on the quality of discharge when sending residents back to their care home. This is evidenced by the increasing number of concerns raised to us by care and nursing homes about poor discharge.

Finally, we recognise that our systems and processes do not always work towards an effective and timely discharge. Delays in review, dispensing medications, and arranging transport all create avoidable hold-ups in getting patients home. Because of these factors, we will continue our focus on discharge in 2018/19 to ensure we deliver the best possible discharge experience for our patients.

What are we trying to achieve

Improving patients' experience of discharge is an important part of our work to improve the efficiency, safety, and timeliness of the discharge process itself. We want our patients, and their relatives and carers, to be fully informed and involved in their discharge from hospital. There are many varied but related factors that impact upon the experience of discharge, and our work ranges across a number of different areas outlined below.

Great discharge starts at admission, and UHS is working on embedding the SAFER patient flow initiative to improve the safety and effectiveness of our discharge process.

A core element of SAFER is ensuring that patients know what is wrong with them, what is going to be done, what they need to go home, and when they can expect to go home.

To actively encourage patients to be involved with their discharge planning, we will provide patients with a checklist to start thinking about what they will need to ensure a timely discharge. The checklist will be included in a new inpatient welcome booklet that will provide patients with information about their stay. The booklet will encourage patients to start thinking about, and planning for their discharge home from the day they are admitted. By thinking ahead we can work to remove avoidable delays. This could range from ensuring that transport is arranged, asking friends or relatives to ensure there is food in the fridge and the heating is on at home, to being clear on medications and their side effects.

We know some patients do not have family support, so we will be developing a discharge volunteer role. These volunteers will support patients in preparing and planning for discharge by ensuring that all of the patient's questions have been answered and all arrangements have been made to enable a safe and positive discharge.

We will also be looking to improve our collaborative working with local care and nursing homes, to ensure a coordinated and joined up approach to discharge to homes. This will include a number of engagement activities, including a care home survey to help triangulate key barriers and obstacles to smooth and safe discharge back to care, nursing, and residential homes.

We will also improve our nursing discharge checklist to ensure patients receive the right information about their medication. This will enable patients to leave the hospital knowing what medication they have been given, how to take it, and what side effects to look out for.

Continue to work with the wards to ensure Complex Discharge Policy is being followed appropriately
Continue to develop the DO, SDO and CHC team to be able to further support patients with timely and relevant information regarding their discharge plans.

Finally, we know that patients want to get home quickly on the day of their discharge, and we are working to ensure that for patients for whom it is safe to do so, we discharge home before lunch. This will require more efficient working and collaboration between clinical teams, ward staff, and pharmacy, but will not only improve patient experience but increase our flow and capacity.

What will success look like

Our aim is for every patient to leave hospital in a timely and safe manner, knowing what has been done, what to look out for, and who to contact if they have any questions. We want our patients to leave having been fully informed and prepared for their discharge, and for the discharge process itself to enhance and not detract from their overall experience of care.

How we will monitor and measure progress

We will continue to monitor patient feedback through the annual National Inpatient Survey, as well as locally through our own inpatient survey. We will focus questions on how prepared patients feel about their discharge and how informed they have been kept about the process. Oversight of performance will be through our quality governance steering group, Trust executive committee, and ultimately Trust Board.

As we continue to embed SAFER, we will track how well we are meeting the estimated day of discharge and how successfully we have removed avoidable obstacles to sending patients home.

We will thematically review calls to our medicines helpline to ensure that patients are being given the right information about their medications when they are discharge.

We will continue to work with local care homes and our commissioners to ensure that our work is collaborative, effective, and joined up, and that discharges to homes are safe, and will monitor the number of concerns being raised to us.

Priority two: Improving end of life care

Why we have chosen this priority

We have outline recent achievements in end of life care in priority seven, however there are some significant areas where we acknowledge we still need to improve.

We are committed to a standard whereby any person in our care thought to be approaching their last days of life will receive individual care based on their needs, delivered with compassion and sensitivity by our staff. We also aim to improve the regular and effective communication between staff and the dying person and those close to them.

We know from patient feedback that we usually get it right:

”All the staff from resus/majors and especially AMU1 were so caring & patient. They took time to listen to our Dad's wishes & listened to the family”.

“The doctor on duty the morning my mother died had such a lovely caring attitude over the phone when he informed me her passing was near. Thank you for all everyone did in the short time Mum was with you”.

“The care received was exceptional. We could not have asked for more and the person concerned died in peace, with dignity and in the most tranquil way possible”.

But there are still some areas where our feedback prompts us to improve:

Communication:

”We all knew what the outcome was going to be but when we ask to see the doctor we were left waiting a very long time if they came at all. I told them I lived in Exeter but every time I phoned I was told the same thing, that he had a quiet night which was not always the case. I feel very strongly that they could have given us more time and information”.

Education:

“I feel that the staff had a serious shortfall and needed a lot of training to be able to deal satisfactorily with end of life. It is necessary for staff to understand all aspects about their patient

and try to understand the emotional distress that families are suffering. It is important the relatives have confidence that staff are in control of the situation and have the knowledge to deal with it".

Meeting the needs of others:

"When it was apparent that Dad was near the end, it would have been nice for him to have been in a separate room so we could have talked without the noise of the other patients".

We believe these are priorities which must be embraced as part of a continuous learning cycle within the organisation.

What we are trying to achieve

Continuing the work started in 2017/18 we aim to continue to improve our care of dying patients and their families and the way this is communicated and documented. We will work towards better formal and informal mechanisms to engage with and hear the voice of patients and families, including families who have been bereaved. This will be achieved through:

- A complete revision of the UHS Individualised End of Life Care Plan including the development of a workable electronic version which can be shared with patients (if well enough) and their families, ideally with a section which can be completed by the families.
- Working with bereaved relatives to learn from their experiences.
- The development of both role specific mandated end of life care education and of communication skills training focused on talking to very ill patients and families about uncertainty and dying.
- Auditing the use of the UHS Individualised End of Life Care Plan and using the results to drive continuous improvement in the care of dying.
- Participation in the National Audit of Care at the End of Life 2018/19 which will audit in-patient hospital deaths in April 2018.
- Utilising the PICKER methodology and system to establish a rolling survey for bereaved families to feedback about their experience.
- Continuing the CEO Listening Lunches for bereaved families.
- Harnessing the feedback from complainants, where their perception is that aspects of end of life care could have been better and where possible working with them to improve.

We recognise we need improved compliance with The NICE Quality Standard 144, 'Care of dying adults in the last days of life' (QS 144 Statement 1 "Adults who have signs and symptoms that suggest that they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering." March 2017). This will be achieved through embedding a 'board to ward' focus on recognising the possibility that a patient may be dying.

In response to the audit of case notes of adult patients who died in September 2016 (UHS Dying in Hospital Audit) we will set up a system through which adults in the last days of life will have their hydration status assessed and documented daily and will have a discussion about the risks and benefits of hydration options.

We aim to facilitate more timely and proactive discussions with patients about their end of life care preferences, including preferred place of care and death, and a cross-organisational infrastructure to record this. This will be achieved through:

- Encouraging patients to talk about their preferences and wishes as they approach the end of their lives.
- Up-skilling the UHS workforce through providing increased opportunities to work alongside the Hospital Palliative Care Team and through communication skills training focused on advance care planning and end of life care.
- Working in partnership with providers of community care, commissioners and the Wessex End of Life Care Network to develop a truly cross-organisational IT system.
- The further development of our 'proactive' palliative care approach for example our new ways of working with our emergency department and AMU, our heart failure team and our regional cystic fibrosis team. Early feedback in February 2018 from a patient with cystic fibrosis seen in outpatient clinic was:

"it was fantastic and really helpful to see palliative care when I am sort of OK and not just when I have been admitted in a crisis."

At UHS we are setting ourselves the goal to ensure that end of life care remains a key priority for the Trust and that we are known as a "dying friendly hospital." This will be achieved through:

- The development of a better corporate structure for End of Life Care within UHS.
- Continuing to raise awareness locally, nationally and further afield, to promote the quality of palliative and end of life care in UHS.
- Collaborative working with our clinical academic colleagues and the Wessex CLARHC.

Last year we worked hard to grow our spiritual care team. We would like to develop the service further and be able to offer comprehensive out of hours service provision by the spiritual care team. By continuing to engage with local religious and faith leaders we will explore ways of meeting the out of hours demand for spiritual care, which mainly relates to the care of dying patients and their families.

