Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 23rd May, 2013
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

MEMBERS TO BE APPOINTED AT ANNUAL COUNCIL

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have 6 scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the health Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.
- To consider Councillor Calls for Action for health and social care matters.
- To respond to proposals and consultations from NHS bodies in respect of substantial

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2012/13

2013	2014
23 May 2013	31 January 2014
18 July	20 March
19 September	
21 November	

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take.

Access – access is available for the disabled. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

variations in service provision and any other major health consultation exercises.

- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch".
- Provide a vehicle for the City Council's Overview & Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.

Southampton City Council's Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

CONDUCT OF MEETING

Terms of Reference

Details above

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

DISCLOSURE OF INTEREST

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Personal Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PERSONAL INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value fo the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having a, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 ELECTION OF CHAIR AND VICE-CHAIR

In the event that the Chair and Vice-Chair are not elected at Annual Council, to appoint a Chair and Vice-Chair to the Health Overview and Scrutiny Panel.

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

4 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

5 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

6 STATEMENT FROM THE CHAIR

7 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 21 March 2013 and to deal with any matters arising, attached.

8 SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY COMMITTEES: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION

Report of the Head of Service, Communities, Change and Partnerships, Southampton City Council, seeking agreement to the revised arrangements for assessing substantial change in NHS provision, attached.

9 SOUTHAMPTON CITY COUNCIL SOCIAL CARE : ANNUAL PLANS AND PRIORITIES 2013/14

Report of the Director of People, Southampton City Council, detailing annual plans and priorities for Southampton City Council Social Care, attached.

10 SOUTHAMPTON CLINICAL COMMISSIONING GROUP (CCG) ; ANNUAL PLAN AND PRIORITIES 2013/14

Report of the Chair and Chief Officer, Southampton City Clinical Commissioning Group, detailing the annual plans and priorities for the Southampton Clinical Commissioning Group, attached.

11 SOUTHERN HEALTH NHS FOUNDATION TRUST (SHFT) : DRAFT QUALITY ACCOUNT 2012/13

Report of the Clinical Quality Manager, Southern Health NHS Foundation Trust, providing details of the draft quality account for comment, attached.

12 SOLENT NHS TRUST : DRAFT QUALITY ACCOUNT 2012/13

Report of the Interim Chief Executive, Southampton City Council, detailing activities at Solent NHS Trust and the draft Quality Account for 2012/13, attached.

13 UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST (UHS): QUALITY ACCOUNT 2012/13

Report of the Director of Nursing, University Hospital Southampton, detailing performance in 2012/13 and priorities for 2013/14, attached.

Wednesday, 15 May 2013

HEAD OF LEGAL, HR AND DEMOCRATIC SERVICES

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 21 MARCH 2013

Present: Councillors Pope (Chair), Claisse, Jeffery, Parnell and Tucker

Apologies: Councillors Lewzey and Keogh

42. **MINUTES OF THE PREVIOUS MEETINGS (INCLUDING MATTERS ARISING)**

RESOLVED that :-

i. the minutes of the meeting held on 31 January 2013 be approved, subject to the following amendments:-

- **Minute 36 – Outcome of the Care Quality Commission Routine Inspection of Southampton General Hospital – Page 23 – Staffing**. Penultimate sentence to read "The use of agency staff was also discussed including the costs".
  Future Inspections – the following wording to be added "….had not been made aware of the inspection and had learned of it directly from the CQC via officers ".

Matters Arising

- **Minute 36 – Resolution** - reassurance that action was being taken at Southampton General Hospital, in relation to future CQC inspections.

ii the minutes of the meeting held on 28th February 2013 be approved, subject to the following amendments:-

- **Page 28 – Anita Beer – University Hospital Southampton**
  the following comments to be added :-
  - "The Panel expressed concern about the University Hospital's lack of accountability relating to transport"; and
  - "The Panel expressed concern that the University Hospital was not able to provide a clear commitment to exactly what support the hospital could provide".

- **Page 29 – Ian Taylor and Paul Coyne - Bluestar and Uni-link – 2nd bullet point**
  the following comment to be added:-
  - "The Panel expressed concern that Southampton Councillors had not been involved in these groups".

  Page 29 – Dervla McKay – First South Coast – 5th bullet point
  the following comment to be added:-

- "The Panel expressed concern that the public would not be consulted prior to making changes to the bus service".

- **Page 30 – Resolutions** – duplicate iii to be removed.

Matters Arising

- **Page 30 – Resolutions – i -** Further information to be obtained from James Smith, Unison, Anita Beer, University Hospital and Dervla Mckay, First South Coast.

NOTE: Information relating to Park and Ride was included within Appendix 3 to the minutes from Anne Meader and therefore it was not necessary to amend the minutes.

43. **TRANSFER OF PUBLIC HEALTH TO LOCAL GOVERNMENT**

The Panel received and noted the report of the Director of Public Health detailing information on progress being made towards public health functions being transferred to the local authority. (Copy of the report circulated with the agenda and appended to the signed minutes).

Andrew Mortimore, Director of Public Health and Councillor Rayment, Cabinet Member for Communities, were present and provided an overview and answered questions from the Panel.

The following was noted:-

- Political leadership for public health in Southampton would be with the Cabinet Member for Communities reflecting the cross-Council nature of public health.
- The Department of Health published the 2013/14 and 2014/15 budget allocations to fulfill the public health function on 10th January 2013 and the budget allocation for Southampton was £14.313m for 2013/14 and £15.050m for 2014/15.
- The role of the Health and Wellbeing Board, which was non-political, was critical as it was an opportunity to bring health partners together to discuss areas of conflict and new ideas and to work together to the deliver targets and outcomes of the Health and Wellbeing Strategy.
- The Local Authority would be responsible for commissioning all the services listed and all targets had been costed and were achievable.

44. **HEALTHWATCH SOUTHAMPTON**

The Panel received and noted the report of the Joint Associate Director of Strategic Commissioning for the Panel to note the progress towards securing local Healthwatch for Southampton. (Copy of the report circulated with the agenda and appended to the signed minutes).

Councillor Stevens, Cabinet Member for Adult Services, and Harry Dymond, LINk were present and addressed the Panel.

The following was noted:-

- All upper-tier local authorities were required to secure a local Healthwatch in their area by 1st April 2013.
- Southampton would not be able to achieve this deadline as there had been a number of delays due to the Department of Health publishing the final regulations and in the Council determining the final budget for local Healthwatch, following delays in the final grant settlement being announced by Central Government.
- The tender process had commenced and the tender period had been extended.
- Discussions had been held with Southampton Voluntary Services who currently acted as host to the LINk and it had been agreed that Southampton Link would be been asked to continue to their existing role until Healthwatch was in place. The NHS complaints advocacy service would be provided in the interim period by the organisation currently supplying the independent Complaints Advocacy Service (SEAP).
- All bidders, whether local or outside would be measured against the same criteria.

45. **THE NATIONAL HEALTH SERVICE (PROCUREMENT, PATIENT CHOICE AND COMPETITION) (NO 2) REGULATIONS 2013**

The Panel received and noted the report of the Head of Communities, Change and Partnerships providing background to the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013.
(Copy of the report circulated with the agenda and appended to the signed minutes).

Mrs Freeland, Mrs Harding and Mr Hoadley from Southampton Defend the NHS, addressed the meeting and raised the following concerns and issues:-

- The role of their lobby group was to put pressure on the Department of Health to rewrite the regulations and to raise public awareness of the fact that the revised regulations could lead to the fragmentation of the NHS.
- The revised regulations were not significantly different from the original regulations. There was concern they would promote privatisation and cause fragmentation within the NHS as the public sector would not be able to compete against private companies who would “cherry pick” the more cost effective areas of care.
- The role of monitor was of concern as there was very little to support the CCGs if Monitor was to force the tender of services. Southampton Defend the NHS would be writing to the three Hampshire MP’s expressing their concern with the revised regulations.
- There was concern over the urgency for these revised regulations to come into effect on 1 April 2013 and the lack of debate that had taken place

It was noted that the regulations were being made using the negative procedure and that there were 40 days within which MPs or Members of the House of Lords could request a debate.

RESOLVED that Southampton Defend the NHS would provide officers with legal advice and documentation in respect of the guidance, which could then be passed onto the Council’s legal department for review. If, following Council legal advice, the concerns

raised were considered to be justified the Chair would write to the government to highlight the issues.

46. SOUTHAMPTON SAFEGUARDING ADULTS BOARD

The Panel received and noted the report of the Head of Communities, Change and Partnerships providing the Panel with an update on the Southampton Adults Safeguarding Board. (Copy of the report circulated with the agenda and appended to the signed minutes).

Carol Tozer, Independent Chair, Southampton Safeguarding Adults Board (SSAB) and Carol Valentine, Head of Personalisation and Safeguarding were present and detailed the background to the SSAB by way of a presentation.

The SSAB annual report was presented to the Panel for discussion and the following was noted:-

- The SSAB was about to be placed on a statutory footing.
- Safeguarding adults was not a mirror image of safeguarding children as only adults at risk were subject to adult safeguarding arrangements. Children's safeguarding covered all children aged under 18.
- The SSAB annual business plan would be presented to the HOSP on a bi-annual basis.
- Serious Case Reviews (SCR) had very clear national criteria and where appropriate panel members could engage with the process, but as MARAC's dealt with very confidential data it would not be appropriate for them to sit on these panels .

47. PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL - RECOMMENDATIONS

The Panel considered the report of the Head of Communities, Change and Partnerships seeking approval of the draft recommendations in relation to the review of Public and Sustainable Transport Provision to Southampton General Hospital. (Copy of the report circulated with the agenda and appended to the signed minutes).

RESOLVED:-

i. that the recommendations tabled in Appendix 1 be updated as per the Panel's comments and circulated electronically to all members;

ii. that authority be delegated to the Head of Communities, Change and Partnership, following consultation with the Chair, to amend the final report, incorporating the comments of the Health Overview and Scrutiny Panel Members;

iii. that the Chair presented the final report to the Overview and Scrutiny Management committee on 16th May.

48. **HEALTH SCRUTINY 2012/13 - REVIEW**

The Panel considered the report of the Head of Communities, Change and Partnerships updating members on health scrutiny proposals for 2013/14 and seeking agreement on the HOSP contribution to the annual report. (Copy of report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- That as a result of The Local Authority (Public Health and Wellbeing Boards and Health Scrutiny Regulations) 2013, in order for health scrutiny to continue to be carried out by the existing Health Overview and Scrutiny Panel (HOSP), the Council were required to delegate responsibility to OSMC and subsequently the Panel and a recommendation requesting this was approved at Council on 20th March 2013; and

- Further guidance was expected prior to the end of March on whether the power to refer to the Secretary of State could also be delegated to HOSP.

RESOLVED:-

i. that the content of the HOSP contribution to the Scrutiny Annual Report due to be presented to OSMC on 11th April and Full Council on 15th May be agreed; and

ii. that the proposed changes to the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 Scrutiny for 2013/14 be noted.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT, AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY COMMITTEES: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION		
DATE OF DECISION:		23 MAY 2013		
REPORT OF:		HEAD OF SERVICE, COMMUNITIES, CHANGE AND PARTNERSHIPS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dorota Goble**	**Tel:**	**023 8083 3317**
	E-mail:	**dorota.goble@southampton.gov.uk**		
Director	**Name:**	**Dawn Baxendale**	**Tel:**	**023 8083 2966**
	E-mail:	**dawn.baxendale@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

This paper seeks the agreement of the revised Health Overview and Scrutiny Panel (HOSP) to the existing framework for assessing substantial change in NHS provision across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) region.

RECOMMENDATIONS:

(i) That the Panel agrees the Arrangements for Assessing Substantial Change in NHS Provision as previously agreed by Health Overview and Scrutiny Committees (HOSCs) and providers across the SHIP region.

REASONS FOR REPORT RECOMMENDATIONS

1. To agree a consistent way of working across the SHIP region in relation to health scrutiny arrangements.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the

Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) areas.

4. It describes the actions and approach expected of relevant NHS bodies or relevant health services providers and local authorities with health scrutiny functions when proposals that may constitute substantial service change are being developed. It also outlines the principles that will underpin each parties' role and responsibility.

5. This is the third refresh of the framework, originally developed with advice from the Independent Reconfiguration Panel. The amended framework places greater emphasis on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit from doing so. The updated framework is attached at Appendix 1.

6. It is intended that these arrangements will support:

- Improved communications.
- Better coordination of engagement and consultation with service users, carers and the public.
- Greater confidence in the planning of service change to secure improved outcomes across the SHIP region.

7. The framework was previously agreed across the HOSCs and all local NHS organisations in the SHIP area and considered by the HOSP in June 2012. The purpose of this paper is to seek the agreement of the HOSP to the principles set out in the document set out in Appendix 1.

RESOURCE IMPLICATIONS

Capital/Revenue

8. None

Property/Other

9. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

10. None

Other Legal Implications:

11. None

POLICY FRAMEWORK IMPLICATIONS

12. None

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	N/A

SUPPORTING DOCUMENTATION

Appendices

1.	Southampton, Hampshire, Isle of Wight, and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS Provision
2.	

Documents In Members' Rooms

1.	
2.	

