Southampton NHS
University Hospitals NHS Trust

Our Quality Account
2010/2011

Contents

Foreword

Welcome to our Quality Account for 2010/11. As a hospital Trust, we strive to ensure continuous improvement in the quality of our services for patients. This report sets out our progress and information about the quality of services we provide for this year, and our priorities for quality improvement for the forthcoming year.

The Trust Board is committed to improving quality as a top priority. We define this quality as being world-class providers of patient experience, patient safety and clinical outcomes. We have a proactive and rigorous approach, using our Patient Improvement Framework (PIF) (appendix 1) to prioritise and drive the achievement of quality.

As one of the largest acute teaching Trust hospitals in the UK, it is our responsibility to deliver our service around the needs of our patients and our customers. Over the years we have listened carefully and developed our services based on these needs.

As a measure of our success, in 2010/11 more patients than ever before chose Southampton University Hospitals NHS Trust (SUHT) for their health care needs and despite the highest patient volumes seen, we continue to significantly improve the quality of our services, reduce the infection rates for C-Diff and MRSA, meet national waiting time targets for most specialities and reduce the overall number of complaints.

Our staff experience has significantly improved, evidenced by our staff survey results and we made clear progress in moving towards the 2020Vision with ever-greater levels of work in our defining specialist services.

In conclusion, I want to emphasise the commitment from the entire Trust to a strategy based on quality and safety that will deliver an improved patient experience. This is endorsed not only by the Trust Board but at every level in the organisation.

The improvements delivered over the last year are indicative of the engagement and active participation throughout the Trust. There is recognition of the important positive impact quality improvements have on our patients' experience. We will continue to evolve our quality plans to ensure we deliver an ever improving service.

To the best of my knowledge and belief, and in accordance with the regulations governing quality accounts, the information contained in this document is accurate and can be relied on.

Signed

Chief Executive
Date: 26th April 2011

Introduction to Southampton University Hospitals NHS Trust:

Our Vision

Our 2020Vision is:

'To be a world-class centre of clinical academic achievement, where staff work together to ensure patients receive the highest standards of care, and the best people want to come to learn, work and research.'

To continue to support delivery of our 2020Vision, the Trust has three priorities for our strategic objectives which wholeheartedly place clinical quality as a key priority throughout the Trust. This followed a full review and consultation process during 2010, through Trust Executive Committee and Trust Board, to set our focus for future years:

SUHT: Our strategic objectives for 2010/11

- SO1 Trusted on quality
- SO2 Delivering for taxpayers
- SO3 Excellence in healthcare

The Trust continues to make good progress toward achieving our 2020Vision through the balance of delivering excellence, quality and value to tax payers.

Our Quality Governance Strategy gives clear direction and a shared vision for how we ensure that quality is a priority at all levels in the Trust. It also outlines how Quality Governance is organised within the Trust as part of a whole-system approach to improving standards. Our Patient Experience Strategy and our Patient Safety Strategy support the strategy and our 2020Vision. Our model for delivery is through our innovative Patient Improvement Framework which, since 2007, has set out priorities for patient safety, patient experience and clinical effectiveness.

The framework is clinically supported and driven by our divisions and the board. By listening and learning from patient and staff feedback, and consulting with our commissioners, the priorities are reviewed and updated every year. Improvement programmes with targeted clinical metrics are then developed against these priorities. Our aspiration is to consistently surpass patient expectation.

Quality for patients

Improving performance in clinical quality for 2010/11 has remained a top priority and focus for the board. We are determined to go further and faster to be a high performing Trust. This year has seen some significant achievements, and in particular I would note the following:

1. Improved levels of patient satisfaction: more than 95% patients rated the Trust care good, very good or excellent, and 96% of our patients would recommend us to family and friends

2. A 25% reduction in hospital acquired pressure ulcers

3. 90% of all staff said their role makes a difference to patients. This rises to almost 10 out of 10 nurses saying they feel that their role makes a difference to patients

4. The Trust remains in the top 20% of employers for staff job satisfaction and for having fewer staff saying they intend to leave

5. A further reduction in Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia from 7 cases in 2009/10, to 5 in 2010/11; and in C. Diff reducing from 123 cases in 2009/10, to 89 cases in 2010/11, which places us as a top performer in the country.

6. Improvements in standards for same sex accommodation from 14% patients required to share mixed sex accommodation in March 2010, reduced to 4.7% in March 2011, which has resulted in improved patient feedback

7. In-hospital mortality continues to fall, from 1967 inpatient deaths (excludes Countess Mountbatten hospice) in 2008/09, to 1715 in 2010/11.

8. Unconditional registration with the Care Quality Commission (replaces compliance with the core Standards for Better Health requirements).

We will continue to explore more efficient and effective ways to support care delivery and quality improvement and ensure that this is underpinned by research, innovation and clinical audit. We have set out our top future quality priorities against safety, experience and clinical outcomes, which have been discussed and consulted on widely. The board will monitor progress and drive the delivery of these priorities as part of our quality journey to excellence.

The board would like to congratulate everyone for their hard work and professionalism in delivering such high standards of care, improving patient outcomes and their focus on patient safety. The quality improvements made this year will certainly set a precedent for the next.

Quality for our staff

Supporting our staff is key to achieving success with our 2020Vision. One of our core goals to achieve this is to improve staff experience and strengthen staff engagement. Progress is measured through the results of annual staff attitude surveys, which include questions on how staff rate the Trust as a place to work year on year, and the pride which they take in working here. Examples of our work to increase organisational effectiveness around quality and to embed quality in the Trust in this area include:

Staff Satisfaction and feedback: The findings of the staff attitude survey have also enabled the Trust to prioritise action on improving two-way communication with staff, increasing the take-up of equality and diversity training. Overall staff engagement has increased from below average in 2009 to above average in the 2010 national survey with many areas scoring in the top 20%.

Staff health and wellbeing: A wellbeing forum is now established with staff representation across the Trust, to develop effective ways of identifying and reducing workplace pressures experienced by staff. The Trust's return to health programme, with action plans for all managers to address wellbeing as an integral part of their responsibilities, is now proven to show it reduces overall absence length. The 12 month rolling average rate for absence for the Trust is 3.6% currently.

Leadership: The Trust's education department (IDEAL) delivers the Trust's Learning and Development strategy, with a focus on personal and team development, and building competence in change management and leadership. In 2010 we launched our own Leadership Academy to develop our clinical leaders.

Appraisals: Ensuring that all staff have clear personal objectives and development plans, underpinned by regular review meetings. We have a target of ensuring 85% of staff have appraisals which we are working hard to achieve. There is also an increasing emphasis on the quality of the process which will be audited between 2011/2012.

Through all of this work we want to ensure that our staff have pride in their jobs and are proud to work at SUHT.

Our quality management systems

Progress against each of our strategic objectives is reported to Trust Executive Committee and Trust Board quarterly. Supporting each of the strategic objectives are key priority measures of success, to help us assess our progress towards the 2020Vision. For the strategic objective 1 Trusted on Quality, our measures of success are

- Our NHS Litigation Authority rating
- Our compliance with the Care Quality Commission
- Progress in meeting our Cquin standards
- Managing our bed capacity, and
- Ensuring that we meet the Monitor compliance framework requirements.

These measures are reflected in the sections that follow.

How we monitor and report on quality:

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

There is regular reporting of our Hospital Standardised Mortality Rate (HSMR) to Trust Board. This is also a priority that has been identified for next year.

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

We hosted the Trust's fourth annual clinical effectiveness conference in November 2010, celebrating audits that have led to improved patient outcomes, safety and experience, with the National Clinical Director for Trauma as keynote speaker.

The patient improvement framework focuses on patient safety, patient experience and patient clinical outcomes; the Trust sets improvement targets on the quality priorities each year. These common themes are also mirrored in the Trust's committee structures and high level reporting practices. An integrated approach ensures that staff understanding of quality is embedded throughout the organisation and reflected in the Trust's quality dashboards and key performance indicators.

Assurance framework

The Trust Board is accountable for the systems of internal control and risk management. The chief executive is responsible for ensuring the delivery of a high quality service to patients and for the delivery of quality and performance targets.

For operational delivery, this responsibility is delegated to the medical director and the director of nursing for governance and quality and to the chief operating officer for performance targets.

Board engagement

Over the last year, the Trust Board has actively engaged in increasing understanding of the key components of quality, for example through board development seminars; taking clinical visits to the divisions; talking to frontline staff and ensuring the Trust is compliant with the Clinical Quality Commission's (CQC) 'Essential Standards of Quality and Safety'.

The Audit & Assurance Committee now devotes half its agenda to quality issues which require an in-depth review and scrutiny.

The board has developed a 'quality pyramid', which integrates financial and quality high level performance to ensure that effective management of financial resources does not have a negative impact on the delivery of a high quality service.
The Trust Board has reviewed the recommendations of nationally relevant external reports and publications for quality, and taken forward actions as appropriate.

Action for this year is to:

- embed the program of executive quality walk-rounds;
- develop a framework to provide patient stories at Trust Board;
- tackle and report on the five areas that our patients say they feel we could improve;
- develop the new integrated report on complaints, patient feedback and incidents quarterly for Trust Board;
- continue to listen to patients and aim to surpass their expectations.

Board reports

The Trust Board gains assurance on quality in various ways, via: -

- the monthly key performance indicator (dashboard) quality report;
- the monthly rolling program of patient improvement framework reports covering:
    - • patient experience
    - • patient safety
    - • clinical outcomes / effectiveness
    - • the quarterly regulatory assurance report
    - • Board visits to divisions to review delivery of the quality agenda.

In addition, the Audit & Assurance Committee and the Trust Executive Committee receive copies of minutes from the Trust's Quality Governance steering group.

Clinical standards accreditation

The attainment of National Health Service Litigation Authority (NHSLA) standards, which embed safety into practice, is an important achievement for the Trust. We met level 2 for Southampton General Hospital in December 2008, and in Maternity Services in September 2010.

NHSLA is a national body which works to improve risk management practices in the NHS.

The next section explains in more detail our progress to date, and how we plan to achieve the priorities for next year

Our progress and top priorities for quality improvement in 2011/12

This section of our Account discusses our progress in the priority areas we chose last year, and the priorities we have chosen for 2011/12.

How we agree our priorities for quality improvement

Deciding our priorities for improvement is a real team effort. The development of this account has been shared widely both within the Trust with our staff, and with our primary care Trust colleagues and community partners and other key stakeholders.

In March 2007 SUHT Trust Board agreed a Patient Improvement Framework (PIF) and this framework continues to form the basis of our Quality Governance assurance. The PIF is updated and reviewed annually. It is designed to reflect a broad approach to quality, to include national drivers, for example, Lord Darzis' 'High quality Care for All' command paper, and more recently the Department of Health Outcomes Framework for 2011. It also is prioritised to our local community quality priorities included in our PCT commissioner contract, and to our own risk register and assurance framework. This approach helps us to be sure that we focus on the most appropriate areas for our patients. The most recent 2010/11 Patient Improvement Framework is at annexe A.

Communication is a key overarching theme that we continue to work on with our staff and patients. The patient improvement framework update reflects the staff feedback we received during the development of the quality account. To determine these priorities, we began consulting with our staff in November 2010.

We assessed each initiative in terms of:

- impact on quality, considering the improvement in safety, outcomes and experience;
- feasibility, as a reflection of the ease of implementation, resources required and likely time to completion or delivery.

Review of our progress in 2010/11

Patient Safety; our performance in 2010/11:

Thromboprophylaxis – preventing venous blood clots

Our goal in 2010/11 was: To achieve documented risk assessments in 90% of patients for appropriate venous thromboprophylaxis (VTE) by quarter 4.

VTE prevention was identified as a top clinical priority for the NHS in the 2010-11 Operating Framework. It had already been identified as a top safety priority in the Trust. In 2010-11 the Commissioning for Quality and Innovation (CQUIN) payment framework made a proportion of our income conditional on a VTE-related requirement, and a NICE quality standard was issued.

Key requirements for this programme are to:

- ensure all adult patients admitted to the Trust undergo a risk assessment for VTE based on the Department of Health tool [with 90% the required minimum];
- provide preventative measures in accordance with the risk assessment;
- provide information to patients on VTE;
- ensure staff are provided with education and training on VTE;
- audit our performance and ensure improvement where required;
- submit data on performance from all admissions on the national database (Unify).

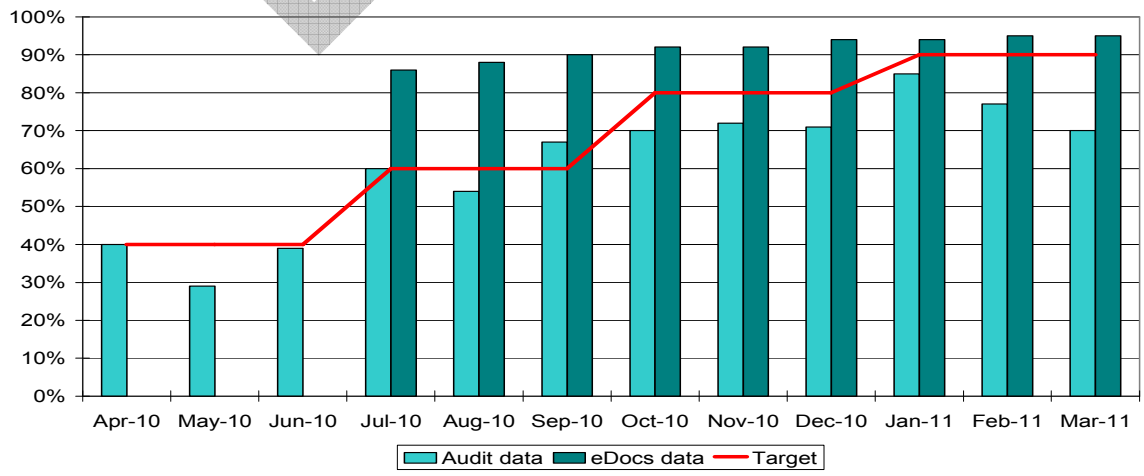
An extensive programme has continued through the year with progress across all six requirements. By March 2011 our e-records demonstrated that 95% of adult admissions undergo a risk assessment but we have not yet achieved e-data submission for all areas, so this is 95% of the patients where we have data. Our Unify submission for year-end, which is based on all our patients was 83.75%.