What will success look like

1. Staff will be competent and compassionate in caring for patients and their families at the end of life.
2. Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan which will include:

- Personal goals and wishes
- Preferred care settings
- Current and anticipated preferences for symptom management and maintaining hydration
- Needs for care after death

3. Whenever possible patients we will support patients to be cared for in their preferred place of care.

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

5. Each adult patient will have an agreed individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support.

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

7 The National Care of the Dying Audit results will have improved from the previous National and UHS audits.

How we will monitor and measure progress and where we will report that progress

1 We will record the training delivered and attended as part of role specific mandatory end of life care education across divisions and staff groups to demonstrate we are meeting the Trust's target levels. Education Leads report to the End of life Care Board on their divisional compliance with role specific End of Life care education.

2 We will carry out spot audits of case notes of patients recognised as approaching the end of life monitoring:

- The quality of documentation, including the UHS Individualised End of Life Care Plan.
- Anticipatory prescribing
- Communication between the health care team and patients and their families
- Discussions about care preferences including preferred place of death
- Assessment of hydration and nutrition requirements and each patient's ability to eat and drink.

3 We will participate in the National Care of the Dying Audit and benchmark our performance against the national picture and our previous results.

4 An annual End of Life Care Action Plan will drive our continued quality improvement and be shared quarterly with senior divisional management and executive teams. Reports of progress will be presented through the Trust's End of Life Care Groups to the Trust's executive committee and the Board of Governors. Reports and action plans will be cascaded through divisional and care group mechanisms to ward level.

Priority three: Shared decision making

Why have we chosen this priority

Shared decision making (SDM) has been defined by the National Shared Decision Making Collaborative as:

'"a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preferences." (NICE 2015)

The shared decision making process is a conversation which takes place in the "black box" of consultation. The conversation draws on each of the participants' skills and expertise. The clinician brings knowledge and insight of diagnosis, pathology, treatment options available, and evidence-based information about risks and outcome probabilities, and the patient brings knowledge and insight of their personal values, outcome preferences, and experience of illness, social circumstances, and attitude to risks. (Coulter and Collins 2011).

There are a number of policy drivers supporting the business case to ensure high quality shared decision making is delivered to patients. These include:

- Benefits in improved allocative efficiency and effective value. These improvements are delivered by mitigating the risk of market failure in the "black box" of consultation from asymmetrical information. (Blomgvist 1991; Gafni, Charles and Whelan 1998; Lee 1995; and Mulley, Trimble, and Elwyn 2012).
- Statutory duties of CCGs and NHS England to promote patient choice and the duty to promote involvement of patients and carers in decisions about prevention and diagnosis of their illness, and in their treatment and care. (Health and Social Care Act 2012 s23(1)(13H) and s25(1)(14U)).
- Statutory duties of providers to deliver person-centred care to patients, including: delivering care and treatment which reflects their preferences; collaboratively assessing needs and preferences for care and treatment with the patient; and supporting patients to make decisions about their care to the maximum extent possible. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2936 reg 9).
- The contractual requirement for providers to deliver against regulation 9, outlined in the NHS Standard Contract (Full Version) Service Conditions SC10.
- The common law duty to obtain informed consent which, following the judicial ruling of the UK Supreme Court, includes the need to present options and risks up-front to patients. There is also a vicarious liability for those who make provision for those services. (Montgomery v Lanarkshire Health Board 2015).

A shared decision making approach to making decisions in healthcare is a departure from traditional, paternalistic, models of healthcare services. Effective delivery of high quality shared decision making needs culture change across whole pathways and services.

Shared decision making may already be happening in the NHS in England, but the quality is not routinely monitored, and there is no national reporting for shared decision making. Contractual levers such as CQUIN present an opportunity for us to promote shared decision making, lead quality improvement and meet our statutory duties.

What we are trying to achieve

NHSE have asked us to carry out the Shared Decision Making CQUIN for two years, with year one focusing on transcatheter aortic valve implantation (cardiology) and neuro-oncology teams.

Our approach to achieving this will begin with planning. A working group has been established to agree on which parts of the pathway (decision nodes) present different treatment options and review tools. An implementation plan will be written and submitted to commissioners which will include a team building and training plan for staff, and agreement of a plan for the mechanisms for gathering, and analysing information about decisions made to ensure evaluation.

We will then undertake a pilot to test and evaluate the use of our SDM tool and further develop it to meet shared patient and service needs.

What will success look like

This is a difficult one to answer. NHSE themselves are unsure of how to measure the success of this CQUIN as effectively it is a culture change. We are expected to survey patients before and after, beginning to use SDM in consultations. However, we will not be penalised if the post-SDM questionnaires show no improvement. The same applies to the staff questionnaires that were administered before and after SDM training, no penalty applies for failing to show an improvement post-SDM training.

We have been advised to try and apply the principles of SDM within consultations with the help of a Decision/Option Grid which states simply benefit/risks of each option. Clinicians in both departments have developed these Option Grids and use them as an aide memoire in consultations. Our aim is to ensure that the patient is fully informed and is a 50/50 partner in decisions involving their healthcare.

How we will monitor and measure progress and where we will report that progress

We produce quarterly reports for NHSE which accomplish that purpose. These reports go to the clinicians involved and to NHSE via contracting. We will also report to our commissioners on progress against our implementation plan including any new patient cohorts.

Patient safety

Priority four: recognition and management of the deteriorating patient

Why have we chosen this priority

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

Managing the risks associated with the deteriorating patient has been identified as a recurring theme through incident reporting, serious incident investigations and complaints during 2016/17 and 2017/18.

We are committed to building on the significant progress made as described in priority four (2017/18). This progress has meant that we are now in a position to identify our most useful tool to focus on in identifying and preventing deterioration, which is (MEWS). However, although we have used this tool within the Trust since 2000, there are least six different modified MEWS algorithms used across UHS and we currently sit as an outlier across the region for not adopting the Royal College of Physicians National Early Warning System (NEWS) tool.

We recognise now that the identification of deterioration starts in the community, and that systems need to work together with a single scoring system from community through to acute hospitals. To deliver the best quality for our patients we need a standardised assessment method which is streamlined, speaks the same language across primary and secondary care, helps streamline handing over care and which can utilise healthcare resources more effectively. The NEWS tool offers this refinement.

What we are trying to achieve

- Ability to track deterioration more precisely.
- Whole systems approach to deterioration, escalation and response.
- Better outcomes for patients – reduction in higher scoring acuity levels.
- Standardisation of NEWS 2 across Trust.
- Ability to facilitate early detection, diagnosis and escalation.
- Reduction in safety errors.
- Share key patient information.

What will success look like

- One tool across Trust for adult patients (excluding paediatrics and obstetrics).
- Seamless language from community to acute hospitals and back out.
- Ability to track patient's deterioration.

- Research and audit associated with whole systems deterioration.
- Collaborative pan pathway system.
- Evidence based prioritisation of resources.
- Seamless transitions of care.
- Align hospitals within UHS and region.
- Close working with Wessex Academic Health Sciences network to develop this community of practice.

How we will monitor and measure progress and where we will report that progress

- Reduction in patient safety matters associated with deterioration.
- Monitoring of where we have rolled out across UHS.
- Gain feedback from partners.
- Monitoring number of outreach calls and expect an increase.
- Monitor cardiac arrests and expect a reduction

Priority five: Keeping patients eating, drinking and moving

Why have we chosen this priority

Our success with this priority in 2017/18 has established an excellent baseline for continued improvement. In 2018/19 we are looking at developing the role of patient support volunteers who will be multi-trained, enabling them to undertake the roles of mobility volunteers, meal time assistants and time for you involvement. This volunteer role will be enhancing the work undertaken through the Eat drink move initiative.

What we are trying to achieve

Through these projects we hope to continue to promote physical activity of patients in hospital to reduce the risk of deconditioning and the consequences of this.

What will success look like

- Enhanced patient safety
- Improved reports of patient satisfaction
- More timely discharges
- Reduced length of stay
- More timely admissions for other patients
- Reduced laundry costs where hospital gowns/pyjamas are used

In addition, it would lead to enhanced mental wellbeing of people as they are encouraged to take greater responsibility for their own health and become active participants in their personal health journey. Many more of their red days would be green days and in the last 1,000 days, each and every day counts.