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

Report Tracking

VERSION NUMBER:	1
DATE LAST AMENDED:	13/5/13
AMENDED BY:	D Goble

FOR DEMOCRATIC SERVICES USE ONLY:

DATE AND TIME REPORT RECEIVED: Date [ ] Time: [ ]

CLEARANCE: [ ] [TYPE YES or NO]

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Southampton, Hampshire, Isle of Wight and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS provision (revised April 2013)

Purpose and Summary

1) The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Authority areas.

2) It describes the actions and approach expected of relevant NHS bodies or relevant health service providers and Local Authorities with health scrutiny functions when proposals that may constitute substantial service change are being developed and outlines the principles that will underpin the discharge of each parties' role and responsibilities.

3) The document is the third refresh of the 'Framework for Assessing Substantial Service Change' originally developed with advice from the Independent Reconfiguration Panel (IRP)[1] and updates the guidance relating to the key issues to be addressed by relevant NHS bodies or relevant health service providers when service reconfiguration is being considered. Emphasis is placed on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit to our respective communities from doing so.

4) This framework has been amended following the publication of 'The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013'[2], which were laid before parliament on 8 February 2013. These regulations followed from changes made to local authority health scrutiny in the Health and Social Care Act 2012.

5) The legal duties placed on relevant NHS bodies or relevant health service providers and the role of health scrutiny are included to provide a context to the dialogue that needs to be taking place between relevant NHS bodies or relevant health service providers and the relevant local authority/authorities to establish if a proposal is substantial in nature. In this document, the term 'NHS' and 'NHS bodies' refer to:
   - Local Area Teams of the NHS Commissioning Board
   - Clinical Commissioning Groups
   - NHS Trusts and NHS Foundation Trusts

6) It is intended that these arrangements will support:
   - Improved communications across all parties.
   - Better co-ordination of engagement and consultation with service users carers and the public.

[1] http://www.irpanel.org.uk/view.asp?id=0
[2] http://www.legislation.gov.uk/uksi/2013/218/contents/made

- Greater confidence in the planning of service change to secure improved outcomes for health services provided to communities across Southampton, Hampshire, the Isle of Wight and Portsmouth.

7) Section 242 of the NHS Act places a statutory duty on the NHS to engage and involve the public and service users in:
   - Planning the provision of services
   - The development and consideration of proposals to change the provision of those services
   - Decisions affecting the operation of services.

8) This duty applies to changes that affect the way in which a service is delivered as well as the way in which people access the service.

9) Section 244 of the NHS Act 2006 places a statutory duty on relevant NHS bodies or relevant health service providers to consult Local Authorities on any proposals for significant development or substantial variation in health services. NHS organisations will note that this duty is quite distinctive from the routine engagement and discussion that takes place with Local Authorities as partners and key stakeholders.

10) Significant development and substantial variation are not defined in the legislation but guidance published by the Department of Health and Centre for Public Scrutiny on health scrutiny make it clear that the body responsible for the proposal should initiate early dialogue with those health scrutineers to determine:
    1. If the health scrutiny committee consider that the change constitutes a significant development or substantial variation in service
    2. The timing and content of the consultation process.

11) Where it is agreed that a set of proposals amount to a substantial change in service, the NHS body or relevant health service provider must draw together and publish timescales which indicate the proposed date by which it is intended that a decision will be made. These timescales must also include the date by which the local authority will provide comments on the proposal, which will include whether the NHS Body has:
    - Engaged and involved stakeholders in relation to changes; and,
    - Evidenced that the changes proposed are in the interest of the population served.

    It is therefore expected that the NHS body or relevant health service provider works closely with health scrutineers to ensure that timetables are reflective of the likely timescales required to provide evidence of the above considerations, which in turn will enable health scrutiny committees to come to a view on the proposals.

12) The development of the framework has taken into account the additional key tests for service reconfiguration set out by the Chief Executive of the NHS. Where it is agreed that the proposal does constitute a substantial

change the response of a health scrutiny committee to the subsequent consultation process will be shaped by the following considerations:

- Has the development of the proposal been informed by appropriate engagement and involvement of local people and those using the service? This should take account of the relevant equality legislation and be clear about the impact of the proposal on any vulnerable groups.
- The extent to which commissioners have informed and support the change.
- The strength of clinical evidence underpinning the proposal and the support of senior clinicians whose services will be affected by the change.
- How the proposed service change affects choice for patients, particularly with regard to quality and service improvement.

13) NHS organisations and relevant health service providers will also wish to invite feedback and comment from the relevant Local Healthwatch organisation, which have been established by the Health and Social Care Act 2012 to build on the work of Local Involvement Networks (LINks) in facilitating the involvement of adults and children using health and social care services in their area. Local Healthwatch has specific powers, including the ability to refer areas of concern to health scrutineers and Healthwatch England, and specific responsibilities, including advocacy and complaints, and signposting to information. Health scrutiny committees expect to continue good relationships with patient and public representatives and will continue to expect evidence of their contribution to any proposals for varying health services from the NHS.

14) The framework attached at Appendix One identifies a range of issues that may inform both the discussion about the nature of the change and the response of health scrutiny committees to the consultation process. The intention is that this provides a simple prompt for assessing proposals, explaining the reasons for the change and understanding the impact this will have on those using, or likely to use, the service in question.

15) The framework is not a ‘blueprint’ that all proposals for changing services from the NHS / relevant health service provider are expected to comply with. The diversity of the health economy across the Southampton, Hampshire, Isle of Wight and Portsmouth area and the complexity of service provision need to be recognised, and each proposal will therefore be considered in the context of the change it will deliver. The framework can only act as a guide: it is not a substitute for an on-going dialogue between the parties concerned. It is designed for use independently by organisations in the early stages of developing a proposal, or to provide a basis for discussion with health scrutineers regarding the scope and timing of any formal consultation required.

17) Although it remains good practice to follow Cabinet Office Guidance in relation to the content and conduct of formal consultation, health scrutiny committees are able to exercise some discretion in the discharge of this duty. Early discussions with the health scrutiny committee whose populations are affected by a proposal are essential if this flexibility is to be used to benefit local people.

18) Any request to reduce the length of formal consultation with a health scrutiny committee will need to be underpinned by robust evidence that the NHS body or relevant health service provider responsible for the proposal has engaged, or intends to engage local people in accordance with Section 242 responsibilities. These require the involvement of service users and other key stakeholders in developing and shaping any proposals for changing services. Good practice guidance summarises the duty to involve patients and the public as being:
    1. Not just when a major change is proposed, but in the on-going planning of services
    2. Not just when considering a proposal, but in the development of that proposal, and
    3. In decisions that may affect the operation of services

19) All proposals shared with health scrutiny committees by the NHS body or relevant health service provider – regardless of whether or not they are considered substantial in nature - should therefore be able to demonstrate an appropriate consideration of Section 242 responsibilities.

20) Individual health scrutiny committees will come to their own view about the nature of change proposed by an NHS body or relevant health service provider. Where a proposal is judged to be substantial and affects service users across local authority boundaries the health scrutiny committees concerned are required to make arrangements to work together to consider the matter.

21) Although each issue will need to be considered on its merits the following information will help shape the views of health scrutiny committees regarding the proposal:
    1. The case of need and evidence base underpinning the change taking account of the health needs of local people and clinical best practice.
    2. The extent to which service users, the public and other key stakeholders including GP commissioners have contributed to developing the proposal. Regard must be given to the involvement of ‘hard to reach groups’ where this is appropriate, including the need for any impact assessment for vulnerable groups.
    3. The improvements to be achieved for service users and the additional choice this represents. This will include issues relating to service quality, accessibility and equity.
    4. The impact of the proposal on the wider community and other services. This may include issues such as economic impact, transport issues and regeneration as well as other service providers affected.

5. The sustainability of the service(s) affected by proposals, and how this impacts on the wider NHS body or relevant health service provider.

22) This information will enable health scrutiny committees to come to a view about whether the proposal is substantial, and if so, whether the proposal is in the interest of the service users affected.

23) The absence of this information is likely to result in the proposal being referred back to the responsible NHS Body or provider of NHS services for further action.

24) If an NHS body or relevant health service provider consider there is a risk to the safety or welfare of patients or staff then temporary urgent action may be taken without consultation or engagement. In these circumstances the health scrutiny committee affected should be advised immediately and the reasons for this action provided. Any temporary variation to services agreed with the health scrutiny committee, whether urgent or otherwise, should state when the service(s) affected will reopen.

25) If the health scrutiny committee affected by a proposal are not satisfied with the conduct or content of the consultation process, the reasons for not undertaking a consultation (this includes temporary urgent action) or that the proposal is in the interests of the health service in its area then the option exists for the matter to be referred to the Secretary of State. Referrals are not made lightly and should set out:
    - Valid and robust evidence to support the health scrutiny committee's position. This will include evidence that sustainability has been considered as part of the service change.
    - Confirmation of the steps taken to secure local resolution of the matter, which may include informal discussions at NHS Commissioning Board Local Area Team level.

<u>Guiding Principles</u>

26) The four health scrutiny committees and panels in Southampton, Hampshire, the Isle of Wight and Portsmouth work closely in order to build effective working relationships and share good practice.

27) Health scrutiny committees will need to be able to respond to requests from the NHS or relevant health service providers to discuss proposals that may be significant developments or substantial variations in services. Generally in coming to a view the key consideration will be the scale of the impact of the change on those actually using the service(s) in question.

28) Early discussions with health scrutiny committees regarding potential for significant service change will assist with timetabling by the NHS and avoid delays in considering a proposal. Specific information about the

steps, whether already taken or planned, in response to the legislation and the four tests (outlined in paragraph 12), will support discussions about additional information or action required.

29) Some service reconfiguration will be controversial and it will be important that health scrutiny committee members are able to put aside personal or political considerations in order to ensure that the scrutiny process is credible and influential. When scrutinising a matter the approach adopted by the HOSCs will be:
    1. Challenging but not confrontational
    2. Politically neutral in the conduct of scrutiny and take account of the total population affected by the proposal
    3. Based on evidence and not opinion or anecdote
    4. Focused on the improvements to be achieved in delivering services to the population affected
    5. Consistent and proportionate to the issue to be addressed

30) It is acknowledged that the scale of organisational change currently being experienced in the NHS coupled with significant financial challenges across the public sector is unprecedented. Consultation with local people and health scrutiny committees may not result in agreement on the way forward and on occasion difficult decisions will need to be made by NHS bodies. In these circumstances it is expected that the responsible NHS body or relevant health service providers will apply a 'test of reasonableness' which balances the strength of evidence and stakeholder support and demonstrates the action taken to address any outstanding issues or concerns raised by stakeholders.

31) If the health scrutiny committee is not satisfied that the implementation of the proposal is in the interests of the health service in its area the option to refer this matter to the Secretary of State remains.

32) All parties will agree how information is to be shared and communicated to the public as part of the conduct of the scrutiny exercise.

Appendix One – Framework for Assessing Change

Key questions to be addressed

Each of the points outlined above have been developed below to provide a checklist of questions that may need to be considered. This is not meant to be exhaustive and may not be relevant to all proposals for changing services

The assessment process suggested requires that the NHS or relevant health service providers responsible for taking the proposal forward co-ordinates consultation and involvement activities with key stakeholders such as service users and carers, Local Healthwatch and other relevant Patient and Public Involvement Forums, NHS organisations, elected representatives, District and Borough Councils, voluntary and community sector groups and other service providers affected by the proposal. The relevant health scrutiny committee(s) also need to be alerted at the formative stages of development of the proposal. The questions posed by the framework will assist in determining if a proposal is likely to be substantial, identify any additional action to be taken to support the case of need and agree the consultation process.

Name of Responsible (lead) NHS or relevant health service provider:
Brief description of the proposal:
Why is this change being proposed?

Description of Population affected:

Date by which final decision is expected to be taken:

Confirmation of health scrutiny committee contacted:

Name of key stakeholders supporting the Proposal:

Date:

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Case for Change 1) Is there clarity about the need for change? (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement) 2) Has the impact of the change on service users, their carers and the public been assessed? 3) Have local health needs and/or impact assessments been undertaken? 4) Do these take account of : a) Demographic considerations? b) Changes in morbidity or incidence of a particular condition? c) Impact on vulnerable people and health equality considerations?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
d) Potential reductions in care needs? (e.g. falling birth rates) e) Comparative performance across other health providers? f) National government police g) local 5) Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to service quality or the patient experience? 6) Do the clinicians affected support the proposal? 7) Is any aspect of the proposal contested by the clinicians affected? 8) Is the proposal supported by GP commissioners?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
9) Will the proposal extend choice to the population affected? **Impact on Service Users** 10)How many people are likely to be affected by this change? Which areas are the affecting people from? 11)Will there be changes in access to services as a result of the changes proposed? 12)Can these be defined in terms of a) waiting times? b) transport (public and private)? c) travel time? d) other? (please define) 13)Is any aspect of the proposal contested by people using the service?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Engagement and Involvement 14)How have key stakeholders been involved in the development of the proposal? 15)Is there demonstrable evidence regarding the involvement of a) Service users, their carers or families? b) Other service providers in the area affected? c) The relevant Local Healthwatch? d) Staff affected? e) Other interested parties? (please define) 16) Is the proposal supported by the key stakeholders?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
17) Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this? **Options for change** 18)How have service users and key stakeholders informed the options identified to deliver the intended change? 19)Were the risks and benefits of the options assessed when developing the proposal? 20)Have changes in technology or best practice been taken into account? 21)Has the impact of the proposal on other service providers, including the NHS, local authorities and the voluntary sector, been evaluated? 22)Has the impact on the wider		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
community affected been evaluated (e.g. transport, housing, environment)? 23)Have the workforce implications associated with the proposal been assessed? 24)Have the financial implications of the change been assessed in terms of: a) Capital & Revenue? b) Sustainability? c) Risks?? 25)How will the change improve the health and well being of the population affected?		