Manual audits for the year have shown steady improvement on correct prophylaxis (treatment) with an average of 88% receiving appropriate medicine prophylaxis and 85% appropriate mechanical prophylaxis over the final quarter.

SUHT: Our VTE risk assessment progress 2010/11

(sample: patients where e-data is available)

Documented risk assessment on admission



Reducing the incidence of pressure ulcers

Our goal in 2010/11 was: To achieve a 25% reduction in grade 3 and 4 hospital acquired pressure ulcers.

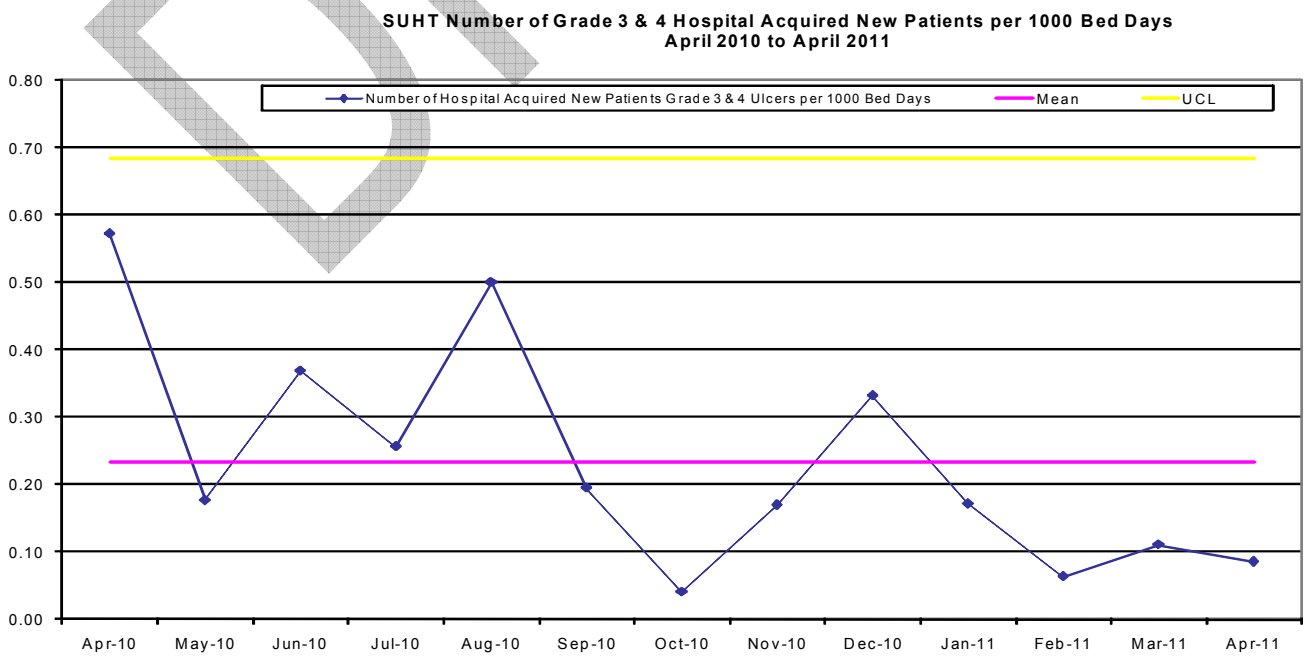
Pressure ulcers are graded using a national system from grade 1 to grade 4. Grade 4 is the most serious. The Trust achieved the 25% reduction in grade 3 and 4 pressure ulcers - 78 incidents compared to total number of 81 for last year. This is a significant achievement and one that has an impact not only on patient safety but also their experience. Such a decrease also reduces cost and increases productivity: a patient with a grade 4 pressure ulcer costs an additional £11,000 through increased length of stay and dressings.

Ward managers and matrons review the occurrence of hospital acquired pressure ulcers, and now present their root-cause analysis detailed investigations to a formal panel meeting. This ensures that lessons are learnt locally, and themes and trends shared across the Trust.

This reduction was achieved over the last six months of the year. In July 2010 we took part in a Department of Health led pilot project to use a new approach to service improvement, called rapid spread methodology. We called our project the Turnaround project. Patients identified as at high risk of developing pressure ulcers through the Braden assessment tool were included in a structured programme of two hourly nurse rounds to address pressure relief and skin care. All our general wards participated in the project and acquired full or partial accreditation dependent on the extent to which they implemented Turnaround. Six wards were given exemplar status for the way in which they embraced the project and their success in achieving no further reported hospital acquired pressure ulcers.

We have also seen a significant reduction in grade 2 hospital acquired pressure ulcers. This is a key quality measure where we have demonstrated significant improvement.

SUHT: Our pressure ulcers reduction progress 2010/11



Patient Experience: Our performance in 2010/11

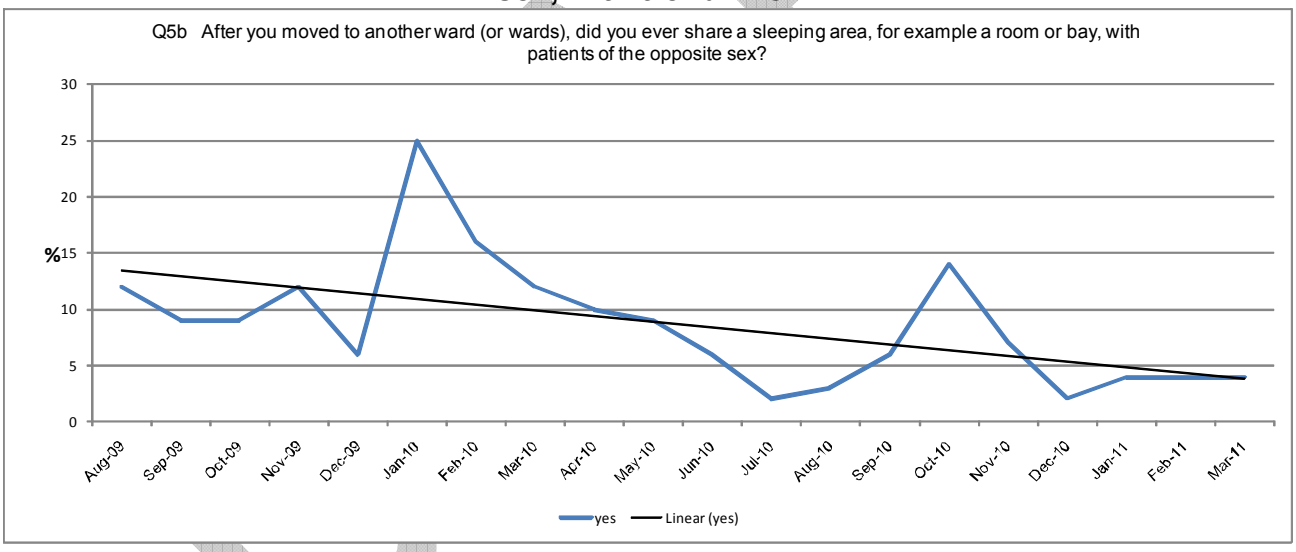
Our goal in 2010/11 has been to ensure patients have the best experience of our facilities, care and treatment as possible. We are delighted to be able to report that 96% of patients consistently expressed high levels of satisfaction with their care and 95% of patients would recommend the hospital to family and friends. 92% of patients reported always being treated with privacy and dignity by our staff. Performance in two of our specific target areas is detailed below.

Same Sex Accommodation

Following our comprehensive improvement programme in 2009/10, we are proud of our sustained achievements in this area. In 2010/11, we have continued to ensure over 99% of inpatient clinical areas are consistently compliant with Department of Health same sex accommodation regulations.

We survey our patients' experience of same sex accommodation with over 200 patients every month. Less than 5% of patients now report sharing accommodation.

% of patients reported sharing ward accommodation with patients of the opposite sex, with trend line.



Complaints

With over 120,000 patient episodes a year, our complaint rate is very low at 0.5%. We have improved our 2010/11 performance in responding to complaints about care and treatment. We have consistently exceeded our 75% target of responding to complainants in the agreed timescales and were over 90% in 9 of the 12 months of this year.

We are also seeing a downward trend in the number of complainants who return dissatisfied after our initial response, indicating an improvement in the quality of our investigations and responses.

We use feedback from all complaints and other patient feedback to improve our services.

Patient Outcomes - Our performance in 2010/11

For 2010-11 there were three priority areas:

- Developing, using and improving on locally led outcome measures;
- Participating in nationally set Patient Reported Outcome Measures (PROMS), with a focus on:
- Reducing the Trust's Hospital Standardised Mortality Rate (HSMR)

We intend to continue with these for 2011-12.

Locally led outcome measures

The Trust has a wide range of services and across all areas there is a need to reflect on outcomes. In 2010 we reported progress in a number of areas, including improving discharge summaries, treating patients who have suffered heart attacks, and stroke care. Updates on these are detailed below along with two further examples of 'locally led' outcome reports received by the board: trauma care and transcatheter aortic valve implantation (TAVI).

Improved discharge summary

We have continued to develop our discharge summaries for GPs and, in audit by our local GP practices, achieved above average levels of completeness and legibility. However, we recognise that there is more work to do to ensure that the summaries reach our GP practices quickly and consistently. We are working closely with our PCT colleagues to develop the use of electronic summaries with GP practices that are currently not able to access the systems available locally.

April 2010 Results of Survey By local GP Practices On Discharge Summaries Received:

SHIP* Provider Trusts	Trust	Trust	Trust	Trust	Trust	SUHT	Trust	MEAN
A Completeness	66%	64%	62%	64%	58%	78%	61%	66%
B Timeliness	16%	26%	9%	21%	52%	11%	50%	20%
C Legibility	93%	84%	88%	100%	88%	99%	99%	92%

*SHIP: Southampton, Hampshire, Isle of Wight, Portsmouth PCT area

Developing a fully functioning heart attack centre

Our heart attack centre is now established, and offers 24 hour and seven day a week emergency angioplasty treatment. An additional consultant has been appointed in 2011, and our plans include expansion to cover patients from Salisbury. In 2011 over 91% of our patients received treatment for their heart attack within the national target time of 90 minutes from arrival in hospital.

Stroke Service update

There has been a focus on stroke in the last financial year. SUHT was seen to be a poor performer a year ago and we have made enormous improvements.

A key indicator is the stroke national vital sign target, which is defined as the percentage of patients spending more than 90% of their time in hospital in a specialist stroke unit. Access to a specialist stroke unit improves outcomes for patients who have suffered a stroke. We have improved from around 40% of our patients spending more than 90% of their time on a stroke unit in April 2010, to 85% patients in March 2011. This is a fantastic achievement and a result of major service redesign.

We now admit stroke patients directly to our acute stroke unit 24/7 and the percentage of patients following this pathway increases month on month. Changes in the overall stroke patient care pathway should show further improvements in the quality of our stroke care; in particular we will be developing early supported discharge for stroke patients, who will be able to have their specialist stroke rehabilitation at home under certain circumstances.

We continue to perform strongly and meet the targets for our 7 day transient ischaemic attack (TIA) service.

As a result of the work we have done on the service, we were the winner of the Service Improvement Award at the Hospital Heroes presentations 2010-11.

Trauma Audit and Research Network (TARN)

TARN provides a national framework for the collection, submission and scrutiny of trauma survival data by hospitals and crucially, supports comparison with other hospitals. The framework allows a common approach across different centres which supports systematic clinical audit. This was taken to the Board as an example of locally led outcome data because of our intention to develop as a major trauma centre.

TARN submissions allow a wide range of reports but a key indicator of outcomes is presented as survival rate. For SUHT for the period January 2009 to December 2010, we had 3.5 additional survivors for every 100 trauma patients treated. This means, allowing for severity and other diseases, our patients did better than would be expected. These results place us in the top third of Trusts participating in TARN.

Transcatheter aortic valve implantation (TAVI)

TAVI is a recently developed intervention that can be used as an alternative to standard surgical aortic valve replacement. The procedure is performed on the beating heart without the need for a sternotomy or cardiopulmonary bypass. TAVI is performed in approximately 35% of the patients referred for possible TAVI treatment. This procedure is considered for patients who would be at too high a risk to undergo conventional aortic valve replacement. A review by the network and specialist commissioning in Nov 2010 concluded that the TAVI programme in SOTON was of a very high standard and comparable to centres with greater experience.

SUHT has a relatively small number of patients so it is not possible to draw statistically significant conclusions. However, indications are that outcomes are broadly in line with those in other UK TAVI centres. One year survival rates appear to exceed those achieved in the PARTNER trial.

SUHT TAVI Outcomes to 2011

	Number/percentage (25 in SUHT)	Benchmark
Procedural success	24	98% (TAVI Registry)
Emergency surgical AVR	1 patient	0.7% (TAVI Registry)
Deferred to apical TAVI	1 patient	
30 day survival	92% (2 patients)	95% (PARTNER trial)
1 year survival	80%	69.3% (PARTNER trial)
Peri-procedural MI	0	1% TAVI Registry)
TIA	0	0.6% (TAVI Registry)
Endocarditis	0	
Pacemaker required	4 (16%)	6% (TAVI Registry)
Creatinine >265	5	
Renal replacement therapy	2	
Stroke	1 (4%)	5% (PARTNER trial)
Vascular surgical repair	1 (4%) (this 88 yr old is still doing well)	16.2% (PARTNER trial)

Patient Reported Outcome Measures (PROMS)

These are nationally defined measures across four surgical interventions, of which SUHT undertakes two: hip replacement; knee replacement. It is expected that the range of interventions included will expand.