We will be monitoring length of stay across the areas taking up this initiative, as well as looking at patient experience, the percentage of patient up and dressed in their own clothes, pressure ulcer and falls rates and rates of discharge to own residence. In addition to changes in these outcomes, we will be looking for a change in culture, where patients being dressed in their own clothes and moving around the ward is the norm.

The initiative will be rolled out area by area with medicine for older people (MOP) and acute medical unit (AMU) already starting, and surgery, orthopaedics and stroke anticipated to follow April 2018. Training sessions will be offered to all ward staff to encourage them to embrace the change.

Success will be a change in culture so that all patients who are well enough are up, dressed and moving around the ward safely. All patients will be offered snacks and drinks at intervals throughout the day and there will be a variety that will meet the patients' dietary needs. It is hoped there will be an improvement in the outcome measures mentioned above which will enhance the improvements made with the roll out of the SAFER board rounds and red to green days.

How we will monitor and measure progress and where we will report that progress

Data has been collected on MOP prior to intervention to gather a baseline. This was monitored monthly for five months and is now reviewed every quarter. The intention is to gather data pre implementation in all areas so we can track the improvement. This will be reported to the Eat drink move working party and the clinical area. By November 2018 we will produce a report that will summarise the improvements made across the different areas with the roll out of this initiative. It is important to remember that Eat drink move is not all about outcome measures but rather an improved experience for the patient which will become part of the embedded culture at UHS.

Priority six: Delivery of the national safety strategy for maternity care

Why have we chosen this priority

Maternity is different from other clinical specialities as most pregnant women are generally healthy and pregnancy is a natural physiological process that usually culminates in the birth of a healthy baby.

We receive excellent feedback for our maternity services via our Friends and Family feedback:

"Very happy with all the midwives. There is a strong team of staff. They should all be very proud of themselves. Very attentive and extremely helpful and informative with everything. Midwives deserve a pat on the back. The team made me feel confident and helped me massively with the right techniques".

"Cannot thank all the staff enough for being amazing, helping me deliver the baby and providing extra support with breast feeding. Thank you all so much".

“Great care from labour ward HDU and Lyndhurst, including all staff I was in contact with. Very supportive and understanding”.

”All staff absolutely fantastic. You would not have known the ward was full. Took the time to call us all by name at all times. We had an exceptional, caring experience from start to finish”.

”The entire team for my c-section was professional, supportive and absolutely wonderful. The post care was exceptionally good. Many thanks”.

However we remain aware of the potential for safety issues for this patient cohort. The vast majority of deaths and injuries in maternity care are unexpected outcomes, but where a death or injury could have been avoided the consequence for both families and the professionals involved can be devastating. Trusts that are able to demonstrate compliance with recommendations made with the Maternity Safety Strategy and NHS Resolutions 10 criteria, are likely to deliver safer maternity services and may be expected to have fewer cases of brain injuries or other harm which can lead to negligence claims.

Maternity safety has always been a fundamental driver within maternity at UHS.Since 2015 we have signed up to the Department of Health’s (DoH) ambition to halve the number of stillbirths, neonatal deaths and brain injuries that occur during or soon after birth, as well as maternal deaths, by 2030. This forms part of our sign up to safety initiative. We have attended all of the quality improvement workshops with NHS Improvements and we have an agreed Quality Improvement plan in place.

What we are trying to achieve

Safety incidents within maternity services have lasting impacts on women their families and staff. Therefore the service recognises that in the coming year there needs to be a greater focus on leadership, culture in learning, reviewing data and good review processes alongside openness, honesty and good communication. We are committed to providing a focus on patient safety, professional and public accountability, whilst acting responsibly when things go wrong. The maternity service understands that it is important that the response to all incidents is one of openness and learning with a drive to reduce future risk for patients, support for patients, staff and anyone who may suffer as a consequence.

In addition we plan to continue to drive quality improvement by becoming part of the Wessex Maternity Community of Practice to provide a regional forum to profile QI and patient safety in support of Local Maternity Systems in Wessex.

What will success look like?

All women, babies and families across maternity care settings will have a safe, reliable and quality healthcare experience. We will have created the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system, including SHIP collaborative. We will

also be contributing to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

How we will monitor and measure progress and where we will report that progress

The maternity service is developing an action plan to ensure monitoring and deliver of all of the separate elements highlighted within the November 2017 Safer Maternity Care National Maternity Safety Strategy Progress and Next Steps Report, including the 10 criteria for the CNST discount. The action plan will be monitored and scrutinised. We plan to deliver this action plan by end of May 2018. Monitoring will be lead nationally by the Maternity Transformation Programme and locally monitored through the UHS Women and Newborn Governance Group with oversight from the divisional management team (DMT) and QGSG as requested.

Compliance with the criteria will be assessed through a verification process that will be completed by the end of June 2018.

Priorities for clinical effectiveness

Priority seven: antimicrobial resistance (AMR)

Why have we chosen this priority

In Europe 25,000 people die each year as a result of hospital acquired infections from five key resistant bacteria. Globally a failure to address the problem of bacteria resistance could cost 10 million deaths by 2015, at a financial cost of 366 trillion.

Total antibiotic consumption in hospitals based in England has been increasing steadily and these increases in prescribing ultra broad-spectrum agents have coincided with increased antibiotic resistance in the UK. Antimicrobial resistance (AMR) is the ability of micro-organisms to withstand antimicrobial treatments such as antibiotics. This resistance occurs as bacteria, for example, adapt and find ways to survive the effects of an antibiotic, meaning the drug no longer works to fight the infection it was previously used to treat. The more an antibiotic is used, the more bacteria become resistant to it.

The consequences of AMR include increasing treatment failure for the most commonplace infections, such as urinary tract infections and decreasing the treatment options available where antibiotics are vital, such as during cancer treatment when patients are prone to infection. Without effective antibiotics, even minor surgery and routine operations could become high risk procedures if serious infections cannot be treated

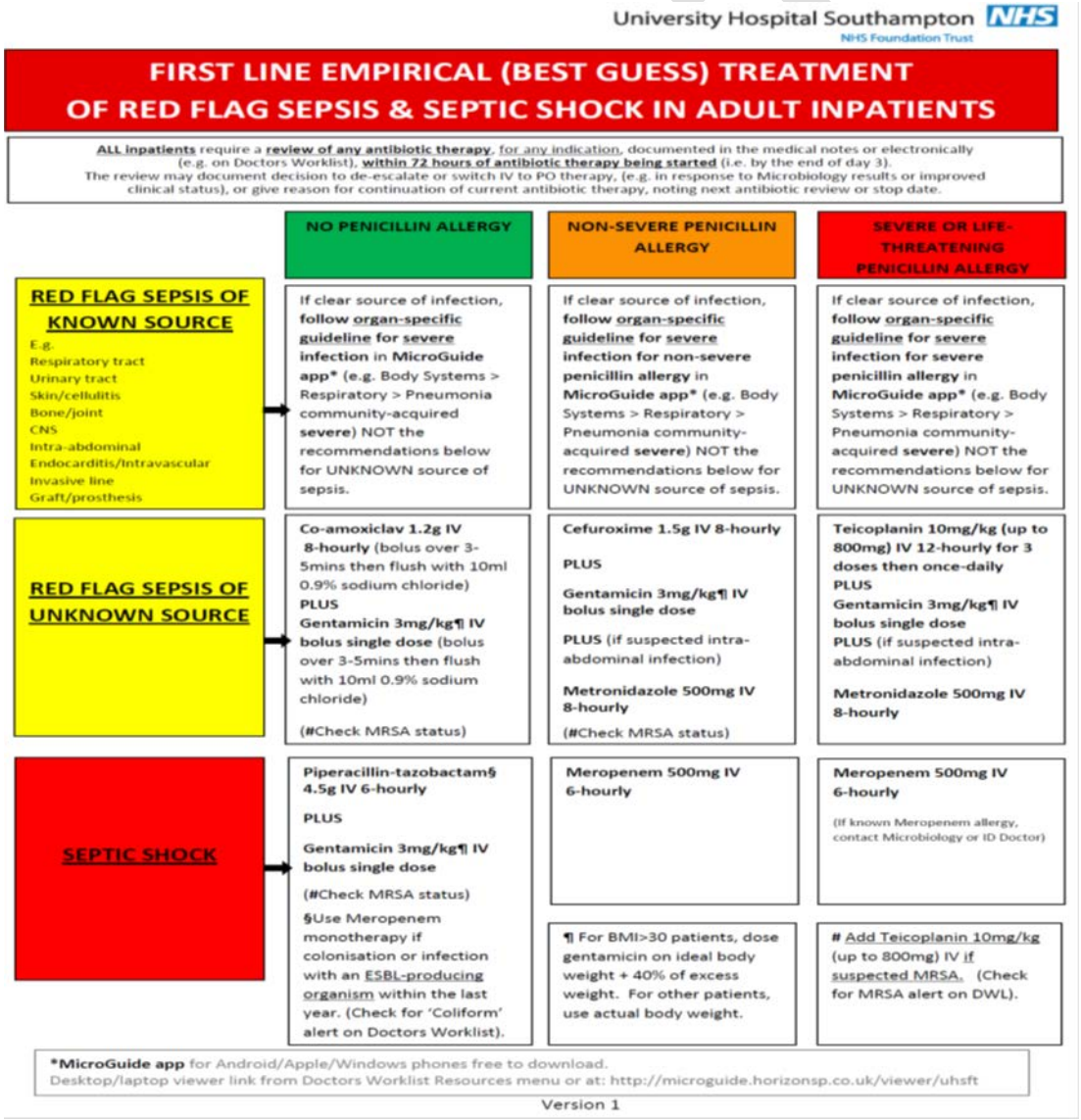
The world's largest healthcare incentive scheme to prevent the growing problem of antibiotic resistance was launched last year. The programme offers hospitals incentive funding worth up to £150 million to support expert pharmacists and clinicians review and reduce inappropriate prescribing. Providers will also receive payments for gathering and sharing evidence of antibiotic consumption, and review within 72 hours of the beginning of treatment.