Southampton, Hampshire, Isle of Wight and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS provision (revised April 2013)

Purpose and Summary

1) The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Authority areas.

2) It describes the actions and approach expected of relevant NHS bodies or relevant health service providers and Local Authorities with health scrutiny functions when proposals that may constitute substantial service change are being developed and outlines the principles that will underpin the discharge of each parties' role and responsibilities.

3) The document is the third refresh of the 'Framework for Assessing Substantial Service Change' originally developed with advice from the Independent Reconfiguration Panel (IRP)[1] and updates the guidance relating to the key issues to be addressed by relevant NHS bodies or relevant health service providers when service reconfiguration is being considered. Emphasis is placed on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit to our respective communities from doing so.

4) This framework has been amended following the publication of 'The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013'[2], which were laid before parliament on 8 February 2013. These regulations followed from changes made to local authority health scrutiny in the Health and Social Care Act 2012.

5) The legal duties placed on relevant NHS bodies or relevant health service providers and the role of health scrutiny are included to provide a context to the dialogue that needs to be taking place between relevant NHS bodies or relevant health service providers and the relevant local authority/authorities to establish if a proposal is substantial in nature. In this document, the term 'NHS' and 'NHS bodies' refer to:
   - Local Area Teams of the NHS Commissioning Board
   - Clinical Commissioning Groups
   - NHS Trusts and NHS Foundation Trusts

6) It is intended that these arrangements will support:
   - Improved communications across all parties.
   - Better co-ordination of engagement and consultation with service users carers and the public.

[1] http://www.irpanel.org.uk/view.asp?id=0
[2] http://www.legislation.gov.uk/uksi/2013/218/contents/made

- Greater confidence in the planning of service change to secure improved outcomes for health services provided to communities across Southampton, Hampshire, the Isle of Wight and Portsmouth.

7) Section 242 of the NHS Act places a statutory duty on the NHS to engage and involve the public and service users in:
   - Planning the provision of services
   - The development and consideration of proposals to change the provision of those services
   - Decisions affecting the operation of services.

8) This duty applies to changes that affect the way in which a service is delivered as well as the way in which people access the service.

9) Section 244 of the NHS Act 2006 places a statutory duty on relevant NHS bodies or relevant health service providers to consult Local Authorities on any proposals for significant development or substantial variation in health services. NHS organisations will note that this duty is quite distinctive from the routine engagement and discussion that takes place with Local Authorities as partners and key stakeholders.

10) Significant development and substantial variation are not defined in the legislation but guidance published by the Department of Health and Centre for Public Scrutiny on health scrutiny make it clear that the body responsible for the proposal should initiate early dialogue with those health scrutineers to determine:
    1. If the health scrutiny committee consider that the change constitutes a significant development or substantial variation in service
    2. The timing and content of the consultation process.

11) Where it is agreed that a set of proposals amount to a substantial change in service, the NHS body or relevant health service provider must draw together and publish timescales which indicate the proposed date by which it is intended that a decision will be made. These timescales must also include the date by which the local authority will provide comments on the proposal, which will include whether the NHS Body has:
    - Engaged and involved stakeholders in relation to changes; and,
    - Evidenced that the changes proposed are in the interest of the population served.

    It is therefore expected that the NHS body or relevant health service provider works closely with health scrutineers to ensure that timetables are reflective of the likely timescales required to provide evidence of the above considerations, which in turn will enable health scrutiny committees to come to a view on the proposals.

12) The development of the framework has taken into account the additional key tests for service reconfiguration set out by the Chief Executive of the NHS. Where it is agreed that the proposal does constitute a substantial

change the response of a health scrutiny committee to the subsequent consultation process will be shaped by the following considerations:

- Has the development of the proposal been informed by appropriate engagement and involvement of local people and those using the service? This should take account of the relevant equality legislation and be clear about the impact of the proposal on any vulnerable groups.
- The extent to which commissioners have informed and support the change.
- The strength of clinical evidence underpinning the proposal and the support of senior clinicians whose services will be affected by the change.
- How the proposed service change affects choice for patients, particularly with regard to quality and service improvement.

13) NHS organisations and relevant health service providers will also wish to invite feedback and comment from the relevant Local Healthwatch organisation, which have been established by the Health and Social Care Act 2012 to build on the work of Local Involvement Networks (LINks) in facilitating the involvement of adults and children using health and social care services in their area. Local Healthwatch has specific powers, including the ability to refer areas of concern to health scrutineers and Healthwatch England, and specific responsibilities, including advocacy and complaints, and signposting to information. Health scrutiny committees expect to continue good relationships with patient and public representatives and will continue to expect evidence of their contribution to any proposals for varying health services from the NHS.

14) The framework attached at Appendix One identifies a range of issues that may inform both the discussion about the nature of the change and the response of health scrutiny committees to the consultation process. The intention is that this provides a simple prompt for assessing proposals, explaining the reasons for the change and understanding the impact this will have on those using, or likely to use, the service in question.

15) The framework is not a ‘blueprint’ that all proposals for changing services from the NHS / relevant health service provider are expected to comply with. The diversity of the health economy across the Southampton, Hampshire, Isle of Wight and Portsmouth area and the complexity of service provision need to be recognised, and each proposal will therefore be considered in the context of the change it will deliver. The framework can only act as a guide: it is not a substitute for an on-going dialogue between the parties concerned. It is designed for use independently by organisations in the early stages of developing a proposal, or to provide a basis for discussion with health scrutineers regarding the scope and timing of any formal consultation required.

17) Although it remains good practice to follow Cabinet Office Guidance in relation to the content and conduct of formal consultation, health scrutiny committees are able to exercise some discretion in the discharge of this duty. Early discussions with the health scrutiny committee whose populations are affected by a proposal are essential if this flexibility is to be used to benefit local people.

18) Any request to reduce the length of formal consultation with a health scrutiny committee will need to be underpinned by robust evidence that the NHS body or relevant health service provider responsible for the proposal has engaged, or intends to engage local people in accordance with Section 242 responsibilities. These require the involvement of service users and other key stakeholders in developing and shaping any proposals for changing services. Good practice guidance summarises the duty to involve patients and the public as being:
    1. Not just when a major change is proposed, but in the on-going planning of services
    2. Not just when considering a proposal, but in the development of that proposal, and
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19) All proposals shared with health scrutiny committees by the NHS body or relevant health service provider – regardless of whether or not they are considered substantial in nature - should therefore be able to demonstrate an appropriate consideration of Section 242 responsibilities.

20) Individual health scrutiny committees will come to their own view about the nature of change proposed by an NHS body or relevant health service provider. Where a proposal is judged to be substantial and affects service users across local authority boundaries the health scrutiny committees concerned are required to make arrangements to work together to consider the matter.

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5. The sustainability of the service(s) affected by proposals, and how this impacts on the wider NHS body or relevant health service provider.

22) This information will enable health scrutiny committees to come to a view about whether the proposal is substantial, and if so, whether the proposal is in the interest of the service users affected.

23) The absence of this information is likely to result in the proposal being referred back to the responsible NHS Body or provider of NHS services for further action.

24) If an NHS body or relevant health service provider consider there is a risk to the safety or welfare of patients or staff then temporary urgent action may be taken without consultation or engagement. In these circumstances the health scrutiny committee affected should be advised immediately and the reasons for this action provided. Any temporary variation to services agreed with the health scrutiny committee, whether urgent or otherwise, should state when the service(s) affected will reopen.

25) If the health scrutiny committee affected by a proposal are not satisfied with the conduct or content of the consultation process, the reasons for not undertaking a consultation (this includes temporary urgent action) or that the proposal is in the interests of the health service in its area then the option exists for the matter to be referred to the Secretary of State. Referrals are not made lightly and should set out:
    - Valid and robust evidence to support the health scrutiny committee's position. This will include evidence that sustainability has been considered as part of the service change.
    - Confirmation of the steps taken to secure local resolution of the matter, which may include informal discussions at NHS Commissioning Board Local Area Team level.

<u>Guiding Principles</u>

26) The four health scrutiny committees and panels in Southampton, Hampshire, the Isle of Wight and Portsmouth work closely in order to build effective working relationships and share good practice.

27) Health scrutiny committees will need to be able to respond to requests from the NHS or relevant health service providers to discuss proposals that may be significant developments or substantial variations in services. Generally in coming to a view the key consideration will be the scale of the impact of the change on those actually using the service(s) in question.

28) Early discussions with health scrutiny committees regarding potential for significant service change will assist with timetabling by the NHS and avoid delays in considering a proposal. Specific information about the

steps, whether already taken or planned, in response to the legislation and the four tests (outlined in paragraph 12), will support discussions about additional information or action required.

29) Some service reconfiguration will be controversial and it will be important that health scrutiny committee members are able to put aside personal or political considerations in order to ensure that the scrutiny process is credible and influential. When scrutinising a matter the approach adopted by the HOSCs will be:
    1. Challenging but not confrontational
    2. Politically neutral in the conduct of scrutiny and take account of the total population affected by the proposal
    3. Based on evidence and not opinion or anecdote
    4. Focused on the improvements to be achieved in delivering services to the population affected
    5. Consistent and proportionate to the issue to be addressed

30) It is acknowledged that the scale of organisational change currently being experienced in the NHS coupled with significant financial challenges across the public sector is unprecedented. Consultation with local people and health scrutiny committees may not result in agreement on the way forward and on occasion difficult decisions will need to be made by NHS bodies. In these circumstances it is expected that the responsible NHS body or relevant health service providers will apply a 'test of reasonableness' which balances the strength of evidence and stakeholder support and demonstrates the action taken to address any outstanding issues or concerns raised by stakeholders.

31) If the health scrutiny committee is not satisfied that the implementation of the proposal is in the interests of the health service in its area the option to refer this matter to the Secretary of State remains.

32) All parties will agree how information is to be shared and communicated to the public as part of the conduct of the scrutiny exercise.

Appendix One – Framework for Assessing Change

Key questions to be addressed

Each of the points outlined above have been developed below to provide a checklist of questions that may need to be considered. This is not meant to be exhaustive and may not be relevant to all proposals for changing services

The assessment process suggested requires that the NHS or relevant health service providers responsible for taking the proposal forward co-ordinates consultation and involvement activities with key stakeholders such as service users and carers, Local Healthwatch and other relevant Patient and Public Involvement Forums, NHS organisations, elected representatives, District and Borough Councils, voluntary and community sector groups and other service providers affected by the proposal. The relevant health scrutiny committee(s) also need to be alerted at the formative stages of development of the proposal. The questions posed by the framework will assist in determining if a proposal is likely to be substantial, identify any additional action to be taken to support the case of need and agree the consultation process.

Name of Responsible (lead) NHS or relevant health service provider:
Brief description of the proposal:
Why is this change being proposed?

Description of Population affected:

Date by which final decision is expected to be taken:

Confirmation of health scrutiny committee contacted:

Name of key stakeholders supporting the Proposal:

Date:

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Case for Change 1) Is there clarity about the need for change? (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement) 2) Has the impact of the change on service users, their carers and the public been assessed? 3) Have local health needs and/or impact assessments been undertaken? 4) Do these take account of : a) Demographic considerations? b) Changes in morbidity or incidence of a particular condition? c) Impact on vulnerable people and health equality considerations?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
d) Potential reductions in care needs? (e.g. falling birth rates) e) Comparative performance across other health providers? f) National government police g) local 5) Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to service quality or the patient experience? 6) Do the clinicians affected support the proposal? 7) Is any aspect of the proposal contested by the clinicians affected? 8) Is the proposal supported by GP commissioners?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
9) Will the proposal extend choice to the population affected? **Impact on Service Users** 10)How many people are likely to be affected by this change? Which areas are the affecting people from? 11)Will there be changes in access to services as a result of the changes proposed? 12)Can these be defined in terms of a) waiting times? b) transport (public and private)? c) travel time? d) other? (please define) 13)Is any aspect of the proposal contested by people using the service?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Engagement and Involvement 14)How have key stakeholders been involved in the development of the proposal? 15)Is there demonstrable evidence regarding the involvement of a) Service users, their carers or families? b) Other service providers in the area affected? c) The relevant Local Healthwatch? d) Staff affected? e) Other interested parties? (please define) 16) Is the proposal supported by the key stakeholders?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
17) Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this? **Options for change** 18)How have service users and key stakeholders informed the options identified to deliver the intended change? 19)Were the risks and benefits of the options assessed when developing the proposal? 20)Have changes in technology or best practice been taken into account? 21)Has the impact of the proposal on other service providers, including the NHS, local authorities and the voluntary sector, been evaluated? 22)Has the impact on the wider		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
community affected been evaluated (e.g. transport, housing, environment)? 23)Have the workforce implications associated with the proposal been assessed? 24)Have the financial implications of the change been assessed in terms of: a) Capital & Revenue? b) Sustainability? c) Risks?? 25)How will the change improve the health and well being of the population affected?		