Patients are asked about their health related quality of life before and several months after their operation. A disease-specific and a more general measure are used.

SUHT data show similar results to the national picture, with the majority of patients achieving health gains from their hip or knee replacement but with a small number (7% for hips, 11% for knees) reporting a deterioration post-operatively.

SUHT PROMS results April 2009 to July 2010

	Hip replacement		Knee replacement	
	England	SUHT	England	SUHT
Cases included	21,340	109	23,907	111
Improvement in index made – ie what difference the operation made (Index is 0 to 1. 1 being perfect health)	+0.405	+0.400	+0.289	+0.263
Patients who after the operation said: Health improved No change Health worsened	 87.0% 6.2% 6.7%	 86.0% 7.3% 6.4%	 77% 11% 11%	 76% 13% 12%

NB numbers included mean that there are no statistically significant differences between SUHT data and national data.

Hospital Standardised Mortality Rate (HSMR)

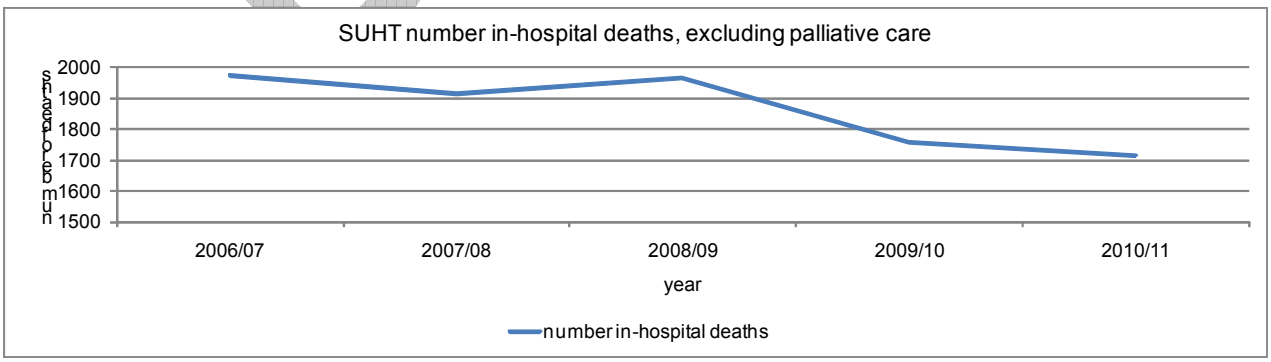
We have made some good progress in improving our Trust patient mortality rate, however there is still more work to do and so HSMR remains our top Outcome priority for the coming year 2011/12.

Our progress last year:

In 2010/11, our Aim was:
To reduce the Trust's overall HSMR to 90 by the end of March 2011 (bench marked against the revised 2009/10 data).

In 2010/11 more patients than ever before chose Southampton University Hospitals NHS Trust (SUHT) for their health care needs. Despite the highest patient volumes seen, the number of patient deaths in the Trust has continued to fall gradually over the past 5 years.

SUHT in-hospital deaths, excluding palliative care 2006-2011



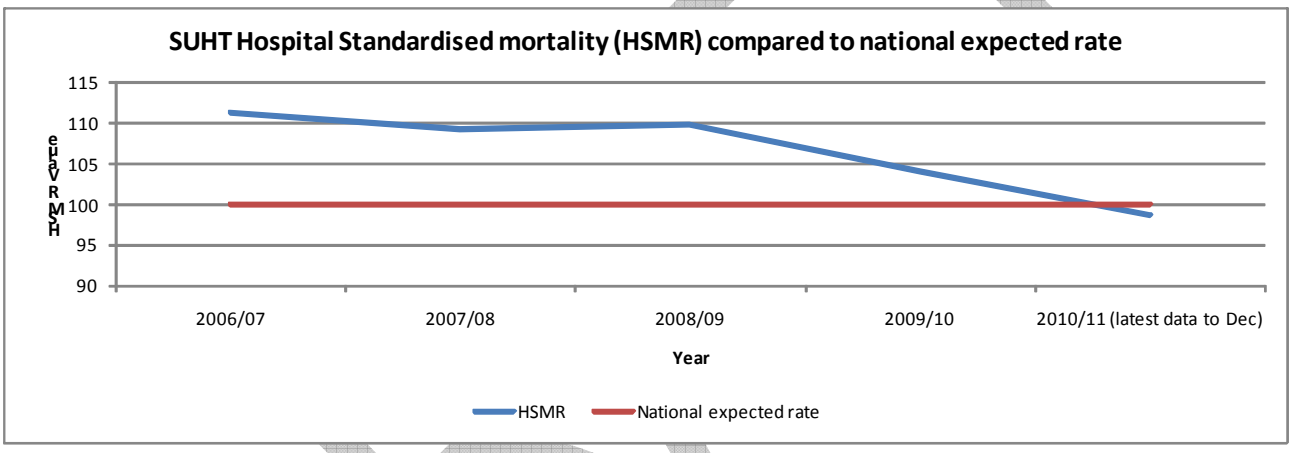
In 2010/11 the Trust treated 129,199 patient admission spells. 1715 deaths represents a percentage of 1.3% of our patients.

Reducing the Trust's Hospital Standardised Mortality Rate

The HSMR is a benchmarking ratio, of observed deaths / expected deaths (x100). It is used as an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect compared to the general population. We can use information presented in this way to help us compare our performance fairly, for example with other hospitals of similar size or type nationally, or in a similar patient catchment area.

Of the two measures relating to HSMR, the Trust is performing above average in terms of the national expected rate (96.7 as against 100); but below the national average of 90. This means that our HSMR will be on the upper edge of the national 'as expected' category for mortality next year. Our priorities for patient outcomes for 2011/12 reflect our emphasis on achieving an HSMR in line with the national average.

Our HSMR results by site from 2005 to 2011, source Dr Foster Intelligence



Our relative risk score is one of the highest for our Trust type, meaning that our patients are scored by Dr Foster as being sicker than average. Southampton is a regional tertiary centre and our patient acuity audits confirm that our patients are expected to be more complex than average.
In-depth review of the clinical data for all our patient groups with a higher than expected HSMR continues. Detailed clinical review with the Dr Foster Intelligence Unit and Imperial College for both the obstetric and palliative care teams has shown no cause for concern. Countess Mountbatten Hospice does have a lower proportion of coded non-elective admissions than would be expected for a hospice facility, being 70% rather than an expected 85%. Changing our approach to coding the patients admitted here will have no adverse effect on their care, but would reflect the standards of care we provide more accurately. However we are not complacent, and our work next year will continue to focus on both clinical development and information systems support, to better understand and improve our mortality rate data.

Our areas of work to improve our HSMR during last year focused on practical developments, and on improving our communications and information systems that support patient care.

Identifying deteriorating patients more quickly

We have improved our processes for the escalation of care for patients showing deterioration, by increased training for the nursing and medical staff. This includes using the modified early warning monitoring system (MEWS) tool. Use of MEWS has increased by nearly 20% since Dec '09, and directly improves planning and care for these unwell patients.
As a result of using the MEWS system, while our % rates of unplanned admissions into general intensive care have increased to higher than the national average, being 31% (nationally 21% [National Confidential Enquiry into Patient Outcome & Death NCEPOD 2005], unexpected deaths and delays in admission to intensive care have all fallen.

Further information about this story can be found in our patient safety report on our website.

Safer surgical operations

We implemented the World Health Organisation 'Safer Surgery Checklist' in all our operating theatres as normal daily practice. Our audits earlier this year showed that the checklist was part of normal practice in all areas except two: emergency and cardiac theatres. Following further work with the relevant teams, the checklist was re-audited. Near full compliance to the checklist has now been demonstrated.

Safety in medicines

We have improved the information we give divisions about incidences relating to medicine reconciliation and allergy recording for their action to maintain improvement. We are also focusing on missed medication doses. We have audited our wards to understand why doses are missed and are then taking appropriate action to prevent these occurrences. A 'Critical Medicines' list has been developed for medication that should not be omitted without medical instruction, and the systems of supply have been reviewed to ensure that a delay in the supply chain is not a cause for missed dose. We have also reduced the number of medicine administration errors.

Improving communications

We are developing an electronic medical handover process, linking to patient acuity monitoring and acknowledgement of test results with better clinical information (primary and secondary diagnoses to support risk stratification) on our electronic patient information systems and electronic discharge summary systems. This will enable clinical staff to focus on the most ill patients first.

Our top priorities for 2011/12

Summary

Safety:

Priority 1: VTE: VTE (venous thromboembolism) prevention was identified as a top clinical priority for the NHS since 2010, and in our Trust. We will continue to work to achieve risk assessments in 90% of our patients for appropriate venous thromboprophylaxis by quarter 4

Priority 2: We want to continue to improve our reduction of pressure ulcers to support our ultimate aspiration to reduce avoidable pressure ulcers to zero. We will aim to reduce grade 3 and 4 hospital acquired pressure ulcers by a further 25% on last year's outturn, and to reduce grade 2 hospital acquired pressure ulcers by 20%.

Priority 3: Is to reduce the number of avoidable falls that result in high harm by 50%.

Experience:

Priority 4: Nutrition and hydration – Patient food, nutrition and hydration is a top priority for us. We will work with our catering provider to ensure over 90% of patients report hospital food to be good, very good or excellent. In addition, we will ensure over 95% of patients receive nutritional screening (MUST) within 24 hours of admission.

Priority 5: Communication – We want to keep patients, relatives and carers fully informed about their treatment and care & involve them in decisions, so we aim to reduce complaints and concerns relating to communication by 20% (from 45 to 36 p.a where communication and information is the primary concern)

Outcome:

Priority 6: Although we have made good progress in reducing our patient mortality rates, there is still work to do, and this will remain a key priority for patient outcomes next year. We will continue to drive down the hospital standardised mortality rate (HSMR) to below the national expected rate by March 2012.

Priorities for Patient Safety for 2011/12

Reducing VTE (venous thromboembolism)
VTE (venous thromboembolism) prevention was identified as a top clinical priority for the NHS since 2010, and in our Trust. We will continue to work to achieve risk assessments in 90% of our patients for appropriate venous thromboprophylaxis by quarter 4

Reducing Pressure Ulcers
To reduce grade 3 and 4 hospital acquired pressure ulcers by a further 25% on last year's outturn and to reduce grade 2 hospital acquired pressure ulcers by 20%.

The rationale for this priority is to continue to improve our reduction of pressure ulcers to support our ultimate aspiration to reduce avoidable pressure ulcers to zero. This is also a contractual requirement and a goal of Safety Express, a DH led initiative in which the Trust is participating.

An annual plan of action will be developed to support the delivery of this improvement priority and will include:-

- continuing with the Root Cause Analysis panels for grade 4 pressure ulcers but also including grade 3s;
- fully implementing the Turnaround process for all wards and securing sustainability;
- a program of audits on nursing practice;
- training and awareness;
- developing the whole health economy pathway;
- participating in safety express.

The Tissue Viability Steering Group will oversee the delivery of the plan and key performance data will be collated on our central database and monitored weekly.

Reducing Avoidable falls
Our aim is to reduce the number of avoidable falls that result in high harm by 50%. This is a contractual requirement, part of our Turnaround project and also a goal of Safety Express.

An annual plan of action will be developed to support the delivery of this improvement priority and will include:-

- the development of a multi-factorial assessment for frail elderly patients;
- patient and public awareness campaign;
- the launch of falls link nurses as advisors and trainers;
- developing the whole health economy pathway;
- participating in safety express;
- the development of Root Cause Analysis panels to review falls where high harm has been sustained.

The Falls Prevention Group will oversee the delivery and monitor the effectiveness of the plan.

Priorities for Patient Experience for 2011/12

PIF Priority	Rationale	Proposed Improvement Target	Measurement Source
Nutrition and Hydration To ensure no needless malnutrition To enhance patient experience of hospital food	• Top priority for SLINKS (PPI feedback) • Feedback from CQC Visit • Achieved amber and red on 2010/11 targets • 2010 National Patient Survey Feedback • Real time inpatient survey feedback • Ombudsman Report into older people	**Target 1**: 95% patients receive MUST screening within 24 hours of admission by year end **Target 2:** 90% patients assessed as high risk via MUST have appropriate nutrition care plan in place. **Target 3:** 90% patients report hospital food to be good, very good or excellent **Target 4**: 95% patients that need help at mealtimes receive this	**Target 1**: Monthly MUST audit on CQD Dashboard **Target 2**: Monthly MUST audit on CQD Dashboard **Target 3**: Monthly real time inpatient survey **Target 4:** Monthly real time inpatient survey
Patients as partners To keep patients, relatives and carers fully informed about their treatment and care and involve them in decisions	• Frequent theme in complaints, PALS and patient feedback that we do not keep patients, relatives or carers sufficiently informed about progress with their care and treatment or involve them in the decision-making about • 2010/11 CQUIN for pt experience – achieved locally but not on national inpatient survey • 2010 national inpatient survey results • Real time monthly survey results	**Target 1:** Achievement of 2011/12 National CQUIN for patient experience **Target 2**: Sustain month on month local performance on the 5 CQUIN patient survey questions **Target 3**: Reduction in level 1/2/3 complaints and concerns relating to poor communication/provision of verbal information by 20%	**Target 1**: Amalgamated score of 5 questions from national inpatient survey • Pt involvement in decisions about their care • Finding someone to talk to about worries and fears • P&D when discussing condition or treatment • Being told about medication side effects on discharge • Pts told who to contact about worries or fears after discharge **Target 2**: Monthly real time inpatient survey **Target 3**: Monthly complaints and concerns data (agree baseline by Div/care group and ward in Q1)

In the patient experience section of our patient improvement framework in 2011/12, we will keep working on previously agreed priorities for discharge and safeguarding vulnerable adults and add a new priority for documentation.

Along with this we will deliver a whole organisation improvement programme for improving customer service and embedding our organisation's values.