Given the measurable impact to our patients and the additional financial resource available to support us delivering we have chosen this as a priority this year to ensure our practice is exemplary.

What we are trying to achieve

Our ultimate aim is driven by the 2020 UK AMR 'goal' to cut inappropriate prescribing of antibiotics by 50%. Our approach to achieving this is via:

- Face-to-face teaching targeting junior medical staff.
- Regular presentations at consultant meetings for education purposes.
- Ongoing antibiotic stewardship ward rounds.
- Revision of Trust sepsis guidelines to bring them in line with the most current evidence.



University Hospital Southampton NHS
NHS Foundation Trust

FIRST LINE EMPIRICAL (BEST GUESS) TREATMENT OF RED FLAG SEPSIS & SEPTIC SHOCK IN ADULT INPATIENTS

ALL inpatients require a **review of any antibiotic therapy**, for any indication, documented in the medical notes or electronically (e.g. on Doctors Worklist), **within 72 hours of antibiotic therapy being started** (i.e. by the end of day 3).
The review may document decision to de-escalate or switch IV to PO therapy, (e.g. in response to Microbiology results or improved clinical status), or give reason for continuation of current antibiotic therapy, noting next antibiotic review or stop date.

	NO PENICILLIN ALLERGY	NON-SEVERE PENICILLIN ALLERGY	SEVERE OR LIFE-THREATENING PENICILLIN ALLERGY
RED FLAG SEPSIS OF KNOWN SOURCE E.g. Respiratory tract Urinary tract Skin/cellulitis Bone/joint CNS Intra-abdominal Endocarditis/Intravascular Invasive line Graft/prosthesis	If clear source of infection, **follow organ-specific guideline for severe infection** in **MicroGuide app*** (e.g. Body Systems > Respiratory > Pneumonia community-acquired **severe**) NOT the recommendations below for UNKNOWN source of sepsis.	If clear source of infection, **follow organ-specific guideline for severe infection for non-severe penicillin allergy** in **MicroGuide app*** (e.g. Body Systems > Respiratory > Pneumonia community-acquired **severe**) NOT the recommendations below for UNKNOWN source of sepsis.	If clear source of infection, **follow organ-specific guideline for severe infection for severe penicillin allergy** in **MicroGuide app*** (e.g. Body Systems > Respiratory > Pneumonia community-acquired **severe**) NOT the recommendations below for UNKNOWN source of sepsis.
RED FLAG SEPSIS OF UNKNOWN SOURCE	**Co-amoxiclav 1.2g IV 8-hourly** (bolus over 3-5mins then flush with 10ml 0.9% sodium chloride) **PLUS** **Gentamicin 3mg/kg¶ IV bolus single dose** (bolus over 3-5mins then flush with 10ml 0.9% sodium chloride) (#Check MRSA status)	**Cefuroxime 1.5g IV 8-hourly** **PLUS** **Gentamicin 3mg/kg¶ IV bolus single dose** **PLUS** (if suspected intra-abdominal infection) **Metronidazole 500mg IV 8-hourly** (#Check MRSA status)	**Teicoplanin 10mg/kg (up to 800mg) IV 12-hourly for 3 doses then once-daily** **PLUS** **Gentamicin 3mg/kg¶ IV bolus single dose** **PLUS** (if suspected intra-abdominal infection) **Metronidazole 500mg IV 8-hourly**
SEPTIC SHOCK	**Piperacillin-tazobactam§ 4.5g IV 6-hourly** **PLUS** **Gentamicin 3mg/kg¶ IV bolus single dose** (#Check MRSA status) §Use Meropenem monotherapy if colonisation or infection with an ESBL-producing organism within the last year. (Check for 'Coliform' alert on Doctors Worklist).	**Meropenem 500mg IV 6-hourly** ¶ For BMI>30 patients, dose gentamicin on ideal body weight + 40% of excess weight. For other patients, use actual body weight.	**Meropenem 500mg IV 6-hourly** (If known Meropenem allergy, contact Microbiology or ID Doctor) # Add Teicoplanin 10mg/kg (up to 800mg) IV if suspected MRSA. (Check for MRSA alert on DWL).

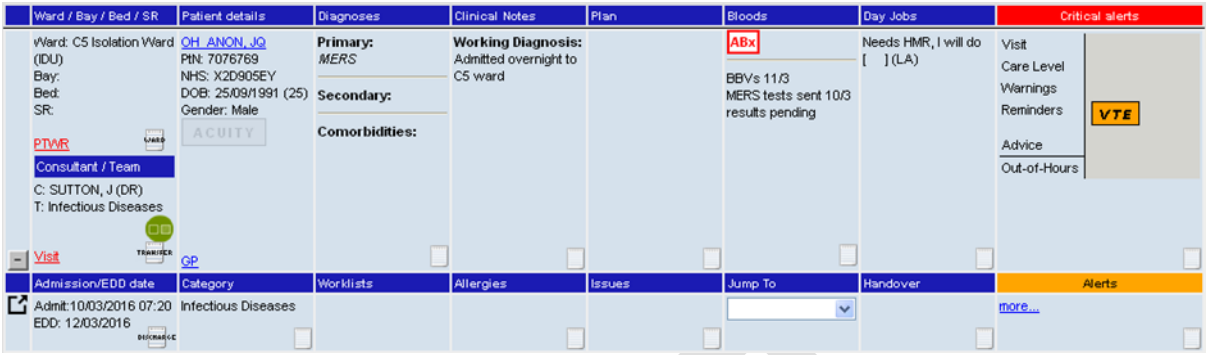
***MicroGuide app** for Android/Apple/Windows phones free to download.
Desktop/laptop viewer link from Doctors Worklist Resources menu or at: http://microguide.horizonsp.co.uk/viewer/uhsft

Version 1

- e-prescribing course lengths (e.g. "trimethoprim for 3 days") to be embedded in the e-prescribing system to guide prescribers. Using e-prescribing to support appropriate durations

with new default options for oral antibiotics to encourage shorter course lengths and prompt patient review.

- Pre-72 hour antibiotic review prompt on Doctors' Work list.



ABx	Patient has started antibiotics, review will be required in the next 48 hours.
ABx	48 hours have elapsed since prescription and review must be completed.
ABx	Review has been completed and patient is still on antibiotics.
ABx	Review has been completed and patient is no longer on antibiotics.

- Pharmacist-led audits of pre-72 hour antibiotic reviews.
- A business case to be submitted to senior Trust leaders for additional nursing/pharmacy/data analyst support.
- Appoint a Band 6 nurse to a new antimicrobial stewardship specialist role to lead on nursing engagement with AMS.
- Appoint a part time data analyst to support pharmacists in data surveillance and antibiotic consumption data submission to Public Health England.
- Micro Guide app to be updated to reflect revised UHS sepsis guideline.
- Revised maternity services sepsis guidelines to be generated.