Southampton, Hampshire, Isle of Wight and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS provision (revised April 2013)

Purpose and Summary

1) The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Authority areas.

2) It describes the actions and approach expected of relevant NHS bodies or relevant health service providers and Local Authorities with health scrutiny functions when proposals that may constitute substantial service change are being developed and outlines the principles that will underpin the discharge of each parties' role and responsibilities.

3) The document is the third refresh of the 'Framework for Assessing Substantial Service Change' originally developed with advice from the Independent Reconfiguration Panel (IRP)[1] and updates the guidance relating to the key issues to be addressed by relevant NHS bodies or relevant health service providers when service reconfiguration is being considered. Emphasis is placed on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit to our respective communities from doing so.

4) This framework has been amended following the publication of 'The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013'[2], which were laid before parliament on 8 February 2013. These regulations followed from changes made to local authority health scrutiny in the Health and Social Care Act 2012.

5) The legal duties placed on relevant NHS bodies or relevant health service providers and the role of health scrutiny are included to provide a context to the dialogue that needs to be taking place between relevant NHS bodies or relevant health service providers and the relevant local authority/authorities to establish if a proposal is substantial in nature. In this document, the term 'NHS' and 'NHS bodies' refer to:
   - Local Area Teams of the NHS Commissioning Board
   - Clinical Commissioning Groups
   - NHS Trusts and NHS Foundation Trusts

6) It is intended that these arrangements will support:
   - Improved communications across all parties.
   - Better co-ordination of engagement and consultation with service users carers and the public.

[1] http://www.irpanel.org.uk/view.asp?id=0
[2] http://www.legislation.gov.uk/uksi/2013/218/contents/made

- Greater confidence in the planning of service change to secure improved outcomes for health services provided to communities across Southampton, Hampshire, the Isle of Wight and Portsmouth.

7) Section 242 of the NHS Act places a statutory duty on the NHS to engage and involve the public and service users in:
   - Planning the provision of services
   - The development and consideration of proposals to change the provision of those services
   - Decisions affecting the operation of services.

8) This duty applies to changes that affect the way in which a service is delivered as well as the way in which people access the service.

9) Section 244 of the NHS Act 2006 places a statutory duty on relevant NHS bodies or relevant health service providers to consult Local Authorities on any proposals for significant development or substantial variation in health services. NHS organisations will note that this duty is quite distinctive from the routine engagement and discussion that takes place with Local Authorities as partners and key stakeholders.

10) Significant development and substantial variation are not defined in the legislation but guidance published by the Department of Health and Centre for Public Scrutiny on health scrutiny make it clear that the body responsible for the proposal should initiate early dialogue with those health scrutineers to determine:
    1. If the health scrutiny committee consider that the change constitutes a significant development or substantial variation in service
    2. The timing and content of the consultation process.

11) Where it is agreed that a set of proposals amount to a substantial change in service, the NHS body or relevant health service provider must draw together and publish timescales which indicate the proposed date by which it is intended that a decision will be made. These timescales must also include the date by which the local authority will provide comments on the proposal, which will include whether the NHS Body has:
    - Engaged and involved stakeholders in relation to changes; and,
    - Evidenced that the changes proposed are in the interest of the population served.

    It is therefore expected that the NHS body or relevant health service provider works closely with health scrutineers to ensure that timetables are reflective of the likely timescales required to provide evidence of the above considerations, which in turn will enable health scrutiny committees to come to a view on the proposals.

12) The development of the framework has taken into account the additional key tests for service reconfiguration set out by the Chief Executive of the NHS. Where it is agreed that the proposal does constitute a substantial

change the response of a health scrutiny committee to the subsequent consultation process will be shaped by the following considerations:

- Has the development of the proposal been informed by appropriate engagement and involvement of local people and those using the service? This should take account of the relevant equality legislation and be clear about the impact of the proposal on any vulnerable groups.
- The extent to which commissioners have informed and support the change.
- The strength of clinical evidence underpinning the proposal and the support of senior clinicians whose services will be affected by the change.
- How the proposed service change affects choice for patients, particularly with regard to quality and service improvement.

13) NHS organisations and relevant health service providers will also wish to invite feedback and comment from the relevant Local Healthwatch organisation, which have been established by the Health and Social Care Act 2012 to build on the work of Local Involvement Networks (LINks) in facilitating the involvement of adults and children using health and social care services in their area. Local Healthwatch has specific powers, including the ability to refer areas of concern to health scrutineers and Healthwatch England, and specific responsibilities, including advocacy and complaints, and signposting to information. Health scrutiny committees expect to continue good relationships with patient and public representatives and will continue to expect evidence of their contribution to any proposals for varying health services from the NHS.

14) The framework attached at Appendix One identifies a range of issues that may inform both the discussion about the nature of the change and the response of health scrutiny committees to the consultation process. The intention is that this provides a simple prompt for assessing proposals, explaining the reasons for the change and understanding the impact this will have on those using, or likely to use, the service in question.

15) The framework is not a ‘blueprint’ that all proposals for changing services from the NHS / relevant health service provider are expected to comply with. The diversity of the health economy across the Southampton, Hampshire, Isle of Wight and Portsmouth area and the complexity of service provision need to be recognised, and each proposal will therefore be considered in the context of the change it will deliver. The framework can only act as a guide: it is not a substitute for an on-going dialogue between the parties concerned. It is designed for use independently by organisations in the early stages of developing a proposal, or to provide a basis for discussion with health scrutineers regarding the scope and timing of any formal consultation required.

17) Although it remains good practice to follow Cabinet Office Guidance in relation to the content and conduct of formal consultation, health scrutiny committees are able to exercise some discretion in the discharge of this duty. Early discussions with the health scrutiny committee whose populations are affected by a proposal are essential if this flexibility is to be used to benefit local people.

18) Any request to reduce the length of formal consultation with a health scrutiny committee will need to be underpinned by robust evidence that the NHS body or relevant health service provider responsible for the proposal has engaged, or intends to engage local people in accordance with Section 242 responsibilities. These require the involvement of service users and other key stakeholders in developing and shaping any proposals for changing services. Good practice guidance summarises the duty to involve patients and the public as being:
    1. Not just when a major change is proposed, but in the on-going planning of services
    2. Not just when considering a proposal, but in the development of that proposal, and
    3. In decisions that may affect the operation of services

19) All proposals shared with health scrutiny committees by the NHS body or relevant health service provider – regardless of whether or not they are considered substantial in nature - should therefore be able to demonstrate an appropriate consideration of Section 242 responsibilities.

20) Individual health scrutiny committees will come to their own view about the nature of change proposed by an NHS body or relevant health service provider. Where a proposal is judged to be substantial and affects service users across local authority boundaries the health scrutiny committees concerned are required to make arrangements to work together to consider the matter.

21) Although each issue will need to be considered on its merits the following information will help shape the views of health scrutiny committees regarding the proposal:
    1. The case of need and evidence base underpinning the change taking account of the health needs of local people and clinical best practice.
    2. The extent to which service users, the public and other key stakeholders including GP commissioners have contributed to developing the proposal. Regard must be given to the involvement of ‘hard to reach groups’ where this is appropriate, including the need for any impact assessment for vulnerable groups.
    3. The improvements to be achieved for service users and the additional choice this represents. This will include issues relating to service quality, accessibility and equity.
    4. The impact of the proposal on the wider community and other services. This may include issues such as economic impact, transport issues and regeneration as well as other service providers affected.

5. The sustainability of the service(s) affected by proposals, and how this impacts on the wider NHS body or relevant health service provider.

22) This information will enable health scrutiny committees to come to a view about whether the proposal is substantial, and if so, whether the proposal is in the interest of the service users affected.

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Description of Population affected:

Date by which final decision is expected to be taken:

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Date:

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON CITY COUNCIL SOCIAL CARE: ANNUAL PLANS AND PRIORITIES 2013/14		
DATE OF DECISION:		23 MAY 2013		
REPORT OF:		DIRECTOR OF PEOPLE		
CONTACT DETAILS				
AUTHOR:	**Name:**	Alison Elliott	Tel:	023 8083 2602
	E-mail:	Alison.Elliott@southampton.gov.uk		
Director	**Name:**	Alison Elliott	Tel:	023 8083 2602
	E-mail:	Alison.Elliott@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

This report headlines key developments since the decision was taken to form the People Directorate. It also describes the emerging direction of travel for the services being transformed through this initiative. It sets out what our approach to initial cost savings, through better and more joined up commissioning and contact with our customers and focuses on the issues that relate to the quality of professional support we deliver to ensure social care services for children, families and adults who need our help provide the right help at the right time.

RECOMMENDATION:

(i) That the Panel notes the report.

REASON FOR REPORT RECOMMENDATIONS

1. This briefing report has been prepared in response to a request for an update on this development at the Panel's meeting on 23 May 2013.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. The Council recognised in 2012 that the formation of a People Directorate had the potential to deliver improved outcomes and services whilst also reducing costs. Price Waterhouse Cooper (PWC) were commissioned in November 2012 to develop specific proposals for the establishment of a People Directorate. This initial review was followed up by a more detailed phase of review activity over the first three months of 2013, developing proposals in relation to seven discreet but linked workstreams relating to the main functions to be carried out in the new directorate alongside the appointment process for the Director of People. Initial work on the seven workstreams facilitated by PWC was completed in early April 2013. Over the last month officers have been further developing the full business cases and implementation plans so that the business cases for different functions work across functions and processes.

4. Alison Elliott joined the council on the 8 April 2013 as Director of People and has taken responsibility for leading this transformation of the council's people focussed services to deliver the better outcomes and customer services at reduced cost identified in the original vision.

5. The review work that has underpinned the Council's preparation for the creation of a People Directorate has focussed on seven Workstreams. The workstreams were developed from a longer list of 16 priority areas for improvement identified by the council. Each has been developed in relation to initial outline business cases, supported by high level implementation plans. The use of external consultancy helped provide a more ambitious sense of what might be possible based upon successful practice elsewhere which helped to establish momentum and ambition into the transformation programme covering the following areas of activity:

    - Adult social care services,
    - Children's services,
    - Housing services,
    - Integrated Commissioning,
    - Customer Services,
    - Supporting the Front Line, and
    - Organisational Design.

6. The development of the seven Workstreams above has made it clear that the areas which offer the greatest scope for improving or maintaining service levels at reduced cost are improving the way we commission services, making how we interface with customers at the 'front door' more effective, flexible and customer centred, particularly in relation to the use of IT.

7. An Implementation Board and Project Teams have been established and the principal work for the remainder of the 2013/14 will be the preparation of the final business cases and implementation plans. These will define how the services will be transformed and it is anticipated that the target operating models will be in place by April 2014. Whilst any 'quick wins' will be

implemented it is not anticipated that significant levels of savings will start to be deliverable until the summer of 2014; the key savings prize for the council will be services that successfully reduce demand for chronic and ongoing dependence upon intensive social care support. As we succeed in achieving this through a remodelled service, some areas of spend will reduce automatically, but overall remodelled services that reduce demand will deliver savings that are safe and sustainable.

8. In addition to the work being delivered as part of the transformation project the other main priorities for the People Directorate identified so far include:

- Improving school performance in relation to the attainment of our children, with a particular emphasis on attendance and exclusions.
- Improving the quality of children's social care, with a focus upon fewer children and young people becoming looked after.
- Improving our safeguarding across Adults and Children's Services in response to Working Together 2013 and impending legislative changes in Adult social care.
- Reducing some of the significant health inequalities that exist within the City and between our people and people in other parts of the country.
- Taking full advantage of our housing stock to best meet the City's housing needs through a range of options.
- Modernising the way that our workforce works and engages with the public mainly through better use of technology.
- Implementing efficient business processes and ensuring all staff model and follow them.
- Improving customer service and developing a "once and done" culture.
- Implementing a performance management culture across all services built upon quality.
- Fully capitalising upon the strength of the good partnership working arrangements we already have in place in the City, building upon the energy and innovation this already generates.

In addition there are significant opportunities to improve consistency and remove duplication by pulling together support services across the Directorate, utilising the expertise across the Directorate, mapping the support currently being provided into families across the Directorate and Health and redesigning services to maximise the value we get from these assets and resources.

9. Adult Social Care continues to place a high demand upon resources and will become increasing challenging. Issues such as a long term trend in increased demand for services to older people arising from demographic changes, and the capacity of the service to meet this demand, combined with pressures in relation to the rising cost of both in-house and commissioned services make adult social care a challenge for Southampton. The drive to implement the personalisation agenda poses challenges for in-house services. The way in which we commission our services will need to develop alongside this and there will be a need for cultural changes in our

practice.