Priorities for Patient Outcomes for 2011/12

In 2011/12, our actions will include:

- development of an electronic patient acuity monitoring system for MEWS, to allow better daily review of escalation process and real-time learning;
- continued work to improve the escalation of care for deteriorating patients by developing recognition and the management of deterioration at ward level, and our outreach services to support these patients;
- continuing to support our established processes for detailed medical team review of cases of unexpected deterioration by clinical specialties;
- guidance and an alert system to prevent medication errors when transferring patients to community hospitals;
- collecting better quality information on primary and secondary diagnoses and co-morbidities;
- the development of an eLearning package to improve understanding of appropriate coding and its importance in medical handover and discharge information;
- making data results more accessible for our consultants to review;
- continuing to develop and improve our electronic discharge information for GPs.

Statements of assurance from the board

This section of our Quality Account evidences that:

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

Review of services

During 2010/11 the Southampton University Hospitals NHS Trust provided 24 NHS services and subcontracted 27 services. More information about these can be found on our website www.suht.nhs.uk

Southampton University Hospitals NHS Trust has reviewed all the data available on the quality of care in all 51 of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100 % of the total income generated from the provision of NHS services by Southampton University Hospitals NHS Trust for 2010/11.

Participation in clinical audits

During the period between 1/4/2010 and 31/3/2011, 44 national clinical audits and 1 national confidential enquiry covered NHS services that Southampton University Hospitals NHS Trust (SUHT) provides.

During that period SUHT participated in 84% (37) national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SUHT was eligible to participate in during the period between 1/4/2010 and 31/3/2011 are as follows:

Confidential Enquiry
Perinatal mortality (CEMACH)

National Audits
Neonatal intensive and special care (NNAP)

Paediatric pneumonia (British Thoracic Society)

Paediatric asthma (British Thoracic Society)

Paediatric fever (College of Emergency Medicine)

Childhood epilepsy (RCPH National Childhood Epilepsy Audit) — Commences May 2011

Paediatric intensive care (PICANet)

Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)

Diabetes (RCPH National Paediatric Diabetes Audit)

Emergency use of oxygen (British Thoracic Society) — No data submitted

Adult community acquired pneumonia (British Thoracic Society) — No data submitted

Non invasive ventilation (NIV) - adults (British Thoracic Society)

Pleural procedures (British Thoracic Society)	No data submitted
Cardiac arrest (National Cardiac Arrest Audit)	
Vital signs in majors (College of Emergency Medicine)	
Adult critical care (Case Mix Programme)	
Diabetes (National Adult Diabetes Audit)	
Heavy menstrual bleeding (RCOG National Audit of HMB)	
Chronic pain (National Pain Audit)	
Ulcerative colitis & Crohn's disease (National IBD Audit)	
Parkinson's disease (National Parkinson's Audit)	TBC
COPD (British Thoracic Society/European Audit)	
Adult asthma (British Thoracic Society)	No data submitted
Bronchiectasis (British Thoracic Society)	Registered for 2011/12
Hip, knee and ankle replacements (National Joint Registry)	
Elective surgery (National PROMs Programme)	
Coronary angioplasty (NICOR Adult cardiac interventions audit)	
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	
Carotid interventions (Carotid Intervention Audit)	
CABG and valvular surgery (Adult cardiac surgery audit)	
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	
Acute Myocardial Infarction & other ACS (MINAP)	
Heart failure (Heart Failure Audit)	
Acute stroke (SINAP)	No data submitted
Stroke care (National Sentinel Stroke Audit)	
Patient transport (National Kidney Care Audit)	
Renal colic (College of Emergency Medicine)	
Lung cancer (National Lung Cancer Audit)	

Bowel cancer (National Bowel Cancer Audit Programme)

Head & neck cancer (DAHNO)

Hip fracture (National Hip Fracture Database)

Severe trauma (Trauma Audit & Research Network)

Falls and non-hip fractures (National Falls & Bone Health Audit)

O neg blood use (National Comparative Audit of Blood Transfusion)

Platelet use (National Comparative Audit of Blood Transfusion

Dementia

A small number of the audits were not on the Trust audit plan last year, but are prioritised for 2011/12 in line with our Trust priorities approach. We chose not to participate in the national acute stroke SINAP audit as this database is still in development nationally, we have local arrangements to collect and use this clinical information.

The national clinical audits and national confidential enquiries that Southampton University Hospitals NHS Trust participated in during 2010/11, are included at appendix 2

The national clinical audits and national confidential enquiries Southampton University Hospitals NHS Trust participated in, and for which data collection was completed during 2010/11, are listed in appendix 2 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 36 national clinical audits were reviewed by the provider in 2010/11 and Southampton University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided listed in appendix 2.

“The reports of 93 local clinical audits were reviewed by the provider in 2010/11 and Southampton University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided, listed in appendix 3.

Research

The number of patients receiving NHS services provided or sub-contracted by Southampton University Hospitals NHS Trust in 2010/2011 (01/04/2010 - 31/03/2011) that were recruited during that period to participate in NIHR supported research approved by a research ethics committee was 12308.

Our commitment to research as a driver for improving the quality of care and patient experience

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

Southampton University Hospitals NHS Trust was involved in conducting 243 NIHR supported clinical research studies in a broad spectrum of medical specialties during 2010/2011.

There were 1073 clinical staff participating in both National Institute for Health Research (NIHR) and non-NIHR supported research approved by a research ethics committee at Southampton University Hospitals NHS Trust during 2010/2011.

Our goals agreed with the commissioners

A proportion of Southampton University Hospitals NHS Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2010/11 and for the following 12-month period are available at www.suht.nhs.uk

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

Reflecting our wide patient catchment area, we agreed three CQUIN programmes in operation. These were one standard contract CQUIN held jointly between all our PCT commissioners, coordinated by NHS Southampton, and one for each of our two specialist services commissioning groups in South Central and South West.

SUHT; Our CQUIN priorities for 2010/11

Indicator source	Standard Contract	South Central Specialist	South West Specialist
National	Venous thromboembolism	Venous thromboembolism	Venous thromboembolism
	Patient experience	Patient experience	Patient experience
Strategic Health Authority	Improving Quality Programme	Improving Quality Programme	Improving Quality Programme
Local	Pressure Ulcers reduction	Special care baby unit bed days	Bone marrow transplant survival
	End of Life care	Haemophilia factor VIII	Paediatric cardiac surgery
	Enhanced Recovery programme		Neonatal care
	Smoking Cessation		

The CQUIN targets set were challenging, however we have made significant progress. These areas remain part of our improvement focus for 2010/11.

What others say about Southampton University Hospitals NHS Trust

Statements from the Care Quality Commission

We are successfully registered with the CQC unconditionally. Southampton University Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is as follows:

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

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

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

- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD.

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

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

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

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

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

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

The Trust has also applied for registration for the 'Assessment or medical treatment for persons detained under the 1983 (Mental Health) Act' and is currently awaiting hearing from CQC in respect of these services.

Southampton University Hospitals NHS Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Southampton University Hospitals NHS Trust during 2010/11.

Southampton University Hospitals NHS Trust is not subject to periodic reviews by the CQC.

Southampton University Hospitals NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission undertook a planned review of compliance at the Southampton General Hospital site in January 2011 and the hospital was found to be compliant with all 16 of the core Essential Standards of Quality and Safety.

Our data quality

Our scores are close to, or above national average for data quality:

Southampton University Hospitals NHS Trust submitted records during 2010/11 to the NHS-wide Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

— which included the patient's valid NHS number was:
96.6% for admitted patient care;
97.7% for out patient care; and
93.9% for accident and emergency care.

— which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
99.7% for out patient care; and
100% for accident and emergency care.

The 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.

Southampton University Hospitals NHS Trust Information Governance Assessment Report overall score for 2010-11 was 73% and was graded Green (Satisfactory).

This represents an improvement from 64% in 2009/10

Our patients from overseas and the Channel Islands are not issued with an NHS number, but are included in our results. This group do not affect our results for the GM practice code, because we are able to identify these patients as non –UK citizens, and the Secondary Uses Service acknowledges this.

SUHT recognises that good quality health services depend on the provision of high quality information. Continuing the work undertaken in 2010/11, SUHT will be taking the following actions to improve data quality:

- Performance management of data quality via Trust, Divisional and Clinical Coding and Information Data Quality Groups, and the corporate Information Quality Assurance Team. Key performance indicators on internal and external timeliness, validity and completion of patient data will be reviewed by the group in conjunction with use of the

Dr Foster comparative analysis information. Areas of poor performance will be identified, investigated and action plans agreed for improvement.

- Continue work to reduce data quality problems at the point of data entry through improved system design, changes to software, and delivery of new computer systems.
- Work towards delivering real time admission, discharge and transfer recoding across more ward areas, thereby supporting improved patient tracking and bed management.
- Support the development of training and education programmes for all staff involved in data collection.
- Maintain a programme of regular internal audit, including data quality, information governance and clinical coding audit.
- Continue to maintain and develop improved compliance with the Information Governance Toolkit standards.

Southampton University Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

However the Trust submitted an Internal Audit to Connecting for Health (CFH) in October 2010, as required to support Information Governance requirement 505 and has an established internal clinical coding audit programme, reporting monthly to the Trust Data Quality Steering Group.

Further Information

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

Clinical effectiveness annual reports, explaining some of our clinical developments in more detail

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

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

In addition, this section includes a summary of our key performance progress, and some examples of the work our teams are engaged in that supports our Trust priorities for quality.

Our Progress and Performance to 2010 11

Key targets	2007/08	2008/09	2009/10	March 2011	2010/11 Targets
A&E patients, % admitted, transferred or discharged within 4 hours (SUHT & Partners)	97.08%	Achieved 98.29%	Achieved 98%	97.0% Full year	**>= 95%**
18 weeks – Admitted patients	76.6%	Achieved >90% in Jan, Feb & Mar 09	Achieved >90% in all quarters	87.2% Full year	Maintain >= 90%
18 weeks – Admitted 95th centile wait	Not measured	Not measured	Not measured	33.9 wks March 11	**<= 27.7 weeks**
18 weeks – Admitted median wait	Not measured	Not measured	Not measured	8.8 wks March 11	**<= 11.1 weeks**
18 weeks – Non admitted patients	91%	Achieved >95% in Jan, Feb & Mar 09	Achieved >95% in all quarters	95.3% Full year	Maintain >= 95%
18 weeks – Non admitted 95th centile wait	Not measured	Not measured	Not measured	23.7 wks March 11	**<= 18.3 weeks**
18 weeks – Non-admitted patients median wait	Not measured	Not measured	Not measured	4.6 wks March 11	**<= 6.6 weeks**
Maximum wait for elective admission	26 weeks national standard achieved	Achieved 3 pts waited >26 wks	Achieved 2 pts waited > 26 wks	Not measured	**Not measured**
Maximum wait for 1st OPA following GP /GDP referral	13 weeks national standard achieved	Underachieved 36 pts waited >13 wks	Achieved 9 pts waited > 13 wks	Not measured	**Not measured**

Maximum waiting times for 15 key diagnostics tests	89 >6 wks at 31/03/08	220 >6 wks at 30/03/09	Achieved 10 pts waited > 6 wks	31 pts > 6wks Full year	Achieve & maintain < 6 weeks
Cancers: 2 week wait (Urgent GP/ GDP referral) to first hospital assessment	99.1%	Achieved 98.98%	Achieved 93%	96.0% Full year	>= 93%
All breast symptoms: referral to first hospital assessment	Not measured	Not measured	Achieved 97.8%	95.8% Full year	>= 93%
Cancers: 31 days (Decision to treat) to first treatment	98.71% (all cancers)	Achieved 99.24% (all cancers)	Achieved 97.3%	97.2% Full year	>= 96%
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (drugs)	Not measured	97.22%	100% *	99.8% Full year	>= 98%
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (surgery)	Not measured	97.22%	95.9% *	95.6% Full year	>= 94%
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (radiotherapy)	Not measured	Not measured	Not measured	97.0% Full year	**>= 94%**
Cancers: 62 days Urgent GP referral to treatment	97%	Achieved 97.09%	Achieved 89%	87.0% Full year	>= 85%
Cancers: 62 days NHS Cancer Screening Service to treatment	Not measured	Not measured	90.2% *	96.6% Full year	>= 90%
Cancers: 62 days Consultant upgraded referral to treatment	Not measured	Not measured	Achieved 95.09%	89.9% Full year	>= 85%
Last minute cancellations: % of elective admissions	1.33% of elective adms	Underachieved 1.3% of elective adms	Failed 1.6% of elective adms	0.9% of elective adms Full year	<= 0.8%
Last minute cancellations not rescheduled < 28 days	15.03% of cancellations	Underachieved 13.8% of cancellations	Underachieved 6.4% of cancellations	5.8% of cancellations Full year	<= 5.0%
MRSA Bacteraemia	36 cases	Underachieved 27 cases	Achieved 7 cases	5 cases Full year	**<= 7 cases**
C.Difficile	525	Achieved 249 cases	Achieved 123 cases	89 cases Full year	**<= 139 cases**

Updates from our services

Our service teams are keen to share the successes that support and add value to our PIF priorities achievements. This section includes a selection of their stories.

Urology Services

Southampton urology provides its services across SUHT, Lymington and by secondment to the ISTC. We provide centralised cancer services for complex renal and pelvic cancer from Winchester and Salisbury, in addition to our local patients. We also provide regional cancer services for metastatic testicular cancer and very complex renal cancers.

Cancer surgery

Around 15-20 patients with metastatic testicular cancer require surgery to remove lymph nodes from around the major abdominal vessels each year. The decision making process is taken through our weekly multidisciplinary team meeting. This includes radiologists, medical oncologists and urologists. A marker of success is the histopathology results of the tissue removed.

Our data show:

Findings	SUHT histopathology results	International review comparison
teratoma differentiated (best treated by removal	78%	30-57%
fibrosis (arguably could have been left)	13%	18-49%
residual cancer	9%	Up to 30%

These figures confirm our excellent decision making processes, which reflect our expertise and long experience with this relatively rare group of patients.