What will success look like

The percentage of UHS patients who receive a dose of antibiotics on any given day will have decreased further and the prescription of ultra-broad spectrum antibacterial agents without appropriate indication will have stopped. The 'just in case' antibiotic prescribing culture will no longer be seen. 90% of UHS patients will have had a documented antibiotic review within 72 hours and the percentage of UHS patients who receive a dose of an antibiotic on any given day will have dropped to 40%.

Standardised mortality for pneumonia, urinary tract infections and septicaemia will all continue to fall.

How we will monitor progress

We will be compliant with the 2018/19 CQUIN for AMR.

Priority eight: Every outpatient encounter adds value

Why have we chosen this priority

UHS sees in excess of 500,000 outpatient (OP) appointments per year and as clinical practice develops more and more patients need to be followed up, such as ophthalmology.

There is evidence already in existence that shows that OP services can transform to ensure every OP encounter adds value, is more responsive, produces less inappropriate visits to hospital and ensures patients are signposted to the right clinician at the right time and right place.

Transforming the patient experience will rely on closer integration, planning and co-ordination of services across a spectrum of clinical settings at national, regional and local level.

Better access to clinical decision making support and specialist advice will significantly impact patients getting the right treatment and removing unnecessary steps from their journey. Maximising the roles of the wider multidisciplinary team to help achieve this will be crucial to ensuring the patient has access to the right clinician first time, and in removing unnecessary delays in their outpatient journey. Whilst some new roles have been adopted or extended this has not been at scale. Extending the range of training and development to opportunities will be essential in delivering a modern workforce, which ensures the extended multidisciplinary teams have the skills, confidence and capacity to work to the full range of their competencies.

Our sustainability and transformation partnerships (STPs) have signed up to reduce outpatient appointments by 20% but increasing the value of every encounter.

What we are trying to achieve

By following up patients based on clinical need rather than set periods of time we hope to provide better access to care and to avoid outpatient appointments which add no value.

Technology allows us to monitor patient's progress remotely rather than relying on a routine follow-up, which we hope will help reduce the stress and expense of patient travel when this isn't necessary.

What will success look like

- Patients managing their own care and connecting with the hospital via new technology.
- 'Priority patients' getting quicker access to limited resources.
- Pathways redesigned based on patient feedback (patient reported outcomes).
- Every outpatient encounter adding value.

How we will monitor and measure progress and where we will report that progress

- Attendance data will be tracked to measure changes in pathways (and reported to the Transformation PMO)

- Patient reported outcomes will be monitored at a service level to understand the impact of new pathways.
- RTT access times will be monitored at a service level.
- Progress will be reported to both our internal and system level Outpatient Transformation Boards.
- Patient surveys will reflect improvement in their experience.

Priority nine: Best use of resources

Why we have chosen this priority

As public-sector organisations NHS Trusts and NHS foundation trusts are expected to demonstrate to their patients, communities and taxpayers that they are delivering value for money, evidencing both efficiency and effectiveness. This is even more important in times of fiscal constraint. NHS Improvement and the Care Quality Commission (CQC) believe there is significant potential for more productive use of resources across the NHS, which would improve quality of care for patients.

In August 2017 NHS Improvement published their Use of Resources assessments document which aims to help patients, providers and regulators understand how effectively Trusts are using their resources to provide high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of operational productivity .

They will do this by assessing how financially sustainable trusts are, how well they are meeting financial controls, and how efficiently they use their finances, workforce, estates and facilities, data and procurement to deliver high quality care for patients. Initially, their approach will focus on acute non-specialist services due to the availability and quality of data in this area.

What are we trying to achieve

- An improved focus on better quality, sustainable care and outcomes for patients.
- For UHS to be proportionate, minimising regulatory burden, and draw on existing data collections where possible.
- To be clear what 'good' looks like – using data from the Model Hospital and Insight Dashboard to help guide improvement in the use of resources and focusing on quality.
- To promote good practice to aid continuous innovation and improvement.

What will success look like

The Use of Resource domain of our next CQC inspection will achieve a rating which is reflective of the organisations' achievements.

PENDING

Conclusion

Response to the Quality Account from Southampton City and West Hampshire Commissioning Groups

Response to the Quality Account from our lead governor on behalf of the Council of Governors

Response to the Quality Account from HealthWatch Southampton

Response to the Quality Account from the Health overview and Scrutiny Panel

Statement of directors' responsibilities for the quality report

The quality report must include a statement of directors' responsibilities, in the following form of words:

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

1. board minutes and papers for the period April 2016 to May 2017
2. papers relating to quality reported to the board over the period April 2016 to March 2017
3. feedback from commissioners dated 8th May 2017
4. feedback from governors dated 3rd April 2017
5. feedback from local HealthWatch organisations dated 1st May 2017
6. feedback from Overview and Scrutiny Committee dated 27th April 2017
7. the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21st June 2016
8. the national patient survey June 2016
9. the national staff survey March 2017
10. the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2017

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

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Appendix One

Quality Improvement Framework

University Hospital Southampton NHS
NHS Foundation Trust

Our Quality Improvement Framework 2018 – 2019
The UHS Way

The QIF is a tool to engage and communicate with staff and patients about transformation projects to improve the quality of care planned for 2018/19. The priorities have been chosen to reflect areas that are important to our patients and staff that need transformational change and enhanced focus to realise improvements by year end.

- The QIF is not designed to replicate the detail in the trust strategy and annual plan or cover all of the key performance indicators and work streams for quality.
- The safety strategy, patient experience strategy and the clinical strategy contain detail on the plans and processes to maintain and improve quality for patients at UHS.
- It forms part of the annual quality account where each year we report on progress against last year's priorities and set priorities for the following year
- Looking after people is at the centre of everything we do and because of this, and the busy, challenging environment we work in, we recognise that supporting caring for and developing our staff is crucial to delivery of the QIF

University Hospital Southampton NHS
NHS Foundation Trust

Our Quality Improvement Framework 2018 – 2019
The UHS Way

Well Led	• Embedding our values • Best use of resources
Safe	• Recognition and management of the deteriorating patient • Deliver the national safer maternity strategy
Responsive	• Embedding SAFER bundle and improving experience of discharge • Keeping patients eating, drinking and moving
Effective	• Every outpatient encounter adds value • Antimicrobial resistance
Caring	• Shared decision making • Improving end of life care

Appendix two: Quality performance data

Two of the agreed metrics used last year are no longer available as we do not collect this information any more:

- Patient Safety Indicator - Falls Assessment tool
- Nutrition % of patients with nutritional screening in 24hrs (as average of monthly %)

For the latter we have replaced it with: Nutrition- % Patients with a care plan in place.

All the Core Indicators are updated with the most recent publications from NHS digital/NHS England/NHS Improvement/Gov.uk with the exception of emergency readmissions which has still not been updated by NHS digital – their data portal says "this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review".

Patient safety indicators					
	2014/15	**2015/16**	**2016/17**	**2017/18 YTD (Jan Inclusive)**	**2017/18 benchmark**
Serious Incidents Requiring Investigation (SIRI)	35	54	63	25	25 for whole year
Never Events	2	7	3	1	0
Healthcare Associated Infection MRSA bacteraemia reduction	5	3	1	1	0
Healthcare Associated Infection Census" (as average of monthly %)	357%	363%	361%	322%	100%
Healthcare Associated Infection Clostridium difficile reduction	37	35	38	27	43 for whole year
Avoidable Hospital Acquired 33* Grade III and IV Pressure Ulcers	26	36	11	12	30 for whole year
Falls - Avoidable Falls	9	3	0	5	1 a month. 12 for whole year
Thromboprophylaxis (VTE) % Patients Assessed (CQUIN)	95.35%	95.18%	94.87%	93.77%	>=95%
Thromboprophylaxis (VTE) Pharmacological prophylaxis (as average of monthly %)	99.46%	97.75%	95.19%	93.55%	>=95%

	Apr - Sep 2015	Oct 2015 - Mar 2016	Apr - Sep 2016	Oct 2016 - Mar 2017
UHS				
Rate Incidents per 1000 admissions	31.50	41.40	44.50	43.90
Number Incidents	5911	7930	8519	8594
Number Severe Harm	54	74	54	47
% Severe harm or death	0.91%	0.93%	0.63%	0.55%
Highest Scores (Non-Specialist Trusts)				
Rate Incidents per 1000 admissions	74.70	75.90	71.80	69.00
Number Incidents	12080	11998	13485	14506
Number Severe Harm	89	94	98	92
% Severe harm or death	2.92%	2.04%	1.73%	2.13%
Lowest Scores (Non-Specialist Trusts)				
Rate Incidents per 1000 admissions	18.10	14.80	21.10	23.10
Number Incidents	1559	1499	1485	1301
Number Severe Harm	2	0	1	1
% Severe harm or death	0.07%	0.00%	0.02%	0.03%
National Ave (Non-Specialist Trusts)				
Rate Incidents per 1000 admissions	39.30	39.60	40.77	41.10
Number Incidents	4647.43	4817.60	4954.89	5122.38
Number Severe Harm	19.98	19.43	18.50	19.29
% Severe harm or death	0.47%	0.43%	0.40%	0.40%

NB: UHS is part of the acute (non specialist) cluster now (1 of 136 organisations) – the Acute Teaching Trusts cluster ended in 2014 when the NRLS had an internal reconfiguration of how they benchmark organisations.