10. For Southampton to deliver high quality services to an increasing population of frail and elderly people that supports them in to be as independent as possible we will need to move our focus onto developing preventative options that draw on the resilience already in the community. This will help us to manage demand and support communities to self-care. The integration of Public Health will help us to target the behavioural change we need to achieve to maximise individuals and communities ability to stay independent and healthy for longer.

11. Southampton will need to ensure it has more effective commissioning and procurement. This will help us to create, shape and develop the market in relation to the increasingly varied needs of our diverse communities to ensure the emergence of sustainable, creative and personalised options for individuals and communities that take full advantage of the creativity and energy of the voluntary sector and our private sector providers.

12. Southampton is well placed to commission integrated services across health and social care and this will need to remain a focus to ensure outcomes for individuals are improved across the whole system whilst maximising whole system resources.

13. The transformation work will redesign Adult Social Care, placing a greater emphasis on prevention and demand management through an effective screening process and an expanded reablement service. There will be greater emphasis on risk based reviews and a focus on Safeguarding. The development of the Integrated Commissioning Unit, with the Clinical Commissioning Group (CCG) will create capacity to manage and monitor provider performance leaving Adult Social Care to focus on individual risk.

14. Children's Safeguarding has made improvements since the last Ofsted Inspection in 2012 but significant challenges remain in a number of areas. There remain issues with the quality and consistency of practice and progress on this has been hampered by the difficulty the service has had in recruiting and retaining experienced, highly performing staff. The numbers of children looked after, children in need and children on child protection plans are much higher than in comparable areas and the service needs to improve to address this to ensure better outcomes for children and address unsustainable cost pressures.

15. The focus has been on addressing these challenges and there has been sustained corporate and Member support to ensure that the service improves.

    However, in order to achieve sustainable improvement and better outcomes for children and young people there is a need to transform the service. The redesign of the service will result in a greater focus on early intervention and prevention focusing on early help and down sizing safeguarding. This will involve restructuring and more significantly a cultural change in relation to

the shared purpose of preventative work and early intervention to improve families' capacity to meet all their needs.

To achieve the change required in Children's and Adults social care our partnerships will be a crucial strength. Partners in health, education and police are committed to working with us over the redesign of our services and we will be working closely with them to ensure that we benefit collectively from our success.

RESOURCE IMPLICATIONS
Capital/Revenue

16. The resources to support the transformation of services in the People Directorate will be provided from existing budgets including the council's transformation fund.

Property/Other
17. . No implications at this stage

LEGAL IMPLICATIONS
Statutory power to undertake proposals in the report:

18. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000

Other Legal Implications:

19. None

POLICY FRAMEWORK IMPLICATIONS

20. These will be defined as the work progresses.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report

SUPPORTING DOCUMENTATION
Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out?	No

Other Background Documents
Equality Impact Assessment and Other Background documents available for inspection at:

1.	None	

Title of Background Paper(s)

Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON CLINICAL COMMISSIONING GROUP: ANNUAL PLAN AND PRIORITIES 2013/14		
DATE OF DECISION:		23 MAY 2013		
REPORT OF:		CHAIR & CHIEF OFFICER SOUTHAMPTON CITY CLINICAL COMMISISONING GROUP		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

Southampton Clinical Commissioning group's (CCG) aim is to deliver locally, excellent care, integrated and designed to meet the needs of patients, and provided by productive partnerships that embrace patients, communities and clinicians.

All of that needs to be affordable and sustainable, of course, so that's where we need to ensure that the way we plan and develop services is undertaken carefully, but in a way that encourages people to come up with new and innovative ideas .

Our role as a CCG is to help this planning process by:

- Providing leadership and experience where it matters and encouraging a sense of mutual trust among the organisations we work with
- Ensuring that clinicians and patients are right at the heart of our approach to planning care
- Encouraging people to be creative and to 'rethink' healthcare
- Setting out challenging but realistic plans and be held accountable for delivering them: we will do what we promise.

The CCG has now been authorised and commenced as a legally constituted organisation on 1st April 2013. The CCG's Strategy and priorities for 13/14 have been developed with active clinical leadership and involvement of patients, wider community and partner organisations.

RECOMMENDATIONS:

(i) The Board is asked to note the 2013/14 CCG priorities.

REASONS FOR REPORT RECOMMENDATIONS

1. To update the panel on forward planning and priorities of the CCG.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Alternatives were considered throughout the consultation and development of priorities. The priorities are evidence and needs based.

DETAIL (Including consultation carried out)

Needs and key challenges

3. **Reducing inequalities** - as the Southampton Joint Strategic Needs Assessment makes clear, we have some of the most deprived wards in the country and substantial inequalities continue to exist between the diverse communities which has a significant impact on health outcomes

4. **Pressures on unscheduled care** - the performance of our healthcare system is generally good. We are privileged to have on our doorstep one of the foremost centres of clinical excellence in the country and the quality of primary care is generally high. However, like many places, the pattern of healthcare provision we have has grown incrementally over a long period and looks increasingly ill-fitted to the future we are facing. In common with many other parts of the country, the continued pressure of rising unscheduled care admissions places our hospitals ‘on the edge’

5. **Affordability and sustainability** - in an era of public sector retrenchment , not least in local government, there is a real danger of crude cost cutting that damages services and thus affects patients and people. One of the challenges we will face each year is to ensure that local health services are as efficient and affordable as they can be whilst delivering improved quality to patients at the same time.

6. **Ownership of the quality of care** - ensuring that all healthcare professionals take personal ownership of the quality and costs of care so that we value the right things. The CCG will work with others to achieve a shared vision of a healthy system where people recognise the interdependence of all parts, primary, secondary, social and community. Where mutual success is ensured because we are bold enough to change the part we play so that our services are designed and integrated to fit the needs of people as individuals, not expecting people to fit in with the way it suits us to be organised.

CCG Strategy

7. The CCG strategy is in 3 main parts:
   - **Preparing the ground** for innovation through gaining control, especially within the planned care and emergency and urgent care system
   - **Tackling the priorities** of Mental Health and Wellbeing, A Healthy Start in Life and Growing Older and Living with Long Term Conditions. These priorities match directly those of our partners in the Health and Wellbeing Strategy. We are already seeing much quicker progress in making improvements in these areas with the benefit of clinical leadership of these programmes
   - However, the really transformational part of our strategy is about bringing this all together in our **integrated personal care programme**. This approach unites risk stratification of our practice populations so that we know who is most at risk of becoming unwell, early intervention and self-care to prevent this, and then learning from our social care partners how personalisation works to deliver better outcomes for people, tailored to their individual needs and delivered through more generic, integrated teams. This means big changes not just for community services, but also a fundamental challenge to the way primary care is delivered.

8. **CCG Objectives for 2013/14 are to:**

   - Take Responsibility for the Quality and Cost of Care
   - Deliver the Annual Plan including Financial and Performance Standards
   - Drive Service and System Change
   - Provide Local Leadership for Integration
   - Establish the CCG as an Effective Organisation

9. **Take Responsibility for the Quality and Cost of Care**

   - Promote understanding of the culture change required in the light of the Francis Report and provide visible leadership in putting the safety and quality of patient care first
   - Develop and pursue a strategic approach to quality improvement
   - Establish systems that safeguard the quality of commissioned services and act promptly to intervene when risks are detected

Since the publication of the Francis report the quality and safety of health services nationally has been thrust into the spotlight.

Where quality and safety are concerned we can't afford to take chances. So, we are working with the providers of health services locally to ensure that patients' quality of care improves further within:

- Patient safety – making sure nothing goes wrong with the care that you receive
- Patient experience – making sure that from start to finish the way you are looked after by the NHS is a positive experience for you
- Clinical outcomes – making sure that you get better, as quickly as possible.

We will be using a wide range of tools and techniques to measure how well the services we commission are performing, and how effective the quality of care they provide is.

10. **Deliver the Annual Plan including Financial and Performance Standards**

- NHS Constitution and other performance standards (such as 95% Emergency Department 4 Hour maximum wait; 18 weeks Referral to Treatment time;)
- Deliver targeted and sustained improvements against the NHS Outcomes Framework
- Continued accountability through contracts in a business like relationship
- Develop plans for 14/15 and beyond
- One of the challenges we will face each year is to ensure that local health services are as efficient and affordable as they can be whilst delivering improved quality to patients at the same time. We call this our QIPP programme - Quality, Innovation, Prevention and Productivity - and it helps us look at how the NHS can deliver efficiency savings whilst maintaining or improving quality; it sets out the need to deliver improved services under tighter budget constraints, ever more important due to the current pressures on public sector budgets.
- We have identified a number of services where we think we can make improvements to quality but also drive down costs – and we will be looking to work with the providers and patients of these services over the next few months to see what we can achieve. The services we are looking at are: urgent care (including the way people use Accident and Emergency services), maternity and children's

services, mental health and learning disabilities, planned and continuing care and the management of long term conditions such as care after stroke, diabetes or COPD (chronic obstructive pulmonary disorder.)

11. **Drive Service and System Change**

- Preparing the system for innovation
  - Develop a clinical referral support service
  - Embed the urgent care dashboard
  - Develop plans to realise the potential of 111 as a single point of access
  - Ensure that actions to implement ECIST recommendations are fully embedded in all providers

- Implement commissioning intentions in
- Develop and implement plans for Integrated Person Centred Care across primary and community services in the City

12. **Provide Local Leadership for Integration**

- Provide effective leadership for the South West Hampshire System
- Further develop Integrated Commissioning and the development of the People Directorate working with Southampton City Council

13. **Establish the CCG as an Effective Organisation**

- Continue to develop the Membership approach

RESOURCE IMPLICATIONS

Capital/Revenue

14. The CCG has an allocation of £280m for the year (which is subject to change in year) with a surplus to be achieved if £2.746m in line with NHS

England Guidance. The challenges around this are largely related to the disaggregation of the PCT and ensuring funding is in the correct place and the increasing pressure / demand on the unscheduled care system.

Property/Other

15. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

16. None

Other Legal Implications:

17. There are no legal implications identified

POLICY FRAMEWORK IMPLICATIONS

18. Decisions made as a result of implementing the identified actions and commissioning intentions may impact on future health and social care policy making

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	NHS Southampton City: Clinical Commissioning Strategy 2012 - 2017 A Healthy and Sustainable Future Summary Document (Consultation Draft)

Documents In Members' Rooms

1.	

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

Southampton City
Clinical Commissioning Group

NHS Southampton City
Clinical Commissioning Strategy 2012 - 2017
A Healthy and Sustainable Future
Summary Document (Consultation Draft)

October 2012

Contents

Please note

The annexes referred to in this document can be found at:

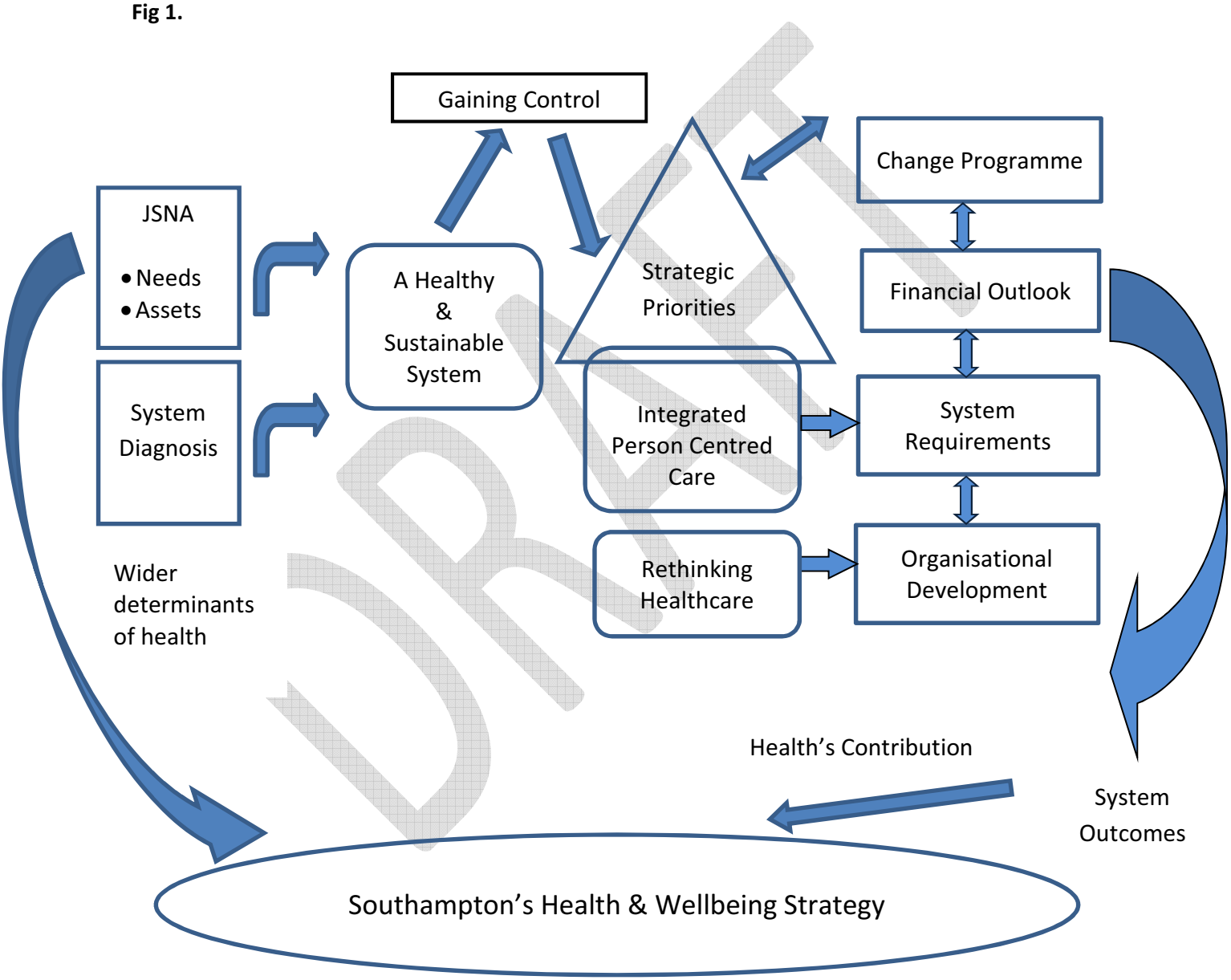
http://www.southamptoncityccg.nhs.uk/have-your-say/consultations-and-engagement

OVERVIEW

1. This document opens with a summary that describes the overall narrative of the CCG's five year strategy (2012-2017): the end to end 'story' of what has driven it, the need for change, the vision of a better future, the main components of its implementation and the plans and change programmes.