We have a long-established and successful practice in image-guided percutaneous cryoablation of renal tumours second only to Mayo Clinic, Rochester, MN. Our technical success rate is 97% with the MDT deciding on no treatment or alternative treatment in the latter patients. Our patients' average inpatient stay was 1 day. The alternative treatment for these lesions is either partial or total removal of the kidney which means either a 3-4 day stay in hospital or for open surgery, a 5-7 day stay.

Children and Young people surgery

Our paediatric urology colleagues see, treat and correct many young patients with complex urological problems. Some require ongoing specialist care and as these young people approach the age of 18, it becomes increasingly difficult to manage them in paediatrics alongside much younger patients. However, it is equally difficult for them to be plunged into the unfamiliar adult urology service. We have developed a transition clinic where patients are seen by both familiar paediatric team members and adult team members. This transition process has been well received by these young patients and presented to our regional meeting in Oxford.

Enhanced recovery

Enhanced recovery for elective surgery has been popularized by a colorectal group in Denmark and has spread across the surgical community, both by geography and speciality. We introduced the program for radical cystectomy in January 2011. Even at this early stage our length of stay post operatively has fallen from around 15 to around 9 days. This has been achieved by a multimodal approach across primary and secondary care including the allied professionals such as physiotherapy, occupational therapy and stoma care. In addition to the obvious savings, these patients are reporting a much improved overall experience with this major surgical procedure.

Surgical staff development

Finally, we have adopted a close system of mentoring and buddying for the last 3 urological surgical appointments and our Trust has been supportive, where necessary, of joint consultant operating. Surgery is recognised as a 'craft' speciality and our system has protected patients and allowed new consultants to develop without detriment to the patients or the service, by maintaining quality and keeping operative times low.

Liver and Pancreatic Services

The Southampton Hepatobiliary and Pancreatic Surgical Service serves a population of 3.8 million people across Dorset, Hampshire, West Sussex and the Channel Islands. We have an established team of Surgeons, Physicians, Oncologists and Radiologists who work as a team to ensure treatment is tailored to each individual patient. The team benefits from a mix of University and NHS doctors, which allows us to provide cutting edge treatment.

We undertake approximately 200 liver and pancreatic resections each year, with outcomes that compare favourably with other major European centres. We place an emphasis on minimally invasive (keyhole) surgery and Southampton is a pioneering centre for laparoscopic liver surgery. We have the leading experience in the UK and our contribution in this field is recognised internationally. We have demonstrated that the technique is safe for the treatment of colorectal liver metastasis. Our results for specialised chemotherapy treatment of other liver tumours (known as TACE) are amongst the best in the world.

The range of treatment options available in Southampton allows more effective treatment of complex and other locally advanced tumours. We have an increasingly large group of these patients that are now benefiting from treatment by our team. All our patients benefit from the mass of expertise available in a teaching hospital environment and the support of a dedicated intensive care team which allow such a complex service to be delivered safely.

Head and Neck cancer

From a five year audit of all out patient attendances of patients on the head and neck clinic we assessed patients who had been treated with curative intent. Non recurrence rates reported to clinic were 79.3% for patients under the OMF team comparing very favourably with gold standard bench mark data of 80% from Liverpool using similar audit methodology

Facial deformity surgery

From national audit data 96% of patients felt they had benefitted from treatment, increased self confidence in 86%, Improved facial appearance in 88%, better smile in 92%, and better dental appearance for 92% of patients.

Bone marrow transplants

Recently the Specialist Services Commissioners for South Central Strategic Health Authority asked the British Society of Blood and Marrow Transplantation's central bone marrow transplant data registry to analyse the stem cell transplant activity and outcome for our unit from 2002-2007. Our results were compared with the rest of the UK. Our 12 month post transplant survival results were found to be as good as, or better than the national average.

Conclusion

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

The Quality Account enables us to qualify our progress comprehensively and agree the priorities for 2011. Future accounts will therefore present a quantitative delivery against a forecast.

We see this as an essential vehicle for us to work closely with our Members' Council, our commissioners and the local community on our future quality agenda as well as celebrating our successes and progress.

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

PCT lead commissioner final support statement:

LINKs final support statement:

OSC final support statement:

(OSC delegated their response to LINKS, see above)

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PCT quality account development feedback

NHS
Bournemouth and Poole

Bournemouth and Poole Teaching Primary Care Trust
Canford House
Discovery Court Business Centre
551-553 Wallisdown Road
Poole
Dorset
BH12 5AG

Tel: 01202 541400

11 May 2011

Our ref: FR/ep

Judy Gillow
Director of Nursing, Midwifery & Patient Services
Southampton University Hospitals NHS Trust
Tremona Road
Shirley
Southampton
SO16 6YD

Dear Judy

Thank you for providing Andrea and me the opportunity to comment on your draft quality account for 2010/11. Our comments overall are that this is an excellent report; it is very clear and concise and flows well. It will represent an excellent resource for patients and therefore we would not change any aspect of it. Compared to other Trusts' draft accounts that we have reviewed, we have found this document much easier to read and the general 'flow' is easier for people who may have less understanding of health and complex medical terminology.

There are a couple of comments on the document itself. On page 5, the second to last paragraph, is this the staff attitude survey, as when you read it, it refers to staff satisfaction and staff attitude; just the terminology, you may want to be consistent.

Priority 3, on page 19: the sentence needs to be finished in this table as it is a little brief at present.

Throughout the document we picked up a number of 'typos', the Trust did not have a capital 'T' in all situations, and 2020Vision sometimes had a gap and sometimes did not.

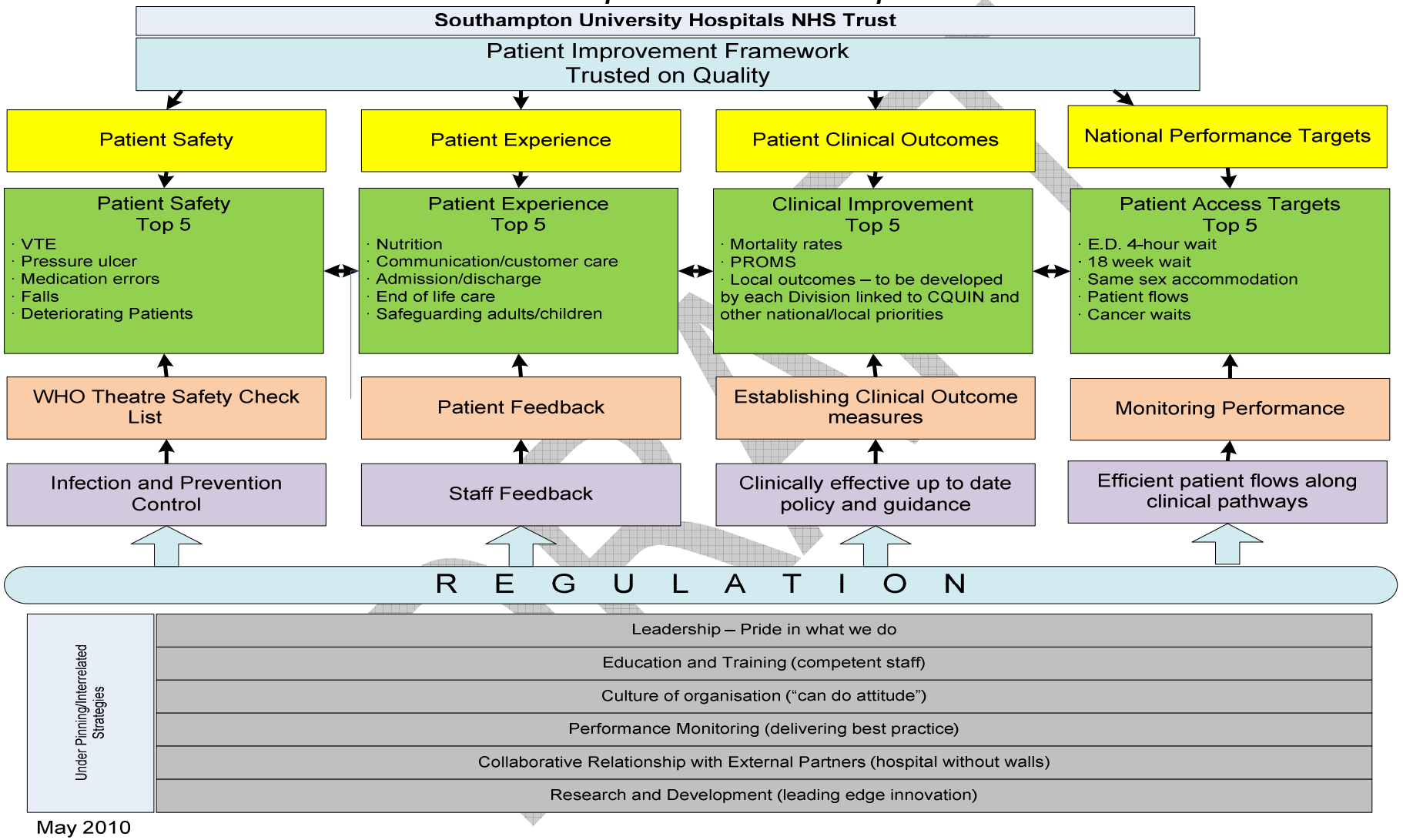
I hope you find our comments useful. Thank you for the opportunity for commenting.

Yours sincerely

Fiona Richardson
Deputy Director of Specialist and Tertiary Commissioning
NHS Bournemouth and Poole

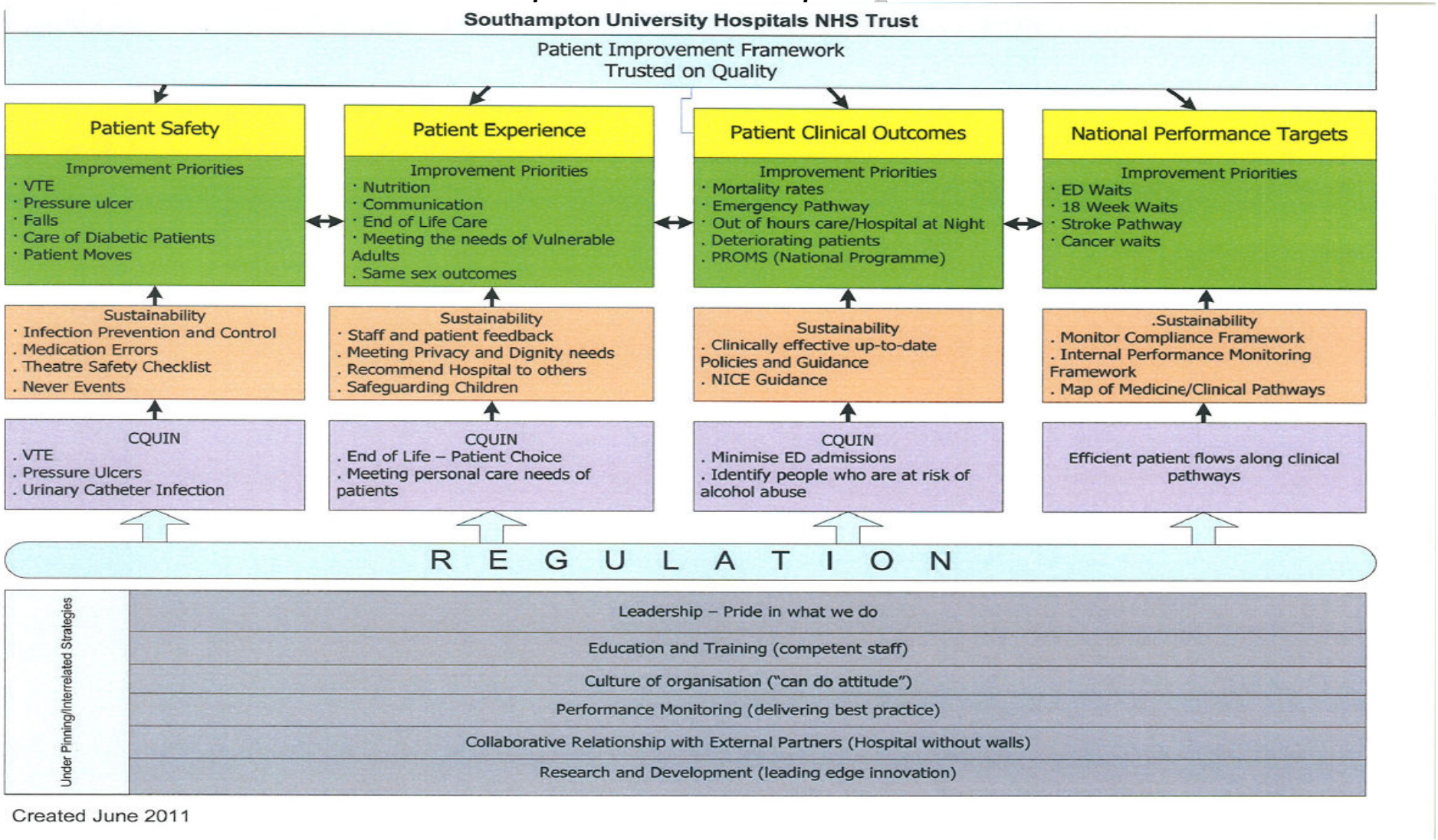
cc
Andrea O'Connell, Deputy Director of Quality Improvement, NHS Bournemouth and Poole

Our Patient Improvement Framework priorities in 2010/11



May 2010

Our draft Patient Improvement Framework priorities in 2011/12



Created June 2011

Appendix 2

National Clinical Audits and National Confidential Enquiries 2010/11

	The number of eligible national clinical audits and national confidential enquires that Southampton University Hospitals NHS Trust participated in during 2010/11, is 36 and these are as follows:	Number of cases submitted	Number of cases required if known	Percentage of cases - the number of cases submitted	National audit report published 2010/11?	National audit report reviewed by local specialty	Description of actions
1	TARN Trauma audit and research network	285	498	58%	Yes	Yes	Multi specialty morbidity and mortality meeting held approximately monthly. Actions around CT scanning and imaging priorities, blood transfusion (Code Red policy), trauma team call out. Areas of notable performance and areas to improve all discussed. Data and actions also discussed in Trauma Working Group. Data submission to be improved by additional input staff and Consultant Lead with time in job plan.
2	British Thoracic Society - Paediatric pneumonia	46	1	>100%	Yes	Yes	Need to better document collection of microbial specimens and report findings.
3	British Thoracic Society - Paediatric asthma audit	69	3	>100%	Yes	Yes	None - maintaining excellent outcomes well above national standards.
4	National Comparative blood transfusion audit - retrospective audit of use of platelets	40	40		No	No	Will depend on the results of the report. To be reviewed at Transfusion Committee.
5	National Comparative blood transfusion audit - O negative	44	40		Yes	No	Actions to be agreed following discussions of final site-specific report.