Cdiff per 100,000 bed days

Table 8b: Financial year counts and rates of C. difficile infection (patients aged 2 years and over) by acute trust – Trust apportioned cases only

	201314	201415	201516	201617
UHS	9	11.8	9.7	9.8
National Average	14.7	15	14.9	13.2
Highest Trust Score	37.1	62.6	67.2	82.7
Lowest Trust Score	0	0	0	0
Lowest Trust Score (non-zero)	0.9	2.8	0.8	1.2

MRSA screening

2016/17	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	201617
Eligible patients	15493	14731	13948	17172	61344
Screened for MRSA	57541	49099	56023	58772	221435
% achieved	371.40%	333.30%	401.66%	342.25%	360.97%
2017/18	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	201718
Eligible patients	16173	15967	15505	4554	52199
Screened for MRSA	56735	37888	54167	19330	168120
% achieved	350.80%	237.29%	349.35%	424.46%	322.08%

Patient experience indicators					
	2014/15	2015/16	2016/17	2017/18 YTD (Jan Inclusive)	2017/18 benchmark
National Friends & Family Test Response Rate					
Emergency department	37.94%	10.76%	6.21%	6.67%	>10%
Inpatients	25.15%	21.74%	20.28%	18.36%	>20%
Maternity		23.38%	29.07%	32.01%	>20%
Percentage of patients recommending UHS to their friends & family					
Emergency department		92.26%	95.42%	97.06%	>90%
Inpatients		96.16%	96.68%	97.10%	>90%
Maternity		95.81%	97.66%	97.50%	>90%
Monthly Real Time Survey - Have you ever shared a sleeping area with patients of the opposite sex during this stay in hospital? (those who gave an answer, as average of monthly %)	13.47%	13%	11.34%	15.56%	<=15%
Same Sex Accommodation (Non clinically justified breaches)	10	5	3	99	20 a month
Nutrition: % Patients with a care plan in place	88%	82%	80%	82%	

Staff FFT					
Staff Recommends Care %	**2016/17 Q1**	**2016/17 Q2**	**2016/17 Q4**	**2017/18 Q1**	**2017/18 Q2**
UHS	91%	92%	92%	93%	93%
Highest Score	100%	100%	98%	100%	100%
Lowest Score	50%	44%	44%	55%	43%

Inpatient Survey		
	2015-16	2016-17
UHS	71.70	67.40
Average (All Providers)	69.64	68.14
Lowest Score (All Providers)	58.90	60.00
Highest Score (All Providers)	86.20	85.20

RHM	RESPONSE RATE														
Emergency department															
	Q1 201516	**Q2 201516**	**Q3 201516**	**Q4 201516**	**Q1 201617**	**Q2 201617**	**Q3 201617**	**Q4 201617**	**Q1 201718**	**Q2 201718**	**Q3 201718**	**Q4 201718**	**201516**	**201617**	**201718**
UHS	19.60%	14.30%	8.94%	4.81%	5.23%	9.52%	6.02%	4.39%	1.88%	15.50%	3.43%		11.96%	6.21%	6.70%
National Average	21.15%	14.55%	13.05%	12.72%	12.99%	13.19%	12.18%	12.45%	12.66%	12.94%	12.41%		14.90%	10.62%	10.48%
Highest Trust	100.00%	45.12%	44.57%	47.22%	44.43%	45.31%	45.03%	45.46%	44.85%	47.15%	58.73%		100.00%	100.00%	100.00%
Lowest Trust	0.03%	0.18%	0.02%	0.19%	0.07%	0.00%	0.23%	0.46%	0.00%	0.30%	0.00%		0.00%	0.00%	0.00%
Inpatient and day case															
	Q1 201516	**Q2 201516**	**Q3 201516**	**Q4 201516**	**Q1 201617**	**Q2 201617**	**Q3 201617**	**Q4 201617**	**Q1 201718**	**Q2 201718**	**Q3 201718**	**Q4 201718**	**201516**	**201617**	**201718**
UHS	22.66%	20.64%	21.22%	22.54%	20.79%	19.11%	19.87%	17.30%	20.76%	18.23%	16.23%		21.74%	19.73%	18.40%
National Average	20.51%	26.08%	24.43%	24.43%	25.77%	25.12%	24.26%	24.32%	26.08%	25.97%	24.27%		23.87%	17.29%	17.37%
Highest Trust	100.00%	100.00%	125.00%	100.00%	100.00%	100.00%	96.67%	100.00%	472.73%	124.49%	100.00%		100.00%	100.00%	100.00%
Lowest Trust	0.06%	4.16%	4.66%	4.56%	4.75%	3.27%	1.70%	3.83%	3.10%	3.10%	2.61%		0.00%	0.00%	0.00%
RHM	**POSITIVE**														
A&E															
	Q1 201516	**Q2 201516**	**Q3 201516**	**Q4 201516**	**Q1 201617**	**Q2 201617**	**Q3 201617**	**Q4 201617**	**Q1 201718**	**Q2 201718**	**Q3 201718**	**Q4 201718**	**201516**	**201617**	**201718**
UHS	94.53%	92.27%	94.04%	93.73%	93.79%	96.34%	94.82%	96.17%	96.61%	97.14%	96.94%		93.74%	95.42%	97.06%
National Average	90.82%	88.14%	87.07%	84.91%	85.95%	86.01%	86.04%	87.02%	87.29%	86.74%	86.35%		87.74%	73.09%	72.56%
Highest Trust	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%
Lowest Trust	58.25%	62.42%	33.33%	46.33%	42.75%	44.75%	48.16%	45.49%	45.75%	46.25%	56.76%		33.33%	42.75%	45.75%
Inpatient and day case															
	Q1 201516	**Q2 201516**	**Q3 201516**	**Q4 201516**	**Q1 201617**	**Q2 201617**	**Q3 201617**	**Q4 201617**	**Q1 201718**	**Q2 201718**	**Q3 201718**	**Q4 201718**	**201516**	**201617**	**201718**
UHS	95.81%	83.04%	96.10%	96.48%	96.35%	96.23%	97.19%	96.83%	96.84%	97.13%	97.30%		92.92%	96.68%	97.07%
National Average	92.61%	95.71%	95.61%	95.70%	95.79%	95.60%	95.54%	95.75%	96.08%	95.85%	95.74%		95.11%	65.71%	64.93%
Highest Trust	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%
Lowest Trust	61.40%	74.44%	71.68%	72.00%	67.97%	66.86%	75.34%	75.55%	75.89%	71.97%	64.29%		61.40%	66.86%	64.29%