The diagram at Figure 1 explains how the story unfolds.

Fig 1.



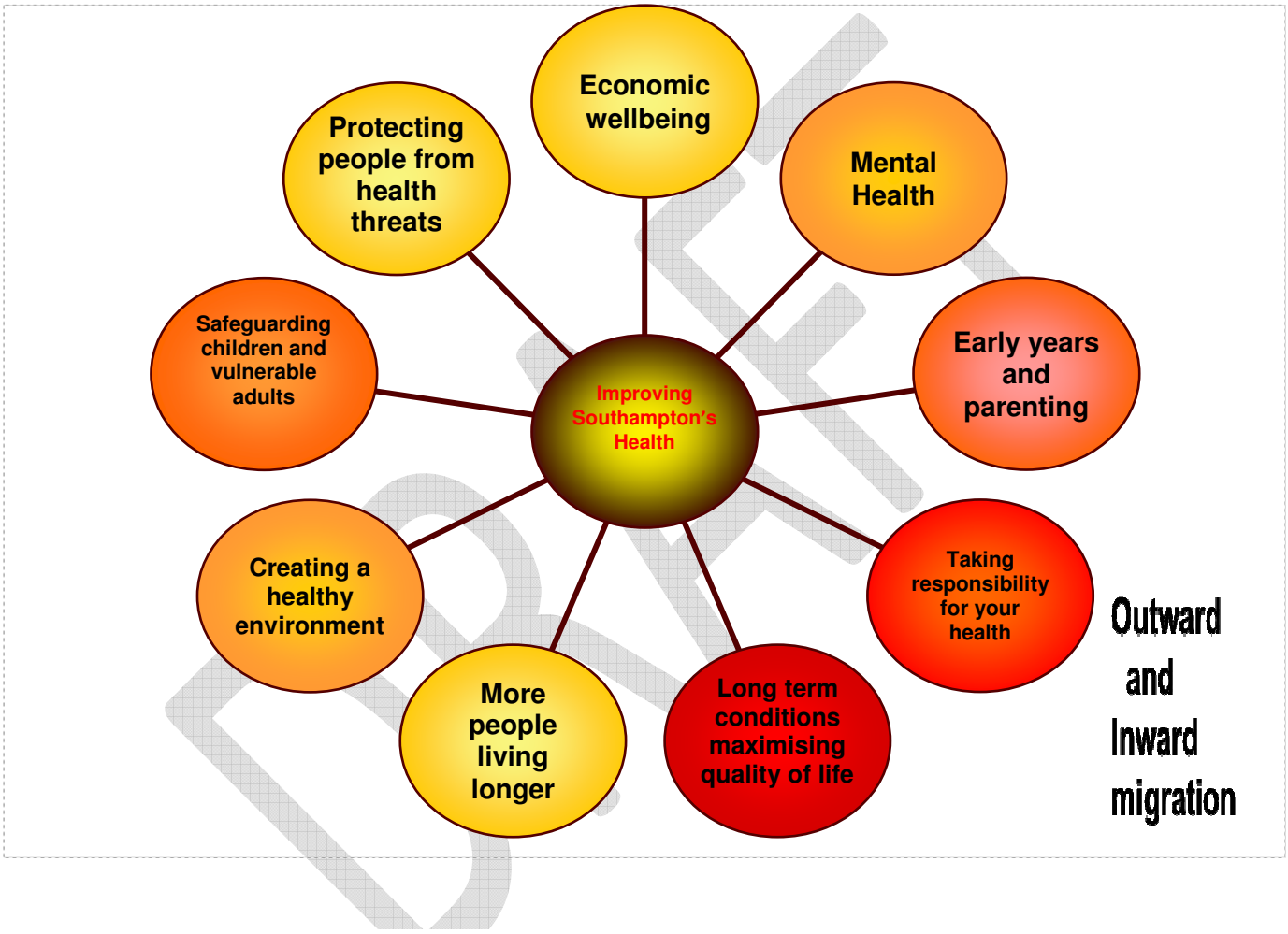
2. Health's contribution to delivering the city's Health and Wellbeing Strategy. Taken together, the outcomes from this strategy will constitute the contribution of the NHS in Southampton to the delivery of the city's Health and Wellbeing Strategy, *Gaining Healthier Lives in a Healthier City*.

DRIVERS FOR OUR STRATEGY

3. Local Drivers: The principal driver for the strategy is the local Joint Strategic Needs Assessment (JSNA) and the resultant joint Health and Wellbeing strategy, *Gaining Healthier Lives in a Healthier City*.

Figures 2 and 3 summarise the key messages of the JSNA.

Figure 2. JSNA KEY THEMES



Southampton is a diverse city with a high level of ethnic backgrounds and significant student population. Whilst the overall health of the population has improved over recent times, the city still faces numerous challenges. Dramatic health inequalities exist within and between communities.

Nationally, Southampton is the 81st most deprived local authority out of 326, and the fifth most deprived in the South East. 23% of residents live in the most deprived Lower Super Output areas (LSOAs) in England. In the next five years people in age groups 5 to 9 years and 70 to 74 years show the largest population increase, with over 20% population increases forecast in both areas. This indicates an ageing population on the one hand and the increase in childbirth on the other, which will mean greater demands on an already pressurised health and social care system.

Figure 3. An Overview of Health in Southampton – key issues	
Dramatic health inequalities are still a dominant feature of health.	Levels of teenage pregnancy, GCSE attainment (despite improvement) and tooth decay in children are worse than the England average (2010)
Premature (under 75) deaths are 58.7% higher in priority neighbourhoods and increasing.	Life expectancy is 7.7 years lower for men in the most deprived areas of Southampton than in the least deprived areas.
Life expectancy not significantly different from the national average, but disability-free life expectancy is significantly lower for both males and females.	Priorities in Southampton include violent crime, drug and alcohol misuse and obesity.
Children and young people **Obesity rates in Year R and Year 6 children are similar to national average.**	**Diabetes** Estimated prevalence of diabetes is around 4.2% and growing due to better reporting and early diagnosis.
Older people **Rates of emergency of admissions for fractured neck of femur increase yearly and are slightly higher than national average.**	**Respiratory disease** Estimated prevalence of COPD in Southampton is higher than national average as are mortality rates, and worse in priority neighbourhoods.
Lifestyle **Adult smoking rates are reducing but remain higher than the SE average. Poor diet and lack of physical activity remains and issue.**	**Cardiovascular disease** Early deaths from smoking, heart disease and stroke are higher than the England average.
Cancer **Early deaths from cancer are high especially in priority neighbourhoods. Breast, bowel and cervical cancer screening uptake is challenging.**	**Mental health** Depression crude prevalence rate of 8.9% for the city which is significantly higher than the national figure of 8.5% but about average compared the city's peer authorities

The CCG is working closely with Southampton City Council in the development of a Health and Wellbeing Board to act as strategic decision-making body for all local health and wellbeing services. The draft Health and Wellbeing Strategy has recognised six priorities for the city:

Priority 1: Early years and childhood
Priority 2: Adolescence and young adulthood
Priority 3: Working age adults
Priority 4: Helping people grow old and stay well
Priority 5: Reducing admissions to hospital from preventable causes of both physical and mental ill health
Priority 6: Improving housing options and conditions for people in the city to support healthy lifestyles.

4. National Policy. Our strategy is based on our local vision but is heavily influenced by the government's national reforms and frameworks and the context of economic challenges we face. The reforms also seek to realise efficiency savings through planning and delivering Quality, Innovation, Productivity and Prevention (QIPP).

The NHS national requirements for Clinical Commissioning Groups are set out in the NHS Mandate. The Secretary of State has recently set out his priorities for 2013/14 and 2014/15:

- Quality of care, in particular compassion, patients' experience and essential standards
- Care for people with long term conditions
- Dementia services
- Reducing mortality from the major killer diseases.

SYSTEM DIAGNOSIS

5. The present system is unsustainable. Despite progress in terms of coping with constrained resources so far, there has been little evidence of the kind of transformational change, at scale, that is necessary. The factors driving this challenge are, broadly:

- Demographics – simplistically, people living longer but with more limiting health problems with increasing age; a shrinking population of working people generating less tax, and among the young, a growing problem of lifestyle related morbidity linked to diet and inactivity

- Technology - the increasing capability to do more for people with new technologies

- Public expectations – people are less willing to accept poor access, poor service and poor outcomes

6. Urgent Care Pressures. Hospitals struggling to cope with the demand for unscheduled care from an ageing population are a familiar story. Locally, University Hospital of Southampton Foundation Trust (UHSFT) has been on 'Black Alert' for a substantial proportion of 2012.

7. In summary, therefore there are three key challenges facing the new CCG:

- The bleak financial outlook for public services in general and NHS and social care in particular and the risk of responding to this with crude, ill thought through 'cuts'
- The ownership of the quality of care by those who deliver it
- The pressures caused by the demand for unscheduled care and the current system response.

HOW THE CCG WILL MAKE A REAL DIFFERENCE

8. Improving Quality and Living within Our Means. Focusing first on quality, banishing wasteful processes, and being responsible about using resources.

9. Gain some control. Prioritising work to improve both urgent and planned care, to make them more consistent and systematic.

10. Liberate creative solutions. Creating the right environment for ideas to flourish.

11. Create and empower real clinical ownership of the interlinked nature of the quality and costs of care.

12. Developing a strategic system wide approach.

13. The Southampton system has had a long history of financial challenge, and while the financial position of UHSFT has improved in the last few years, the system as a whole has been relatively slow to change. In performance terms, the system has been a perennial underachiever, with a definitive diagnosis as to why proving elusive.

14. Clinical leadership. Our clinicians must confront these issues, take ownership and do something about it.

STRATEGIC DIRECTION: THE VISION OF A HEALTHY AND SUSTAINABLE SYSTEM

15. In summary, a healthy and sustainable system will entail:

- Developing trustful, open, business like relationships; mutual interdependence
- Designed around the needs of patients, not organisations
- Being sustainable by putting quality improvement first, especially patient safety
- Driving out waste by dealing with failure demand and eliminating wasteful processes
- Affordable costs of infrastructure
- Being clear about the shape, size and skills of the system we want in future

16. Engaging the Wider Community in Setting Priorities. The developing CCG's approach to priority setting has four phases:

- **Forming the Vision and Values.** Annex A shows a summary of how patients and the public were involved in this strategy.
- **Developing Priorities**
- **Testing the Strategy.** An engagement plan is set out at Annex B.
- **Priority Setting Process**

17. A Three Part Strategy. The CCG's clinical strategy will be delivered through three stages: gaining control, focusing on four priorities, and rethinking healthcare.

GAINING CONTROL

18. More systematic arrangements are needed to reduce variation, drive up quality and create an environment where innovation can flourish. This will take broadly two forms, centred on the introduction of the new NHS111 urgent care service and the development of a system for clinical review of referrals in elective care, both of which will start to be put in place during 2012/13. Both of these initiatives will enable a better understanding of what real demand is (not the system's response) so we can use this to redesign services, to give more responsive, tailored services.

STRATEGIC PRIORITIES 2013/14

19. In the first full year of operation, the CCG will focus on 'Gaining Control' as outlined above and the delivery of the following three strategic priorities:

- Mental health and wellbeing
- A healthy start in life
- Growing older and living with long term conditions.

BRINGING IT ALL TOGETHER: INTEGRATED PERSON-CENTRED CARE

20. We need to 'rethink healthcare' to focus on the individual's needs and look at the whole person not the disease. Many people live with more than one chronic illness and people do not conform to tidy ideas of 'care pathways' but have their own, sometimes complex and often different needs.

Our approach will focus on identifying those most at risk of an acute 'event' and intervening first, as patients with multiple conditions are more likely to be admitted to acute hospital on an urgent care basis.