6	Stroke - National sentinel stroke audit	72	72	100%	Yes	Yes	A number of actions are already in place, responding to other monitoring systems; Vital Signs, Accelerated Stroke Improvement markers, eg: direct admissions of acute stroke patients within 4 hours 24/7 from ED to the acute stroke unit F8, commenced March 2011. All acute stroke patients to spend >90% of admission on F8 will also be achieved through direct admissions. Cardiac monitoring equipment is in the process of being ordered to allow acute stroke thrombolysis on F8 24/7 and there is funding for an additional stroke consultant post to develop a stroke consultant on call rota to support this. Radiology staff and ward staff are aware of the need for a CT brain scan within 24 hours of an acute stroke admission. A new referral process is being used to ensure this. A band 7 speech and language therapist has been appointed to the stroke unit. One of her roles will be to upskill the ward nurses to be able to swallow screen acute stroke patients within 4 hours of admission to the acute stroke unit. A ward sister has implemented the new Trust urinary continence pathway to improve our performance and documentation in this area. The stroke team plans to devise an acute stroke integrated care pathway to improve care and documentation of agreed multi-disciplinary therapy goals within 5 days of admission.
7	National falls and bone health audit	34	60	57%	No	No	We have an internal system of audit to improve falls risk assessments and to reduce the rates of avoidable inpatient falls and injuries, our most recent actions included starting the SGH turnaround project and introducing an updated version of the falls risk assessment tool. We are participating in a whole health economy review with local partners (Hampshire Oversight Scrutiny Committee) to determine how rates of falls in those who have recently accessed acute services could be reduced.
8	Dementia	41	40	103	Yes	Yes	The audit report has been reviewed by a SUHT based multiprofessional group including Elderly Care and Psychogeriatric professionals with the aims of (a) completing the development of a care pathway/bundle for elderly patients with confusional states and dementia (b) reviewing arrangements for determining the appropriate location of care, minimising bed movement and accessing specialist psychogeriatric review of acutely unwell elderly patients with dementia (c) reviewing the arrangements for accessing patient records for patients with dementia when they are admitted under the care of acute physicians.
9	College of Emergency Medicine - Paediatric Fever	50	50	100%	Yes	Yes	Audit results presented at Emergency Department meeting. Reported in quartiles for individual variables.
10	College of Emergency Medicine - Vital signs in majors	50	50	100%	Yes	Yes	Audit results presented at Emergency Department meeting. Reported in quartiles for individual variables.
11	College of Emergency Medicine - Renal colic	50	50	100%	Yes	Yes	National audit results from CEM for 2010 were for a previous set of audits relating to: Pain in children - Continue good practice. introduction of pain sticker system to ensure re-evaluation of pain after analgesia. Adult asthma - ongoing SHO education and new system in majors to ensure early, full recording of all vital signs Neck of femur fracture management - focus on delivering timely analgesia to these patients by re-organising how all patients are received into majors.

12	Adult Cardiac Interventions BCIS - Coronary Angioplasty	All undergoing PCI	As above	100	Yes	Yes	Continue to provide high quality service as indicated by audit results.
13	MINAP including acute Myocardial Infarction and Coronary syndrome.	All Acute Coronary Syndrome	As above	100	Yes	Yes	Review of cases who did not receive reperfusion therapy to ensure they were appropriately managed.
14	NLCA NATIONAL LUNG CANCER	457	100%	>90%	Yes	Yes	Submissions of full records 191; treatment only records 266; TOTAL = 457 (though this number may vary dependent on being able to enter the treatment data into records which have been uploaded by other Trusts with their diagnosis data) Our local IT system (HICCS) is being improved to make it more user-friendly to enter data. Ideally this data would be collected at the MDT which has not been possible. For the 2009 calendar year our raw numbers are about right but insufficient patients have accurate staging, performance status, CNS contact details,FEV1 etc. Importantly some palliative operations were sent to LUCADA as radical operations making our lung resection rate too high. Much of the data is sent to LUCADA in the week before the deadline for submission which makes checking its accuracy impossible. These problems are being ironed out slowly but even in 2011 we are not sending data in real time and some important variables are not possible to input at the MDT.
15	HEART FAILURE AUDIT	140	20 per month	58%	Yes	No	The care group needs to appoint a second consultant cardiologist with an interest in heart failure and to expand inpatient heart failure service. A business case has been submitted. CQUIN will help drive this.
16	VSGBI NATIONAL VASCULAR DATABASE - PERIPHERAL VASCULAR SURGERY (data collected on index procedure: varicose veins / aneurism / lower limb / amputation)	CAROTID LAST YEAR 107, AAA 92, AMPUATIONS 9, LOWER LIMB BYPASS 50+	100%	CAROTID 100%, AAA 100%, LOWER LIMB BYPASS 70% APPROX, AMPUTATION < 20% APPROX	Yes	Yes	Data collection has been prioritised and there is a backlog of lower limb bypass and amputation data.
17	NATIONAL DIABETES AUDIT (CONTINUOUS) PAEDIATRIC	200	200	100%	Yes	Yes	Compare outcomes locally with national outcomes
18	NATIONAL HIP FRACTURE DATABASE	643		100%	Yes	Yes	Increased percentage of patients reviewed by Ortho-Geriatricians within 24 hours Review of Falls and Osteoporosis risk factors DEXA scanning in appropriate patients to identify osteoporosis Improved discharge planning with MDTs Two weekly dedicated NOF operating lists on Tuesdays and Thursdays to improve door to theatre time

19	ICNARC CMPD: ADULT CRITICAL CARE	1433	1433	100%	Yes	Yes	Excellent results no action required
20	RCP National audit of the Management of Familial Hypercholesterolaemia			100%	Yes	Yes	Organisational audit completed. Casenote audit Completed. Site specific report published and action plan developed. Presentation made to Trust at Core Brief.
21	National Joint Registry	988		95%	Yes	Yes	Met regularly with representative from joint registry. Achieving 100% consent to be included with the audit. Backlog down to approximately 50 from around 400 last year. Feedback indicates 95% completeness of data. Post op traceability of replacements. Purpose to identify patients if recall were required. Cost £25 levy per replacement. Great success for nurses and matrons collecting the data. Plans to capture the data at outpatients in future - directly from surgeons. SUHT submitted 988 cases in 2010-11. Trust compliance figures are available through the NJR StatsOnline service on the NJR website.
22	PROMS hips	425 pre-op cumulative	563 pre-op cumulative	75%	Yes	Yes	Sept 16 2010 report indicates SUHT submitting 67.3% (Eng ave 66.9%) hips and for knees submitting 70.9% (Eng ave 68.6%). Recent results show improved participation. On the quality measures SUHT close to England average - this will become more meaningful with increased data. On average quality of life improved more for knee replacements than for hips. Working hard to encourage patients to participate and reduce the number declining completion of questionnaire. Information leaflets in several different languages have recently been made available to patients.
23	PROMS knees	516 pre-op cumulative	668 pre-op cumulative	77%	Yes	Yes	Sept 16 2010 report indicates SUHT for knees submitting 70.9% (Eng ave 68.6%). Recent results show improved participation. On the quality measures SUHT close to Eng ave-will become more meaningful with increased data. On average quality of life improved more for knee replacements than for hips. Working hard to encourage patients to participate and reduce the number declining completion of questionnaire. Information leaflets in several different languages have recently been made available to patients.
24	Head and Neck Cancer (DAHNO)	89	Aim for 100%	>90%	Yes	Yes	Quartiles shown by variable and reviewed locally. The submission numbers are: full records 54; treatment only records 35; TOTAL = 89. There were 17 records which could not be uploaded as they did not have an NHS number, 16 came from the Channel Islands and they do not submit to DAHNO
25	National Bowel Cancer Audit (NBOCAP)	286	Aim for 100%	>90%	Yes	Yes	Data is being collected via local IT system (HICSS) prior to upload to national database. Data completeness report reviewed. 2 year data-lag on published NBOCAP reports. As at Dec 2010 submitted (patients diagnosed from 1 Aug 09 to 31 July 2010. The submission deadline was 06/12/2010 and the report includes patients diagnosed between 1 August 2009 and 31 July 2010 The numbers are: 286 records

26	RCP/VSGBI National Carotid Interventions	106	Aim for 100%	Aim for 100%	Yes	Yes	Submitted approx.106 (100%) of cases for period 1 Apr 10 to 31 Mar 11. Outcomes data indicates SUHT doing well with 1/2 average stroke rate (compared with national average) following discharge after carotid surgery. (Feedback from GM July 10) Run by VSGBI through RCP. Annual formal report published.
27	NCASP Congenital Heart Disease (including paediatric surgery)		Aim for 100%	Aim for 100%	Yes	Yes	Each year every centre has an independent validation visit during which case ascertainment is maximised by checking the CCAD returned data against theatre and catheter laboratory log books.
28	NCASP Adult Cardiac Surgery CABG	>1500	Aim for 100%	>95%	Yes	Yes	SUHT operates one of top 5 busiest practices in the country. SUHT risk-adjusted outcome data suggests our outcomes are in the top 5 in the country. All individual surgeons perform as expected or better than expected when adjusted for risk. Reference: Care quality commission website (heart surgery in the UK).
29	CMACE Perinatal Mortality- continuous data collection. Reports published 2 years after data collected		100%	100%	Yes	Yes	First report published 2010 and disseminated to care group. Results discussed in neonatal unit. Compliance with recommendations being assessed and non-compliance to be reviewed in annual review of National Confidential Enquiries. Linked report published March 2011for 2009 data. No site-specific report.
30	NNAP National Neonatal Audit Programme		100%	100%			Data collection via local IT system, Badgernet.
31	Paediatric Intensive Care Audit Network (PICANET)		Aim for 100%	>90%	Yes	Yes	Site specific interim reports published twice a year. Summary for latest report published August 2010 attached. We admitted 2259 patients over last 3 year period. This makes us the 9th largest unit by number of admissions. Our risk-adjusted standardised mortality rate is 0.73 over this time. Of the larger units (those admitting more than 2000 patients) this is the best outcome data.
32	British Pain Society (BPS) pain database. 3 year project launched November 2009.			Aim for 100%	No	No	SUHT participated in the pilot stage. National project lead is based at this Trust. Work in progress.
33	RCOG National audit of heavy menstrual bleeding against NICE CG44. 4 year project.			Aim for 100%	No	No	PROMS data collection started. SUHT participated in the organisational audit. 12 Months of administering the questionnaires from 1/2/11 to 31/1/12. Collecting patient related outcome measures.
34	RCP National audit of Inflammatory Bowel Disease (NCAPOP)			Aim for 100%	No	No	Adult and paediatric elements of National IBD Audit underway with data inputting up to August 2011.
35	British Thoracic Society (european project) COPD Audit	105		100%	No	No	SUHT submitted organisational data and above required sample for case note data. 105 records. Data collection ends 1 April. Report available September 2011.
36	British Thoracic Society - Adults Non-invasive ventilation				Yes	Yes	The Trust submitted 3 months' data for March / April / May 2011. Report imminent.

Data will be submitted to these 5 eligible national audits in 2011, however no data submitted for these yet during 2010/11:

37	INFLAMMATORY BOWEL DISEASE RCP ADULT CROHNS & UC				No	No	Data collection is in progress until August 2011.
38	NATIONAL DIABETES AUDIT (CONTINUOUS) ADULT				No	No	This audit has been added to the 2011-12 annual audit programme. The care of Diabetic patients has been identified as one of the top 15 priorities for the Trust in 2011-12.
39	PARKINSON'S UK				No	No	Registration is imminent and the Trust plans to participate in this audit in 2011-12.
40	CARDIAC ARREST AUDIT				No	No	SUHT started contributing data on 1st April 2011. All cardiac arrest forms have been aligned to the national database to ensure we collect all the required data.
41	SINAP Stroke national programme						The SINAP programme database is currently being revised and this Trust plans to participate once the final SINAP is launched later in 2011. Local outcomes are reviewed.

The Trust did not participate in the following 5 eligible national audits during 2010/11:

42	British Thoracic Society - Pleural Procedures	This audit was not part of the National clinical audit and patient outcomes programme (NCAPOP) or an acute contract requirement and therefore not automatically included in the audit plans for the organisation at the start of 2010-11 when setting out 'must do' priorities for national clinical audit.
43	British Thoracic Society - Adult community acquired pneumonia	SUHT registered. No data collection as consultant lead submitting to local SHA pneumonia study for CQUIN therefore decision not to duplicate data collection.
44	British Thoracic Society - Bronchiectasis	This audit was not part of the National clinical audit and patient outcomes programme (NCAPOP) or an acute contract requirement and therefore not automatically included in the audit plans for the organisation at the start of 2010-11 when setting out 'must do' priorities for national clinical audit.
45	British Thoracic Society - Emergency use of oxygen	This audit was not part of the National clinical audit and patient outcomes programme (NCAPOP) or an acute contract requirement and therefore not automatically included in the audit plans for the organisation at the start of 2010-11 when setting out 'must do' priorities for national clinical audit.
46	British Thoracic Society - Adult asthma audit	No data submitted as monitored locally.