RHM	NEGATIVE														
A&E															
	Q1 201516	**Q2 201516**	**Q3 201516**	**Q4 201516**	**Q1 201617**	**Q2 201617**	**Q3 201617**	**Q4 201617**	**Q1 201718**	**Q2 201718**	**Q3 201718**	**Q4 201718**	**201516**	**201617**	**201718**
UHS	2.10%	2.72%	3.12%	2.95%	3.03%	1.89%	2.49%	1.59%	1.81%	1.31%	1.65%		2.54%	2.24%	1.42%
National Average	4.15%	6.09%	6.89%	8.37%	7.62%	7.61%	7.63%	7.01%	6.99%	7.22%	7.60%		6.37%	5.31%	5.27%
Highest Trust	29.13%	26.11%	34.78%	37.23%	37.69%	33.31%	41.03%	32.28%	32.97%	31.03%	31.82%		37.23%	41.03%	32.97%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%
Inpatient and day case															
	Q1 201516	**Q2 201516**	**Q3 201516**	**Q4 201516**	**Q1 201617**	**Q2 201617**	**Q3 201617**	**Q4 201617**	**Q1 201718**	**Q2 201718**	**Q3 201718**	**Q4 201718**	**201516**	**201617**	**201718**
UHS	1.33%	0.88%	1.41%	1.07%	1.08%	1.23%	0.75%	0.79%	0.72%	0.77%	1.14%		1.18%	1.00%	0.86%
National Average	3.30%	1.43%	1.48%	1.47%	1.44%	1.56%	1.53%	1.51%	1.37%	1.52%	1.58%		1.80%	1.24%	1.23%
Highest Trust	21.05%	9.34%	10.00%	11.11%	10.55%	13.01%	8.59%	9.54%	17.78%	12.50%	26.19%		21.05%	13.01%	26.19%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%

Patient outcome indicators					
	2014/15	2015/16	2016/17	2017/18 YTD (Jan Inclusive)	2017/18 benchmark
Emergency readmissions, within 28 days (as average of monthly %)	10.40%	10.10%	10.59%	10.83%	<=10%
Hospital Standardised Mortality Rate (HSMR) University Hospital Southampton NHS Foundation Trust	105.19	102.5	95.4	95.57	100
Hospital Standardised Mortality Rate (HSMR) Southampton General Hospital	97.64	93.63	88.3	89.91	<100
Hospital Mortality Rate (%)	1.76	1.63	1.7	1.7	1.61
Patient Reported outcome measures. PROMS hip replacement data contributed	74.10%	86.70%	74.00%	63.00%	>=50%
Knee replacement data contributed	105.90%	103.90%	104.40%	70.00%	>=50%

Past annual figures benchmarked against their own FY Benchmark. Ongoing annual year benchmarked against latest month.

SHMI	January 15 - December 15		April 15 - March 16		July 15 - June 16		October 15 - September 16	
	Value	OD Banding	Value	OD Banding	Value	OD Banding	Value	OD Banding
UHS	0.95	2	0.96	2	0.96	2	0.95	2
National Ave	1	2	1	2	1	2	1	2
Highest Trust Score	1.17	1	1.18	1	1.17	1	1.16	1
Lowest Trust Score	0.67	3	0.68	3	0.69	3	0.78	3
	January 16 - December 16		April 16 - March 17		July 16 - June 17			
	Value	OD Banding	Value	OD Banding	Value	OD Banding		
UHS	0.96	2	0.95	2	0.94	2		
National Ave	1.00	2	1.00	2	1.00	2		
Highest Trust Score	1.19	1	1.21	1	1.23	1		
Lowest Trust Score	0.69	3	0.71	3	0.73	3		

VTE	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
UHS	95.04%	95.12%	94.61%	95.09%
National Ave (Acute Providers)	95.64%	95.45%	95.57%	95.54%
Highest Trust Score) (Acute Providers	100.00%	100.00%	100.00%	100.00%
Lowest Trust Score (Acute Providers)	80.61%	72.14%	76.48%	63.02%
	Q1 2017/18	Q2 2017/18		
UHS	94.48%	93.47%		
National Ave (Acute Providers)	95.09%	95.19%		
Highest Trust Score) (Acute Providers	100.00%	100.00%		
Lowest Trust Score (Acute Providers)	51.38%	71.88%		

PROMS

	2015/16	2016/17 Provisional
UHS	20.77	20.92
National Ave (All Providers)	20.88	21.32
Highest Trust Score (All Providers)	24.75	25.07
Lowest Trust Score (All Providers)	9.36	10.26

PROMS

	2015/16	2016/17 Provisional
UHS	15.06	16.42
National Ave (All Providers)	16.20	16.38
Highest Trust Score (All Providers)	19.97	19.88
Lowest Trust Score (All Providers)	8.33	8.62

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

	January 15 - Dec-15	April 15 - Mar-16	July 15 - Jun-16	October 15 - Sep-16
UHS	44.3	42.6	42.2	43.2
National Ave	27.6	28.5	29.2	29.8
Highest Trust Score	54.8	54.6	54.8	56.3
Lowest Trust Score	0.2	0.6	0.6	0.4

	Jan 15 - Dec-16	Apr 16 - Mar-17	Jul 16 - Jun-17

UHS	45.6	50.1	48.1
National Ave	30.3	30.9	31.2
Highest Trust Score	55.9	56.9	58.6
Lowest Trust Score	7.3	11.1	11.2

		2016/17	2017/18 YTD
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway		92.0%	89.7%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		89.6%	89.1%
All cancers- 62 day wait for first treatment from:	**Urgent GP referral for suspected cancer**	83.0%	86.3%
	NHS Cancer Screening Service referral	96.1%	93.8%
C.difficile variance from plan		-11.6%	-19.4%
Maximum 6-week wait for diagnostic procedure		99.3%	98.5%

Appendix three: CQUIN data

Clinical	CQUIN Scheme	CQUIN Target	National or Local Scheme	Financial Reward for Achieving Scheme
CCGs	Sepsis 2a	Screening all patients for sepsis screening is appropriate who arrive through the Emergency department and inpatients	National	£174,000
CCGs	Sepsis 2b	Initiate intravenous antibiotics within one hour of presentation, for those patients who have suspected severe sepsis, Red Flag or septic shock	National	£174,000
CCGs	Staff health and wellbeing - staffing	To achieve an improvement in two of the three NHSE annual staff survey questions using a baseline survey responses from the 2016 staff survey. Need to improve by 5% points in two of the following questions. 9a = Does your organisation take positive action on health and wellbeing 9b – In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	National	£233,000
CCGs	Staff health and wellbeing – healthy food	Achieve a step change in the health of food offered on the premises and submit national data based on existing contracts with food and drink suppliers	National	£233,000
CCGs	Staff health and wellbeing – flu vaccine	Achieve a 70% uptake on the flu vaccine for frontline clinical staff	National	£233,000
CCGs	Antimicrobial Stewardship 4a	Reduction in antibiotic consumption per 1,000 admissions	National	£175,000
CCGs	Antimicrobial Stewardship 4b	Empiric review of antibiotic prescription	National	£175,000
CCG's	E-Referral	Deliver directly-bookable services to all patients referred from GP and community services	National	£688,000

CCG's	Advice & Guidance	To set up and operate A&G services for non urgent GP referrals, allowing GP's to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative. A&G in the context of this CQUIN refers to structured, non urgent, electronic A&G provided via telephone, email or an online system	National	££698,000
CCG's	Improving services for people with mental health needs who present to A&E	Having identified the top 0.25% of people who attend emergency department (ED) most frequently, review and identify the cohort for whom mental health interventions would have the greatest impact. Review and develop a joint care plan for each person within this cohort including a focus on preventing avoidable ED attendances. Strengthen existing/develop new services to support this cohort. Reduce the number of attendances to ED frequent attendees by 20% ensuring this reduction is sustainable. Also improving the quality of ED diagnostic coding	National	£698,000
CCG's	Improving proactive and safe discharge	Map and streamline existing discharge pathway, roll out protocols in partnership across local systems (acute, community, NHS care home providers). Establishing a process for collection of baseline for responsiveness of community services to provide discharge to assess services. Undertake clinical audit of discharge to assess to ensure appropriate referrals We need to agree trajectories which reflect impact of implementation of local initiatives for: Achieving 70% national target for discharge to usual place of residence (without increasing admissions)	Local	£698,000
CCG's	Sustainability & Transformation Plans	Reinforcing the critical role providers have in developing and implementing local STP's. Encouraging providers and commissioners to work together to achieve financial balance and to complement the introduction of system control as STP Level	Local	£2,792,000