21. Around 86,000 people in Southampton (32% of the population) are estimated to be living with long term health conditions, such as asthma, diabetes, heart disease, hypertension, epilepsy and severe mental illness. A further 2,395 people are receiving regular case management to co-ordinate their complex treatment and care needs.

22. The programme will focus on the prevention of the need for more specialist services by empowering individuals to manage their own care and achieving efficiencies through improved integrated working between relevant services and wider community-based support.

23. We should aim to treat patients sooner, nearer to home and earlier in the course of disease. To do this we need a combination of:

- Earlier detection of those at risk
- Good control to minimize effects of disease and reduce complications
- More effective medicines management
- Reduction in the number of crises
- Promoting independence, empowering people and allowing them to take control of their lives, and prolonging and extending the quality of life
- Provide the most intensive care in the least intensive setting.

24. Integrated Person-Centred Care Programme. The CCG and Southampton City Council are working together to develop a model of integrated care which will improve outcomes for the people of Southampton and their carers. The focus is primarily on elderly people and those with multiple-morbidities and long term conditions.

25. The aim of the programme is to shift service towards proactive identification and management of patients. The strategy aims to reduce the number of unscheduled care admissions for acute care and reduce residential care admissions by increasing the independence of individuals and carers.

RETHINKING HEALTHCARE

26. Moving beyond the short to medium term priorities set out above, and armed with a better understanding of true demand as a result of the system improvements described above in 'Gaining Control', the CCG and its partners will develop and design new approaches to healthcare that do not rely on traditional service distinctions, organisational or professional boundaries.

27. Failure Demand. We need to eradicate, as far as possible, the 'failure demand' that arrives at the hospital door because something else has gone wrong in responding to the patient's need. This is about putting in place the interventions, further upstream in the patient journey that helps to define the problem more accurately.

28. 'Solution Shops' and Value Added Processes. Further, we need to rethink healthcare completely – to banish the concepts of primary and secondary care and think about how to position our assets (staff and equipment) differently.

- Solution shops seek to answer the question, 'What is wrong with this patient?' and deploy highly skilled diagnosticians and diagnostic kit
- Value added services take a known problem and fix it (e.g. hip replacement) by applying specialised skills in a focused and efficient way.

FINANCIAL OUTLOOK

29. NHS Southampton City CCG's Financial Objectives are

- Generate sustainable financial headroom – by achieving a 1% surplus every year; setting aside 2% recurrent headroom; and holding a contingency
- Deliver our quality, innovation, productivity and prevention (QIPP) challenge – by setting aside 0.7% to invest recurrently in new schemes, and investing in population and service growth of around 1.5%. Also, across five years achieve a gross QIPP saving of an average of 6%.
- Ensure tax payers money is used in the best way.

30. Summarised NHS Southampton City CCG Financial Plan 2013/14 to 2017/18

Table1.

	2013/14	2014/15	2015/16	2016/17	2017/18
NHS Southampton City Clinical Commissioning Group Financial Plan 2013/14 - 2017/18	**Final Opening CCG Budget £'000**	**Final Opening CCG Budget £'000**	**Final Opening CCG Budget £'000**	**Final Opening CCG Budget £'000**	**Final Opening CCG Budget £'000**
Acute Care	156,039	157,359	158,700	159,533	160,375
Community and Mental Health Services	72,609	72,991	73,377	73,770	74,168
Continuing Healthcare	25,708	26,338	26,984	27,647	28,326
Primary Care	40,772	41,555	42,354	43,300	44,271
Support Costs	6,280	6,437	6,566	6,697	6,831
Other	1,296	1,475	1,648	1,822	1,997
Centrally Managed Programmes	4,678	2,825	-586	-5,257	-9,976
Surplus	2,997	3,075	3,091	3,091	3,075
Total	**310,380**	**312,055**	**312,133**	**310,603**	**309,066**
Recurrent Allocation	307,520	309,058	309,058	307,513	305,975
Non Recurrent Prior Year Surplus Return	2,860	2,997	3,075	3,091	3,090
Total	**310,380**	**312,055**	**312,133**	**310,603**	**309,065**

CHANGE PROGRAMME

31. The aims and objectives outlined in earlier sections must be converted into practicable plans for implementation. Each year, this will be formulated on the Operating Plan that will also have to take account of:

- Current operational pressures in the system
- The priorities emerging from the CCG membership
- The requirements of the NHS Mandate as it develops.

32. Each year, the CCG will prepare its commissioning intentions in the early autumn, which will form the basis of the change programme for the following financial year.

Draft commissioning intentions for 2013/14 are appended at Annex C (and may be subject to development over the weeks ahead until finalised in the Operating Plan). Annex D also provides a cross reference between current year CCG work programmes and the National Outcomes Framework Indicators and the National Operating Framework Priorities.

SYSTEM REQUIREMENTS

33. Having set out its strategic direction and priorities in this strategy, the CCG needs to define the characteristics of the provision system that is needed to deliver it. This will take broadly three forms:

- System capability
- System capacity
- System configuration.

ORGANISATIONAL DEVELOPMENT

34. Creating a Membership Organisation

The CCG is constituted as a membership organisation comprised of its 37 member practices. The CCG will have a General Assembly comprising representatives of every practice and this will delegate functions to a Governing Body (the 'Board') made up of elected clinical representatives, lay members, a Chief Officer, Chief Financial Officer, Executive Nurse, Director of Public Health and a secondary care doctor.

However, giving real meaning to the term 'membership organisation' is about much more than the constitutional arrangements: the organisational development challenge is about developing the roles and behaviours of the members and their management team to create a real sense *of cohesion, ownership and true partnership.*

35. Learning Together: TARGET Days. Regular clinical education and awareness events addressing local clinical issues in a collective learning format.

36. Developing Clinical Leaders. The CCG has developed an organisational development plan that focuses on developing the capability and capacity of the Governing Body in commissioning, governance, development and communications and engagement competencies. However, it further recognises that success depends on the development and support of a much wider group of clinical leaders whose contribution will be made in and around their daily 'operational' clinical roles, not necessarily in dedicated roles that are part of the governance of the Group.

37. Clinical-Managerial Partnership. The CCG will develop a 'contract' for its clinical leaders that sets out what is expected from them and the support they can expect from the wider team.

38. Working with our providers and co commissioners. The CCG has developed a Compact with West Hampshire CCG that defines how the two CCGs will work together to lead the system in south west Hampshire.

We have also recently commissioned work enabling the leadership community (clinicians and managers, commissioners and providers) to develop a shared common vision and effective governance arrangements to ensure productive joint working. The agreed terms of reference for this initiative are set out at Annex E and the Compact with West Hampshire CCG is presented at Annex F.

39. Joint Working and Commissioning Arrangements with the Local Authority.
In order to adapt and respond to the national and local agenda, the CCG and Southampton City Council are reassessing their current health and social care commissioning arrangements to ensure that both take advantage of the opportunities provided and are able to respond to changing demands. There are a number of joint commissioning appointments in place and the CCG and Council are launching a framework to increase the level of services commissioned together.

We have set out our vision for what we want to achieve by 2015 as:

> *"Working together to make the best use of our resources to commission sustainable, high quality services which meet the needs of local people now and in the future."*

A Joint and Integrated Commissioning Board will be established to ensure effective collaboration, assurance and good governance across the agreed areas of council and health commissioning. The Board will be a sub-board of the Health and Wellbeing Board (HWBB), accountable to the Council's Cabinet and the CCG Governing Body.

SYSTEM OUTCOMES

40. The success of the CCG's strategy will be measured in terms of real improvements in the health of its population. The NHS Outcomes Framework will be used to assess this. Annex G presents an initial baseline in terms of the CCG Quality Profile that has recently been published.

41. The CCG has been closely involved in the development of the city's draft joint health and wellbeing strategy, *Gaining Healthier Lives in a Healthier City*, both through its links with the public health team and the CCG Chair's role as Vice Chair of the Health and Wellbeing Board. Annex H shows the alignment between to the two strategies, and the Commissioning Intentions at Annex Care cross referenced to the relevant sections of both the JSNA and the JHWS.

42. More specifically, the CCG's purpose is "To deliver improved health and wellbeing for **all** in the city" and this includes reduced inequalities in health and in access to services. Annex I sets out how this strategy is aligned to tackling the principal health inequalities in the city's population.

An equality impact assessment (EIA) has been completed for this strategy and is attached at Annex J.

FEEDBACK

43. We want to hear your views on our planned proposals. You can feedback in a variety of ways

Survey: http://www.southamptoncityccg.nhs.uk/have-your-say/consultations-and-engagement

Email us with your comments at info@southamptoncityccg.nhs.uk

Write to us at: **Southampton City Clinical Commissioning Group, Trust Headquarters, Oakley Road, Southampton, SO16 4GX**

WHAT HAPPENS NEXT

44. Once the consultation has closed we will collate all the feedback received into a report which will be presented to the Clinical Commissioning Group in order that a decision can be made about our plans moving forward. This will be communicated to patients and public.

If you would like any further information, please contact info@southamptoncityccg.nhs.uk

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	SOUTHERN HEALTH NHS FOUNDATION TRUST: DRAFT QUALITY ACCOUNT 2012/13
DATE OF DECISION:	23 MAY 2013
REPORT OF:	CLINICAL QUALITY MANAGER, SOUTHERN HEALTH NHS FOUNDATION TRUST (SHFT)

CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY

A Quality Account is an annual report to the public about the quality of services delivered by NHS service providers. Since June 2010 it has been a legal requirement that every NHS service provider should produce and make their Quality Account available. The aim of Southern Health's Quality Account is to share:

- what we have done well in relation to the quality of the services and the standards of care we provide
- what improvements have been made in the quality of services since the 2011/12 Quality Account
- what the Trust has prioritised for improvement in the coming year

RECOMMENDATIONS:

(i) To note and provide comment with regard the draft Quality Account

REASONS FOR REPORT RECOMMENDATIONS

1. To be assured that SHFT are continuing to deliver high quality and relevant care for the population it serves and that the priorities it has set for the coming year are in line with commissioning and JSNA intentions.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

None

DETAIL (Including consultation carried out)

2. Key messages:

- SHFT provides community health, specialist mental health and learning disability services for people across Hampshire and its surrounding area. We serve a population of around 1.3 million people and we are one of the largest providers of these types of service in the UK.
- We employ around 8,000 staff who work from over 150 sites across Hampshire, including community hospitals, health centres, inpatient units and social care services.
- Our aim is to provide high quality, safe services which improve the health, wellbeing and independence of the people we serve.
- Our draft Quality Account has been shared with a wide range of our key stakeholders and partners including LINk/HealthWatch colleagues. We will respond to their comments and suggestions, and where possible will incorporate them in our final account.

RESOURCE IMPLICATIONS

Capital/Revenue

None

Property/Other

None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

None

Other Legal Implications:

None

POLICY FRAMEWORK IMPLICATIONS

None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	Southern Health NHS Foundation Trust: Draft Quality Account 2012/13
2.	

Documents In Members' Rooms

1.	
2.	

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

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Southern Health NHS
NHS Foundation Trust

Quality Account
2012/13

Summary

We have summarised information so that at a glance you can see key messages from this Quality Account.

Achievement against our priorities for improvement

We achieved 4 of 11 priorities for improvement: reducing patient violent incidents by 10%
85% of matron walk rounds found structured handover tool used
use of patient experience surveys to rate overall experience
use of patient experience surveys to show involvement in care

We were close to achieving or showed improvement against previous year's performance in 3 of 11 priorities:
patients on an end of life care pathway
patients with physical healthcare assessment
use of patient reported outcome measures in services

We set ourselves challenging targets and know we have more work to do to meet the remaining priorities:
medicines reconciliations in community hospitals
use of an early warning system to detect physical deterioration
care plans to prevent pressure ulcers
care plans developed with service users

CQC inspections

There were 17 CQC inspections in 2012/13, all to our mental health or social care divisions. 14 inspections found we were fully compliant with the Essential Standards of Quality and Safety set by CQC. Two inspections found minor concerns relating to records and medicine management and one inspection found moderate concern relating to records.

Governance Risk rating

2012/13 risk rating	Annual Plan	Q1	Q2	Q3	Q4
Governance	Green	amber/ red	amber/ red	amber/ green	amber/green

Monitor, the regulator of NHS Foundation Trusts such as Southern Health, uses a governance risk rating to assess performance. In early 2013 we identified issues with our corporate governance arrangements which impacted on our ability to comply with the Trust Constitution. We implemented the plan agreed with Monitor which has resulted in our governance risk rating moving from amber/red to amber/green by year end.

Other achievements

Very low rates of healthcare acquired infections with only 5 cases of C. Difficile
No never events
Total number of serious incidents requiring investigation reduced by 5%
National Mental Health Patient Survey found we had better or same results as the majority of other trusts
Recognised nationally for delivery of the Implementing Recovery through Organisational Change project
Community Diabetes Team won the Health Services Journal award for diabetes care and a Quality in Care award
The Health Services Journal awarded the Chief Executive of the Year to our own Chief Executive, Katrina Percy

Contents

Quality Account

Part 1 - Introduction

It is my pleasure to introduce Southern Health's Quality Account for 2012/13.