In addition to the 26 'eligible' national audits listed above, which the Trust participated in, SUHT also participated in a further 22 national audits (including an additional four national confidential enquiries)

Local clinical audits 2010/11

The number of local clinical audits that Southampton University Hospitals NHS Trust reviewed reports for during 2010/11, is 93 and these are as follows:
The number of local clinical audit that Southampton University Hospitals NHS Trust participated in during 2010/11, is 83 and these are as follows:

	Audit title	Actions
1	Nutrition on ICU	The audit showed that feeding was being established within 24 hours in less than half of patients being admitted to GICU. Numerous delays occurred which prevented adequate calorific intake, some of which could be minimised. Recommendations would include highlighting the deficiencies through education, increasing the awareness among both medical staff and nursing staff to ensure early assessment of nutrition needs and minimise unknown causes of delays or interruptions in feeding. In patients with non-functioning GI tracts, parenteral nutrition could be considered earlier.
2	Timely anaesthetic involvement in care of high risk mothers	Advertise correct method for MAPP referrals and importance of informing anaesthetist on arrival to labour ward for MAPP patients and BMI >40. Plan to do this via theme of the week distributed to all staff at PAH. Look into possibility of electronic referral mechanism linked into e docs.
3	Elective caesarean section list timings	Suggest multidisciplinary proforma formalising pre operative routine, Establish methods to improve turnaround times
4	Re-audit of peri-operative hypothermia	Encourage feedback from recovery nurses to individual anaesthetists. This will be aided by completion of formalised recovery handover
5	Monitoring of alarm settings in outpatient departments	Education of anaesthetic practitioners (ODPs) and new anaesthetists joining department
6	Peri-operative analgesia in orthopaedic day surgery	Form working group.
7	Checking pregnancy status in paediatric surgery patients	1. Survey APA to gain national information 2. Survey surgeons and nurses with in SUHT to gain local opinion 3. Create a multidisciplinary group to discuss methods of improving care
8	Re-audit of laryngeal mask airway cuff pressures	Purchase additional cuff pressure manometers to enable 100% availability

9	NICE CSG SP Discharging patients from community palliative care service	Present findings to team at Countess Mountbatten House (CMH). Caseloads under more scrutiny due to staff shortages. Inform GPs re discharge procedure and re-referral process. Clarify re-referral procedure amongst CMH staff
10	NICE CG 92 Re-audit on primary prophylaxis for venous thromboembolism in CMH	To trial Yellow Risk Assessment for Venous Thromboembolism (VTE) – Adults form. Get Yellow Risk Assessment for Venous Thromboembolism (VTE) – Adults form To Add Yellow Risk Assessment for Venous Thromboembolism (VTE) – Adults form to admissions pack To re-audit after some time
11	Nutrition - feeding in GICU - ? Repeat or duplicate registration of ZAUD1819	Highlight the deficiencies through education. Increase awareness among both medical staff and nursing staff to ensure early assessment of nutrition needs and minimise unknown causes of delays or interruptions in feeding. Parenteral nutrition could be considered earlier in patients with non-functioning GI tracts.
12	Appropriate indication for initiation of haemofilteration in ITU	Add in indication for haemofilteration as tick boxes (as per ADQI) to daily GICU RRT plan. Add in Wight and volume exchange to the GICU RRT plan
13	Compliance with MRSA decolonisation in Critical Care	1. Drug charts pre-printed with chlorhexidine and bactroban 2. Include within nursing care bundle paper work a section asking if decolonisation treatment has been administered and if not then why? 3. Include decolonisation status on the critical care discharge letters. 4. Include chlorhexidine & bactroban in the default equipment for each bed space. 5. Education & training. 6. Clarity regarding decolonisation on re-admission. 7. Re-audit later this year
14	Missed doses	Unsigned doses of clexane to be brought to attention of matrons. Audit to focus solely on doses of clexane not given (February 2011)Train band 4 nurses to administer doses Reminders to staff to ensure reasons given or codes used. To be done at ward level and on training days Antibiotics to be obtained from the other wards as required.
15	Reasons for extended stay on colorectal enhanced recovery programme	Liaise with Stoma Care sister to formulate plan D/W E7 ward physiotherapists Liaise with hospital discharge team re early completion of referral paperwork in preassessment. Work with Anaesthetics. Continued re-audit of compliance.

16	Colorectal HMR audit	Juniors to be provided with Standards when commencing colorectal surgery. Teaching regarding general completion of discharge summaries to be provided to junior doctors during their induction period. Regular review of discharge summaries by senior clinicians.
17	ERALS compliance with protocol	Patient Education on importance on nutrition drinks and mobilisation. Medical and Nursing Staff education update. Review of protocol.
18	Recurrence of hernia following laparoscopic hernia	To review factors may increase the recurrence rate (Used materials, Mesh size and fixation). Conducting a study about Open repair in SGH for comparison.
19	Early antibiotics in sepsis	Continue to increase awareness of the importance of early directed goal therapy in septic patients, among nurses and doctors during every formal teaching session. RAT/triage nurses to highlight patients who meet the criteria of having sepsis. Stress the importance of managing septic patients in the resuscitation room. Encourage clinicians to adhere to Trust guidelines when prescribing antibiotics
20	Majors area pain management	For discussion at consultant meeting in early September 2010. As a result of that meeting the department has set up a working party to address the issues. We feel a whole-department approach is needed. There is also a new Pain Protocol which has been developed and approved for use during the year. This will now be implemented alongside an education programme for nursing and medical staff.
21	Reducing risk in patients admitted to CDU	Further implementation of CDU checklist
22	Pain management in children attending ED	Education of paediatric nursing staff and triage staff to improve awareness of sticker system. Use of advice sheets in triage and paediatrics ED encouraging parents to request further analgesia when necessary. Encourage increased recording of pain scores with each routine set of observations each patient has done.
23	Vital signs in Majors patients	This together with the renal colic and previous pain audits, has resulted in a plan to re-organise how patients are received into the majors area of the department. We aim to address several issues with this: 1.Time to initial observations 2. A system to ensure communication of abnormal observations and recording of action taken 3.Timely administration of analgesia to patients in pain. Changes will be introduced during the next few months. Our new pain guideline, which was planned for autumn 2010, has been delayed and is expected to be able to be introduced in a similar time frame.

24	NICE CG 47 Fever in children	Continue teaching the NICE/CEM guidelines as gold standard within the department. This is part of SHO induction every 6 months. Continue to promote a full set of early observations for febrile children as above via ED Paediatrics Special Interest Group, next meeting Feb 2011. Triage nurse education is key to this. PSIG is responsible for change management. It is recognised that the triage nurse cannot triage efficiently if s/he has to perform a full set of observations in addition to the triage role, since this delays triage of the next patient(s), so although completing observations at triage might seem an easy way to achieve the standard, it is not practical. Therefore febrile children should be sent through to the paediatric area for observations to be taken. They may then sit in the waiting room if clinically appropriate.
25	Analgesia on majors in ED	This together with the renal colic and vital signs in majors audits, has resulted in a plan to re-organise how patients are received into the majors area of the department. We aim to address several issues with this: 1.Time to initial observations. 2.A system to ensure communication of abnormal observations and recording of action taken. 3. Timely administration of analgesia to patients in pain. The new pain pathway will also be implemented. Introduction of these new initiatives is in the week beginning March 7th 2011.
26	CDU VTE prophylaxis	There is now an electronic prompt on Symphony to record VTE risk. It is not possible to go past this screen without filling in the data. Changes to the way patients are received into the “Majors” area of ED on March 2011 means that all patients will now have a formal Trust drug chart, thus ensuring continuity between there and CDU
27	NICE CG 109 transient loss of consciousness	Continue to teach syncope on SHO induction, highlighting the NICE guidelines. Use the planned change in how patients are received into the majors area of the department to further improve the recording of a full set of observations and an ECG.
28	Management of renal colic in ED	This together with the vital signs and previous pain audits, has resulted in a plan to re-organise how patients are received into the majors area of the department. We aim to address several issues with this: 1.Time to initial observations. 2. A system to ensure communication of abnormal observations and recording of action taken. 3.Timely administration of analgesia to patients in pain. Changes will be introduced during the next few months. Our new pain guideline, which was planned for autumn 2010, has been delayed and is expected to be able to be introduced in a similar time frame.
29	Driving advice in TIA	Start aspirin 300mg once aday. Advise not to drive for 1 month Fax form to referring clinician
30	NICE CG 101 Pneumococcal and influenza vaccination in pts with COPD	To add a function to e-Docs, whereby when a diagnosis of COPD is entered on a discharge summary, a note automatically appears as a prompt for GPs to ensure that their patient is up to date with influenza vaccinations.

31	Drug allergy alert	Education (reminding) of junior doctors about specifying details of allergy when clerking a patient with known allergies. We suggested this to be included during induction of new junior Doctors joining the Trust and the ward pharmacists will help reminding doctors in the wards to record specification of allergy if details were not specified on admission: Our colleagues from pharmacy department were happy to look at this and take the leading role in order to implement the changes. '"The future Drug charts"-We suggested that the future drug charts to include(details/specification of allergy) in the drug allergies section. If in future the Trust adapts the t e-prescribing the details of allergy will automatically be requested and included.
32	To assess in what proportion of Dermatology audits audit cycles are actually completed	Actions 1. To review previous dermatology audits and attempted to determine whether in fact they were completed and if so inform the audit department of the results. 2. To attempt to determine whether completing any of the incomplete audits would be worthwhile and if so, attempt to do this. 3.To encourage the dermatology department to register all audits with the Audit department and to complete the audit cycle 4.To re-audit our completion/registering of audits in the future
33	Medical review of AMU patients within 24hrs prior to transfer to ward	Insertion of sentence in nursing handover sheet. - 'has this patient had a medical review in the last 24hrs? if not please seek medical review'.
34	Audit of correction of Hypermetropia in children	Need to consider whether to adopt a guideline or to treat pts on an individual basis, depending on: Degree of Hypermetropia Family History Family preference Careful review for sign of sq/reduced VA Review for change in hypermetropia If treating pts on an individual basis, is there a level of hypermetropia which should always be corrected without any signs of sq/reduced VA eg +8/ +9DS?
35	Descemet stripping endothelial keratoplasty audit of the first three years procedures (2007-10)	Increase numbers. Accept tertiary referrals.Tighten up data collection. 'Refraction / topography / cell counts. Re-audit to chart benefits of experience.

36	Macroproplactin results following polyetheylene glycol (PEG) precipitation	In view of the nonspecific way PEG reduces protein solubility, variable reactivity of macroprolactin in immunoassay, and low reactivity of DxI with macroprolactin, prolactin results should be reported directly from the DxI without the need for PEG treatment prior to analysis. In cases where results do not agree with clinical presentation, imaging study should be considered or the sample should be reassessed with GFC, which is the gold standard.
37	Myelodysplastic syndrome - European guidelines	Consensus interdepartment agreement on relevant investigations were noted after presentation. MDT form to be altered to address this. Uptake of erythropoietin stimulating agents for low risk patients Improved awareness of consideration for iron chelation in suitable low risk patients. 'Improved awareness of consideration for iron chelation in suitable low risk patients This is to be addressed after bone marrow meetings and MDT chair on review of patients referred. Allocation in new consultant job plan
38	Radiographer autonomous reporting - Adult WIC 18 month review	Continue CPD and mentorship as currently
39	Compliance with IRMER procedure N - determine radiation injuries	To be discussed at new IRMER delivery group and action list agreed there.
40	NICE CG 89 Safeguarding Children. Annual results of (SHA) audit	Actions: Training programme on improving staff documentation in the context of SUHT CP/Safeguarding Proforma to be developed and delivered by J March-McDonald by December 2010. Develop new course evaluation forms. Memo to Education Leads. Continue to promote in all training sessions. SUHT CP/Safeguarding Administrator to continue to promote via training bookings.