NHSE	Medicines Optimisation	Transitioning to new arrangements for the use and management of medicines commissioned by specialised services. Adoption of best value generic/biologic products of 90% new patients and 80% of existing patients	Local	£722,000
WHCCG	Shared Decision Making	To develop a condition specific resource to ensure that all treatment options are discussed with patients. TAVI and neuro to be used for the purpose of these years CQUIN. Training staff in how to work with patients to ensure they are aware of the treatment options. Developing a method of recording the data and assessing success	Local	£580,000
WHCCG	Chemotherapy Decision making	Using a specific group of patients, decisions regarding the start and continuation of further treatment to be made in direct consultation of further treatment to be made in direct consultation with peers and then as a shared decisions with the patient, these discussions to be documented. To review our existing chemotherapy practice in relation to the decisions for these groups of patients and put in place procedures to allow for effective and documented peer discussion where not currently in	Local	£190,000
NHSE	Spinal Surgery	To set up a regional documented Spinal MDT with the set-up of a regional policy to manage spinal emergencies including transfer and emergency imaging. All specialised and non specialised spinal surgery to be entered onto the British Spine Registry or Spine Tango and that all elective specialised spinal surgery within the network should have the agreement of the regional MDT either by individual or mandatory audit.	Local	£162,000
NHSE	Enhanced Supportive Care	Identify a cohort of patients newly diagnosed with a terminal illness and record how many are referred to the ESC service at the point of diagnosis. To involve the ESC team from an early stage and use cutting edge evidence based practice in supportive care and technology to improve communication. 80% of the eligible cohort to be referred to the ESC team	Local	£356,000

NHSE	CF Adherence	Extension of randomized trial providing services for cystic fibrosis patients	Local	£271,000
NHSE	HCV	Extension of 2016/17 CQUIN to manage the Infrastructure governance and partnership working across the healthcare providers	Local	£3,914,000
NHSE	SACT	Dose banding principles using local and national dose banding tables	Local	£309,000
NHSE	Rheumatic MDT	Development of coordinated MDT clinics for patients with multisystem auto-immune rheumatic diseases and to ensure data collection and compliance with existing NHSE commissioning policies	Local	£162,000
NHSE	Dental	100% attendance at Oral Surgery Network meetings	Local	£25,000
NHSE	Dental	Reviewing and improving as required the standard and appropriateness of dental referrals into secondary care. The work will be fed through the MCN and recommendations/improvements rolled out across the network group as appropriate. It is also a requirement that this should include an undertaking of an audit of referrals, including the quality of these referrals, , received to identify whether levels of treatment complexity are appropriate for secondary care services	Local	£25,000
NHSE	Public Health	Reducing inequalities and increasing overall coverage of screening programs. The CQUIN is relevant to three screening programs Breast, AA and Bowel	Local	£134,000
			Total	**£13,821,000**

Appendix four: Clinical audit and confidential enquiries data

	Total number of NCAs UHS were eligible to participate in (n=57)	Eligible (57)	Participated (55 = 96%)	% Actual cases submitted / expected submissions
1.	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	Continuous 100%
2.	BAUS Cystectomy	✓	✓	Continuous
3.	BAUS Nephrectomy Audit	✓	✓	Continuous
4.	BAUS Percutaneous Nephrolithotomy	✓	✓	Continuous
5.	BAUS Radical Prostatectomy Audit	✓	✓	Continuous
6.	BAUS Female Stress Urinary Incontinence Audit	✓	✓	Continuous
7.	BAUS Urethroplasty	✓	✓	Continuous
8.	Bowel cancer (NBOCAP)	✓	✓	100%
9.	Cardiac Rhythm Management (CRM)	✓	✓	Continuous
10.	Case Mix Programme (CMP)	✓	✓	
11.	College of Emergency Medicine (CEM)- Fractured neck of femur	✓	✓	In progress
12.	College of Emergency Medicine (CEM)- Pain in children	✓	✓	In progress
13.	College of Emergency Medicine (CEM)- Procedural sedation in adults	✓	✓	In progress
14.	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	✓	✓	In progress
15.	Coronary Angioplasty (NICOR)	✓	✓	100%
16.	Diabetes Foot-care	✓	X	Incompatible data systems
17.	Diabetes in pregnancy (NPID)	✓	✓	100%
18.	Diabetes Transition	✓	✓	100%
19.	Diabetes Inpatient Audit (NADIA)	✓	✓	100% one day snapshot
20.	Diabetes (Paediatric) RCPCH NPDA	✓	✓	In progress
21.	Elective surgery (National PROMs Programme) hips and knees	✓	✓	85% continuous
22.	Endocrine and Thyroid National audit	✓	✓	Continuous
23.	Falls and Fragility Fractures Audit Programme (FFFAP) national hip fracture database	✓	✓	Continuous
24.	Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database	✓	✓	Continuous
25.	Falls and Fragility Fractures Audit Programme (FFFAP) national inpatient falls	✓	✓	continuous
26.	Head and Neck Cancer Audit	✓	✓	In progress
27.	Inflammatory Bowel Disease (IBD) programme - Biological therapies adult and paeds	✓	✓	In progress
28.	Learning Disability Mortality Review Programme (LeDeR)	✓	✓	
29.	Lung cancer (NLCA) (LUCADA)	✓	✓	Continuous

30.	Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	An average of 1400 cases per year
31.	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality	✓	✓	100%
32.	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Mortality	✓	✓	100%
33.	Medical and Surgical Clinical Outcome review programme NCEPOD – cancer in children and young adults (0-25 years)	✓	✓	100%
34.	Medical and Surgical Clinical Outcome review programme NCEPOD – Peri-operative diabetes	✓	✓	ongoing
35.	National Adult Cardiac Surgery Audit	✓	✓	In progress
36.	National Audit of Dementia	✓	✓	Continuous
37.	National Cardiac Arrest Audit (NCAA)	✓	✓	100%
38.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - *Secondary Workstream*	✓	✓	continuous
39.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - *Pulmonary Rehabilitation Audit*	✓	✓	continuous
40.	National Comparative Audit of blood Transfusion 2015 Audit of Patient Blood Management in Scheduled Surgery (NCABT)	✓	✓	100%
	National Comparative Audit of blood Transfusion 2016 Audit of Red Cell and Platelet Transfusion in Haematology	✓	✓	100%
41.	National Clinical Audit of Specialist Rehabilitation for patients with complex needs following major injury (NCASRI)	✓	✓	
42.	National Emergency Laparotomy Audit (NELA)	✓	✓	continuous
43.	National Heart Failure Audit	✓	✓	continuous
44.	National Joint Registry (NJR)	✓	✓	90%
45.	National Maternity and Perinatal Audit	✓	✓	100%
46.	National Ophthalmology Audit	✓	✓	In progress
47.	National Prostate Cancer Audit (NPCA) (2nd year)	✓	✓	100%
48.	National Vascular Registry (NVR)	✓	✓	In progress
49.	Neonatal Intensive and Special Care (NNAP)	✓	✓	
50.	Neurosurgical National Audit programme	✓	✓	
51.	Oesophago-gastric cancer (NAOGC) (NOGGA)	✓	✓	continuous
52.	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	In progress
53.	Renal replacement therapy (Renal Registry)	✓	✓	100%
54.	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP *Clinical patient Audit*	✓	✓	207 expected every quarter
55.	Sentinel Stroke National Audit Programme (SSNAP) SSNAP *Post Acute Organisational Audit*	✓	✓	90%
56.	Serious Hazards of Transfusion (SHOT) UK National haemovigilance scheme *(this is not an audit but an incident reporting database)*	✓	✓	All incidents
57.	UK Parkinson's	✓	X	Data not submitted

Appendix five: Registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. It ensures that health and social care services provide people with safe, effective, compassionate, high quality care and encourages care services to improve.

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

Regulated activity: Surgical procedures
Provider conditions: This regulated activity may only be carried on at the following locations:

- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

Regulated activity: Treatment of disease, disorder or injury
Provider conditions: This regulated activity may only be carried on at the following locations:

- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD
- Lymington New Forest Hospital - Surgical patient pathway and outpatients Wellworthy Road Lymington Hampshire SO41 8QD

Regulated activity: Maternity and midwifery services
Provider conditions: This regulated activity may only be carried on at the following locations:

- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton, SO40 7AR
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA

Regulated activity: Diagnostic and screening services
Provider conditions: This regulated activity may only be carried on at the following locations:

- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD
- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton, SO40 7AR

Regulated activity: Transport services, triage and medical advice provided remotely
Provider conditions: This regulated activity may only be carried on at the following locations:

- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

Regulated activity: Assessment or medical treatment for persons detained under the 1983 (Mental Health) Act Provider conditions: This regulated activity may only be carried on at the following locations:

- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

UHS has no conditions on registration and the Care Quality Commission has not taken enforcement action against University Hospital Southampton NHS Foundation Trust during 2014-2017.