41	**Records management** in child liaison psychiatry	A single point of storage to be made available for open, frequently used notes. Closed and infrequently used notes to be held at the Nursling notes storage for request when required. All Paediatric Liaison letters to be saved to edocs. "Child Mental Health Team" or other suitable title to be used to make team's involvement clear. 'Paediatric Liaison Team to observe basic filing standards in order to secure notes within file. These standards will be met by use of the standard issue NHS file.Use of a front sheet for contact details inserted within the notes. The Paediatric Liaison Team to check the form proposed within Appendix B to ensure this meets the needs of the team. Paediatric Liaison Team to observe nationally agreed standards of note keeping – use of black ballpoint pen, date & time each entry using 24 hour clock, sign & print name, designation and contact details at the end of each entry. Paediatric Liaison Team to have protocol to request generic Paediatric file for review at the time of referral. Paediatric Liaison Team to design a sticker to use within generic Paediatric file highlighting their involvement and the existence of separately held notes.
42	Use and care of cuffed endotrachael tubes in PICU	Results of the audit will be presented to all PICU staff and stakeholders, including paediatric and cardiac anaesthetists. Charts on the recommended CETT sizes will be displayed on intubation trolleys in PICU and distributed throughout theatres. Training updates on cuff pressure measurements on PICU will be provided where necessary.
43	NICE CG 29 Paediatric pressure ulcer risk form following major orthopaedic surgery	It is clear that incidence of pressure ulcers in this population is low. But nurses should follow government recommendations and document patient care and interventions. Recommendations from Essence of Care benchmark(BM) for prevention and management of pressure ulcers (2010) and NICE CG27 should be followed
44	NICE CG 32 Re-audit malnutrition screening in adult orthopaedic pts	Training for clinical staff on revised paperwork Revision of MUST care plans. Actions in the process of being implemented.
45	Enhanced recovery in Gynaecology and Oncology	Raise awareness: Convincing our colleagues and staff to break from surgical tradition Audit & re-audit Monitoring of outcomes e.g. readmission rate Circulate information Transfer experience to other surgical areas ?Obstetrics

46	Neonatal care audit	To start system of SHO reviewing unacknowledged results list pre evening handover and discussing as appropriate at end of handover 1.Trainees' filters on equest to be set to neonatal medicine/surgery and Burley Babies2.To audit this specifically
47	NICE CG 93 Operation of Donor Breast Milk Bank @ PAH	Observe and maintain standards to 100% in line with NICE guidelines
48	Are we using growth charts appropriately in NNU?	Provide training on how to measure head circumference accurately and formally assess competency To be discussed with Matron regarding obtaining new WHO charts Use of Leicester incubator baby measuring device.
49	Neonatal care audit - are we acknowledging results in a timely manner	Part of SHO/Registrar induction. Discuss with IT regarding ANPs. Burley ward manager already informed. Theme of the week to be discussed with consultants. Increased awareness during induction. Ensure appropriate acknowledgement rights are set up. When discharging/transferring a patient, the doctor/ANP is responsible for acknowledging all results. Introduce system for highlighting results - needs further discussion. To be discussed with seniors. At end of PN shifts, SHO is responsible for acknowledging all outstanding results on Burley Babies and feeding back to Burley staff re any inappropriate results coded as Burley Babies. 'Inform Consultants and registrars via audit presentation.
50	Thromboprophylaxis following caesarean section	The need for thromboprophylaxis, dose and timing should be discussed for every patient in theatre by the whole multi-disciplinary team Creation of a laminated form with the various indications and recommended doses for clexane be available in theatre to guide this discussion
51	NPSA Trust Wide Snap Shot Audit of Missed Doses	Outcomes & recommendations in process of being disseminated to Divisions & Care Groups so that policies, procedures and practices can be changed to address shortfalls. This will result in improved patient safety and reduced costs by avoiding re-work and corrective actions. A follow-up audit will be undertaken. Emergency cupboard stocklist amended. Staffnet page - education and Training resource sorted.
52	Re-audit Pharmacy record keeping for controlled drugs	Actions in hand. Escalation: a) Link to risk register required NO – this demonstrates low risk b) Suggested timescale for repeat audit within 13 months.

53	Current physiotherapy practice in Respiratory Centre against BTS Bronchiectasis guidelines	•To develop a new Bronchiectasis leaflet from Physiotherapy that would include airway clearance techniques and an explanation of the diagnosis. '•Review all new Bronchiectasis patients in 3 months. •Education of staff on the Guidelines and need for including the BTS standards in their care. •Education on more detailed noted on HICCS. Leaflet has been written and passed through clinical governance. The consultants have approved its use and we are now in the process of getting patient feedback and quotes to have the leaflet printed properly according to SUHT guidelines.
54	Barriers to Critical Care Rehabilitation	1. Continue current patient referral system 2.Re-audit in 6 months to monitor impact of daily sedation hold protocol 3.Record more detailed reasons when patients are deemed too medically unwell for rehabilitation on a regular basis. Repeat audit imminent.
55	NICE CG 68 Nil by mouth compliance	·Liaise with the Stroke consultants about documenting the need for CVA patients to be NBM on admission and request they cascade this information to ED doctors ·Training for AMU and ED medical and nursing staff regarding the rationale for stroke patients being kept NBM and reinforcing that this means no food/fluid or medication unless clearly documented (including a rationale) by the consultant or senior registrar. The results have been discussed with consultants. Training for medical staff is an ongoing AMU goal.
56	NICE CG 17 Review of number of voice pts with reflux and/or asthma	Leaflet produced for patients. Reflux Symptom Index (RSI) and patient experience used to assess and review patient symptoms Leaflets made available for ENT consultants Reviewing compliance of patients taking Dyspepsia medication Guidance for patients on step down approach to taking medication More thorough assessment of LPR related symptoms. Leaflet has now been developed for patient and consultants and shared. Ongoing training of relevant staff.

57	Accessibility of communication environment on paediatric wards	Leaflet produced for patients. Reflux Symptom Index (RSI) and patient experience used to assess and review patient symptoms Leaflets made available for ENT consultants Reviewing compliance of patients taking Dyspepsia medication Guidance for patients on step down approach to taking medication More thorough assessment of LPR related symptoms. The Speech and language therapy (SLT) service will advise staff on children's communication needs, if the child is already known to the SLT service. Speech and language therapy to liaise with catering and ward staff about the format of new children's menus. The catering arrangements have changed since this audit was done and it is therefore timely to implement changes before this process is finalised. Makaton training arranged for May 2011. Ongoing work on format of menus.
58	Patients not receiving reperfusion therapy for ST-elevation myocardial infarction	Continue current practice. Consider reviewing the way coding is done for STEMI patients as 5/35 did actually have PPCI.
59	Bivalirudin and/or heparin in pts undergoing primary PCI treatment of acute stemi	Recirculate the bivalirudin and heparin guidance Encourage nursing staff to check/crosscheck bivalirudin bolus and infusion doses according to the estimated patient weight (it is not feasible to formally weigh STEMI patients pre PCI)
60	Independent & supplementary non medical prescribing	Diligent record keeping of INMP Repeat audit regularly Monitor feedback from Pharmacy, Wards & GPs.
61	Audit of rivaroxaban prescribing, compliance & side effects in orthopaedics	To continue as per the existing guidelines and re-audit in 1 year or sooner if problems develop.
62	Trauma list audit - efficient use	To improve access to theatres for trauma patients and thus operate when required and reduce length of stay. 'We will create 2 additional lists in core hours for trauma from our existing resource and close the evening list down to delivery efficiencies for theatres.
63	Timing of check Xray in post hip hemiarthoplasty	Presented to M&M. Include in Induction.
64	Saving Lives HII 1 Central Venous Catheter Care.	Jan 11: Central venous catheter care - Audits completed July 2010 and January 2011. July's audit remained at 100% for insertion and 99% for ongoing care. Only 1 area of suboptimal performance required to implement actions. January 2011 audit data not yet analysed.
65	Saving Lives HII 2 Peripheral Intravenous Cannula Care	Jan 11: Peripheral intravenous catheter - Audits completed June 2010 and December 2010. June 2010 audit showed a reduction in compliance compared to February 2010 audit. December 2010 Trust compliance for insertion is at 95% compared to 94% in June 2010, compliance for ongoing care is 94% compared to June 2010 audit of 95%.

66	Saving Lives HII 3 Renal Dialysis Catheter Care	Jan 11: Renal Dialysis Care - Audits completed April 2010 and October 2010. Compliance remains at 100%, no actions required.
67	Saving Lives HII 4 Surgical Site Infection. Acute contract.	Jan 11: Surgical site infection - Audits completed May 2010 and November 2010. Reduction in compliance seen for preoperative care; 95% compliance in May and 90% compliance in November. Reduction in compliance for perioperative care from 100% in May to 95% in November. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme. Infection Prevention Team provided intensive support to areas scoring less than 85% in November's audit, matrons required to provide support and monitoring to areas scoring between 85 - 94%. MRSA patient held record being introduced across Trust. MRSA awareness week carried out June 2010 to raise awareness and education.
68	Saving Lives HII 5 Ventilated Patients (Q27 - accepted alternative)	Jan 11: Ventilated patients - Audits completed April 2010 and October 2010. Compliance remains at 100% for observations and 99% for ongoing care.
69	Saving Lives HII 6 Urinary Catheter Care	Jan 11: Urinary catheter care - Audits completed Aug 2010, next audit due end Feb 2011. Compliance for insertion remains at 98%, compliance for ongoing care has shown a reduction from 98% in March 2010 to 92% in August 2010. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme. No intensive support provided to areas, however this will take place for areas scoring below 85% in Feb 11 audit.
70	Saving Lives HII 7 Clostridium difficile	Jan 11: Clostridium difficile - same as below.
71	Saving Lives HII 8	Jan 11: Saving Lives HII 8 Cleaning and decontamination - New audit, first audit completed October 2010. Trust score of 91% for patients in non contaminated area and 95% for patients in infected area. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme, matrons required to provide support and monitoring to areas scoring between 85 - 94%. Results discussed at Trust Environmental Operational Steering Group. Cleaning and decontamination launch and focus in July 2010.
72	Hand Hygiene Compliance in Clinical Areas	Jan 11: Clinical hand hygiene - Audits carried out quarterly; June, Sep, December 2010, next audit due end March 2011. Junes compliance at 99%, Sep at 97% and Dec at 98%. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme. Infection Prevention Team carrying out intensive support and education to areas scoring less than 85% in December's audit, matrons required to provide support and monitoring to areas scoring between 85 - 94%. Audit assurance checks undertaken on areas of optimal performance. Hand hygiene awareness week completed May 2010 to raise awareness and education. Hand hygiene policy updated and relaunched.
73	Hand Hygiene Compliance during medical ward rounds	Jan 11: Medical hand hygiene - Audits carried out quarterly: May, Aug, Nov 2010, next audit due end Feb 2011. Mays compliance at 91%, Aug at 97%, Nov at 96%. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme. Hand hygiene awareness week completed May 2010 to raise awareness and education. Hand hygiene policy updated and relaunched.

74	NICE CSG SP End of Life (Liverpool Care Pathway)	Ward support when an LCP is started to ensure staff are competent in using the paper work and documentation of relevant assessments. Contact Clinical Educators re existing education programmes for LCP education. 'Liaise with the ward clerks in medicine, cancer care and medicine for older people to document contact with GP after the patient has died on the LCP. This will be modelled on the work that is being undertaken by the ward clerk at Countess Mount Batten House Hospice in contacting the GP and documenting this has been done. Attendance at Care of the Elderly Consultant ward round. Support and education around symptom management for patients under their care.
75	Audit of registered new procedures 2009/10 - Standards for Better Health	Proposals received by Clinical Effectiveness that have not come from the governance lead, will be sent to the governance lead. DGMs add the discussion of new procedures as a standing item to divisional governance board meetings. Check proposal forms to ensure governance group approval and policy followed. Repeat audit for 2010/11 proposals.
76	Trust-wide Re-Audit of Consent Process 2010/11	Consent policy tweak - patient to receive pink copy. Actioned. Reinforce the need for anaesthetist's discussion with patients. Divisional Governance Managers (DGMs) to review results with CE manager and agree specific areas to improve. Specialist medicine to audit an additional 10 cases in next three months. Written information – high level of positive patient feedback. To increase availability of written information for more procedures.
77	Trustwide **Essence of Care** Audit of Privacy & Dignity (b/f)	For Action Planning – Care Group Use of curtain or door signs, importance of closing curtains, ask patients what they prefer to be called, hand wipes before and after meals, answering of call bells, storage of patient property, track patient moves and ensure patients told why being moved, review reasons for noise at night, remind medical staff to ensure confidentiality, privacy and dignity when having confidential conversations. For Action Planning – Corporate. Consider admissions “welcome to our ward” letter/ward orientation sheet. Report hyperlinked.
78	Trustwide **Essence of Care** Audit of Nursing Assessment & Documentation	Draft report lists the following recommendations / requirements: care group action plans to be established by each area's E of C leads; Trust to confirm revised RCP guidance on including an addressograph on every side of the pages in the patient’s records; progress feasibility of developing a standardised abbreviations list with IG lead; implement new transfer documentation (already completed by PC); feedback MUST results to relevant nutritional staff for inclusion in wider Trust plans.

79	Monthly nutrition screening Trust wide MUST audit (continuous)	MUST nutrition screening audit tool has been developed and launched as a continuous Trust wide monthly data collection audit. Results discussed at local led by project lead. Action: to provide all divisions with their results monthly to enable benchmarking. May cycle is 4th monthly cycle and shows statistically significant improvement compared to previous 3 months which indicated a steady rise in compliance. Repeat audit cycles to continue.
80	Monthly Trust wide audit of thromboprophylaxis (continuous)	The audit findings indicate significant improvements in appropriate thromboprophylaxis and documentation since the audit commenced. Documented risk assessment rose from 25% in Feb 2010 to 85% by Jan 2011. Appropriate pharmacological prophylaxis rose from 66% in Feb 2010 to 85% by Jan 11.
81	Repeat audit of ERALS Enhanced Recovery programme - national audit tool - local audit. Prostatectomy, hysterectomy, cyctectomy, colectomy, knee replacement, hip replacement	Patient Education on importance of nutrition drinks and mobilisation. Medical and Nursing Staff education update. Review of protocol.
82	Trustwide **Essence of Care** Audit of Hygiene Personal and Oral	Invite university representative and NVQ training representatives to future essence of care group to determine student and support worker education in personal hygiene. Confirm Trust position on nursing staff performing nail care and remind wards of need to keep nail care equipment available. Complete work on template for ward introduction booklet to indicate same sex facilities. Confirm availability of podiatry service and commence discussions with commissioners to extend. Launch Trust wide standards of care for personal hygiene (as part of clinical accreditation project)
83	Controlled Drug Orders	Remind all areas of need to avoid crossings out.

Report reviewed - actions to be agreed:

84	Pain relief in children following groin surgery	Actions to be agreed
85	Measurement of ETT cuff pressures on CIC U	Actions to be agreed
86	Response to referrals 2010 SGH	Actions to be agreed
87	Response to referrals 2010 CMB	Actions to be agreed
88	Radiotherapy for malignant spinal cord compression	Actions to be agreed

89	Laparoscopic distal pancreatectomy	Actions to be agreed
90	Follow up of babies with antenatal renal pelvic dilatation	Actions to be agreed
91	Re-audit of patient outcome follow up RACPC	Actions to be agreed
92	Safety + efficacy of surgery for cerebral metastases	Actions to be agreed
93	Trustwide WHO Theatre checklist audit 2010	Audit remains active. May 11- draft report for completed audit - insufficient numbers. Operationally difficult therefore re-audit imminent. Sample = Number of patients over two days' data. Some obvious areas of improvement required: Action: 2/30 operating theatres to improve their 'time-out' check. Where compliance is <90% theatres will be expected to repeat audit within short timescale as an action.