Southern Health is one of the largest providers of mental health, community, learning disability and social care services in the country and from 1 November 2012 includes the services formerly known as Oxfordshire Learning Disability Trust (Ridgeway Partnership). We operate from 242 buildings spread across 170 sites comprising Mental Health and Learning Disabilities specialist inpatient units, community hospitals, health centres, social care sites and support facilities.

This year Southern Health's 9,128 dedicated staff members enabled the Trust to treat or support approximately 273,200 people through providing 1,183,842 community contacts, 305,000 outpatient appointments and 243,632 occupied bed days across Hampshire and beyond.

To insert introductory comments from CEO.

Francis report
Ridgeway acquisition and how their priorities are set out (in appendix C) plus that info post acquisition is included in complaints, SIRI data etc.

I hope this report will help patients, service users, carers, our care partners, stakeholders and the public to understand;

- **what Southern Health has done well in relation to the quality of the services and the standards of care we provide**
- **what improvements have been made in the quality of services since the 2011/12 Quality Account**
- **what the Trust has prioritised for improvement in the coming year**

This report has been prepared in accordance with the Health Act 2009, the NHS (Quality Accounts) Regulations 2010, NHS Foundation Trust Annual Reporting Manual for 2012/13 and, as required by these guidelines, has core parts:

Part 1 - A statement by myself as the accountable officer for Southern Health NHS Foundation Trust summarising our view of quality and declaring my, and the Board's, accountability for the content of this report.

Part 2a - How we have performed against the priorities we identified in our 2011/12 Quality Account and what the Trust plans to do to deliver improvements in the quality of services in 2013/14.

Part 2b - Statements of assurance from the Board – this section is nationally mandated and is directly comparable with other Trusts' Quality Reports.

Part 3 - Information chosen by Southern Health to demonstrate the approach and commitment to quality.

Statement on quality from the Chief Executive

The content of this report is consistent with internal and external information presented to and agreed by the Southern Health Board and its subcommittees in 2012/13 and these include:

- **Quality Reports presented to Board**
- **Compliance Reports presented to Assurance Committee**
- **Clinical Audit Reports presented to Assurance Committee**
- **Internal and External Audit Reports presented to Audit Committee and Assurance Committee**
- **Complaints Report presented to Assurance Committee**
- **Board and sub-committee papers and minutes**

This report has been shared with the following with information on feedback received included in Annex D:

- **our governors**
- **our commissioners**
- **Hampshire Healthwatch**
- **Southampton Healthwatch**
- **Hampshire Health and Overview and Scrutiny Committee(HOSC)**
- **Southampton Health Overview and Scrutiny Panel**

To insert CEO comments

Priorites for improvement reflect a sample of work undertaken – lots more happens as well.

?Katrina HSJ award

Signed……xxxxxx……

xxxxxxx

CEO **Date: xxxxxxxx**

Southern Health Services

Community Services

We provide a wide range of services to promote and improve physical health and well-being from birth to end of life. Our multidisciplinary care teams provide care in people's homes, in clinics and in our community hospitals across Hampshire. Specialist nurse teams support people with a variety of conditions including diabetes, Parkinson's, multiple sclerosis. We work closely with primary care colleagues, acute hospitals and residential care homes to provide care. We also deliver Quit4life, Hampshire's stop smoking service.

Lymington New Forest Hospital provides both scheduled (planned) and acute care, and is designed to be a 'one stop shop' with appointment, diagnosis and treatment under one roof. Services include elective day case and short stay surgery, inpatient wards, minor injuries unit, rapid assessment centre and endoscopy.

Child and Family Services

Our child and family services are leaders of the universal 0-19 Healthy Child Programme, offering assessments and interventions based on need and work in partnership with primary care and local authorities. Children's speech and language therapy, occupational therapy and physiotherapy are provided in North East Hampshire.

Adult Mental Health Services

We provide a diverse range of mental health services to adults of working age in Hampshire and Southampton with a focus on enabling people to recover a life beyond illness. Care is delivered by multidisciplinary teams working in community settings and in our mental health units.

Older People's Mental Health Services

We are at the forefront of medical research into dementia and offer an extensive service for older people with a mental illness. We support people in their own homes, in our hospitals, and work closely with our colleagues in private care homes to make sure they are providing the best support for residents with a mental illness.

Specialised Services

We provide a range of specialist mental health services including secure settings for those who need them and some very specialised services for children and young people with mental health needs.

Learning Disabilities Services

We specialise in offering care that is tailored to the individual, making sure their unique needs are met and enabling them to reach their aspirations and develop as much independence as possible. In addition to working with people in their homes and communities, we have a number of specialist settings to help people with complex needs, challenging behaviour, and those who have been in contact with the criminal justice system.

Social Care Services

TQtwentyone, the part of Southern Health which provides social care services, provides support to people with a learning disability and/or mental health needs to live independent and fulfilling lives. TQtwentyone supports nearly 1000 people across Hampshire, Portsmouth, Southampton, the Isle of Wight, Oxfordshire, Swindon and Dorset providing domiciliary care, supported living, tenancy support, holidays and short breaks, day opportunities and specialist residential care.

Part 2a - How we have performed against our priorities and what we plan to do in the future to deliver improvements in the quality of our services

In the 2011/12 Quality Account Southern Health set out specific areas for quality improvement for the following year. These were framed around the three dimensions of quality identified by Lord Darzi and were developed based on what we had learnt about our services and the views of patients, service users and staff.

- **Improving patient safety** – we chose indicators to reflect we do all we can to prevent avoidable deaths and avoidable harm
- **Improving clinical outcomes** – we chose indicators to reflect we always do the right thing at the right time for the right patient or service user
- **Improving patient experience** – we chose indicators to reflect patients and service users should drive the design and delivery of our care

It is important to emphasise these indicators were not the only areas we have focused on. There were many other areas where we did, and will continue to, make improvements but these are the priorities we have included in our Quality Account.

In 2012/13, as in previous years, we set ourselves challenging and aspirational targets which support improved clinical outcomes for patients and service users. We have monitored and reported to the Board our performance against these targets throughout the year.

2012/13 local indicators to be delivered by April 2013

Priority 1: Improving patient safety	Priority 2: Improving clinical outcomes	Priority 3: Improving patient experience
Incidents involving patient violence to reduce by 10%.	100% of patients identified as being at risk of skin damage will have a care plan to reduce the risk of developing a pressure ulcer or other skin damage.	100% of inpatients with a physical healthcare assessment.
100% of medicines reconciliations completed within 72 hours of admission to an inpatient unit.	95% of patients identified to be at the end of their life (within 1 year) are on an End of Life Care Pathway.	Use of a patient reported outcome measure in all services across the Trust.
100% of patients where there was appropriate use of an early warning system.	85% of Matrons walk round results can demonstrate evidence of a structured handover tool in use in the service area.	100% of service users have a care plan that has been developed with them and/or their main carer.

The inclusion of two further measures based on the patient experience survey was agreed following

discussion with directors and approval by the Chief Medical Officer in order to provide a richer picture of patient feedback.

Use of patient experience surveys to ask 'How would you rate your experience of our service as a whole?'
Use of patient experience surveys to ask 'were you involved in decisions about your care?'

Performance reporting

Performance against these local indicators is included in part 2a and summarised in annex A. Information from the former Oxfordshire Learning Disability Trust is not included in these performance reports as it makes it difficult to show progress against targets originally set by Southern Health.

If information on an indicator has been available from previous years this has been included to provide comparison and show progress. We have highlighted some of the work undertaken and initiatives introduced to improve the quality of services we offer. We have also set out how we performed against national indicators.

The Oxfordshire Learning Disability Trust (Ridgeway Partnership) set out their own priorities for improvement in their 2011/12 Quality Account. On acquisition by Southern Health on 1 November 2012, it was agreed that the former Ridgeway Partnership staff continued working towards meeting these priorities with performance against these indicators included in annex C.

Figures for healthcare acquired infections, complaints, incidents, serious incidents requiring investigation (SIRI), staff training numbers all include information from the former Oxfordshire Learning Disability Trust from 1 November 2012 onwards.

Monitor Governance Risk Rating

Monitor, the regulator of NHS Foundation Trusts such as Southern Health, uses a governance risk rating to assess performance. Risk ratings are monitored to identify potential and actual problems.

We declare every quarter whether we are meeting the targets with a status of red, amber/red, amber/green and green ratings given for governance risk. The actual risk ratings for the Trust compared to our planned rating for both the current and prior year are shown below.

2012/13 risk rating	Annual Plan	Q1	Q2	Q3	Q4
Governance	Green	amber/red	amber/red	amber/green	amber/green
2011/12 risk rating	**Annual Plan**	**Q1**	**Q2**	**Q3**	**Q4**
Governance	Green	amber/red	amber/red	amber/red	amber/green

In early 2012 we identified issues surrounding our corporate governance arrangements which impacted on our ability to comply with the Trust Constitution. We have implemented the plan agreed with Monitor during the year and this has resulted in our governance risk rating moving from amber/red in quarters one and two in 2012/13 to amber/green by quarter three 3.

At the end of 2012/13, the Trust's governance risk rating was amber/green.

Priority 1: Improving safety - how we have performed

1.1 Incidents involving patient violence which result in physical injury to reduce by 10%

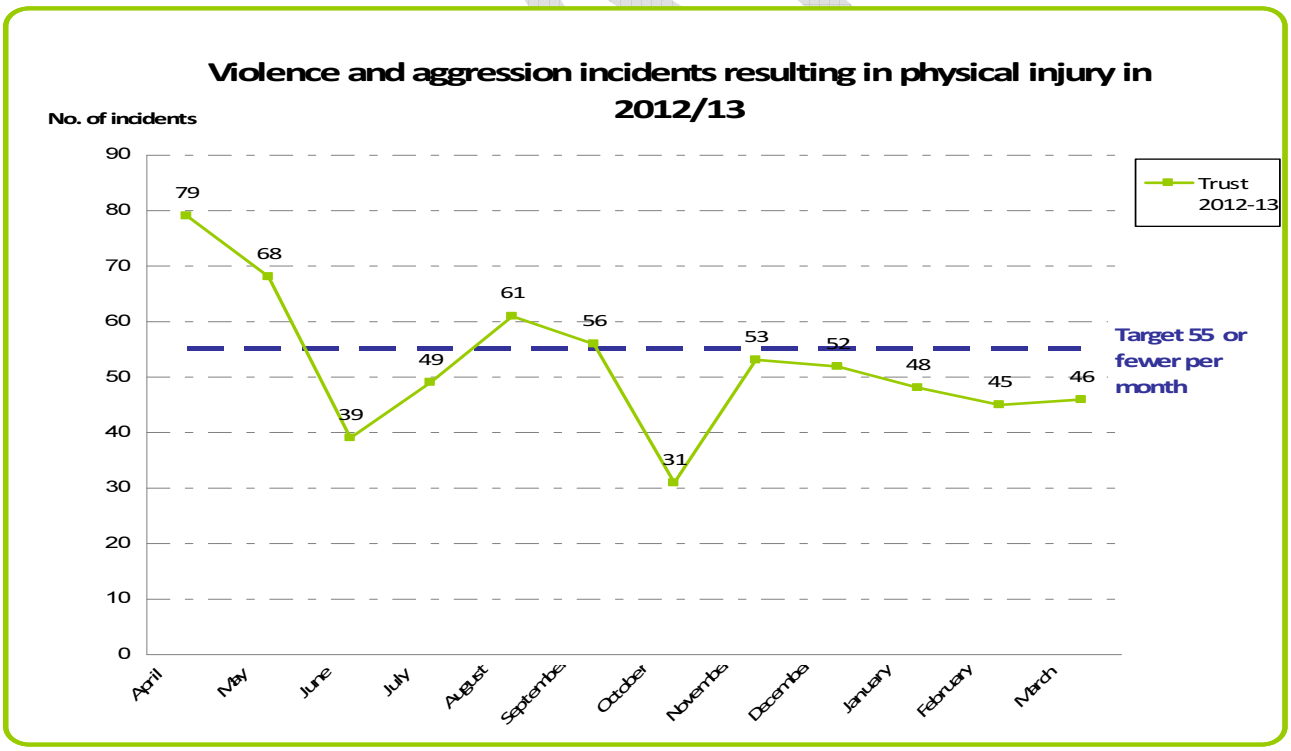
Aim

Southern Health wanted to build on progress identified in the 2011/12 Quality Account towards reducing numbers of incidents involving patient/service user violence with a focus this year on reducing those incidents which result in physical injury. The Trust remains committed to improving patient safety by reducing the number of violent incidents on service users and staff, which occur predominantly in our Mental Health, Learning Disabilities and TQtwentyone services.

What we have achieved

We have achieved this target. There were a total of 627 incidents involving patient violence resulting in physical injury as defined by the National Reporting and Learning System in 2012/13 compared to 736 in 2011/12. This resulted in:

- **a reduction of 14.8% in total number of violent incidents resulting in physical injury**
- **a reduction of 42% in patient to patient violent incidents resulting in physical injury**
- **a reduction of 8.5% in patient to staff violent incidents resulting in physical injury**



There was a reduction in incidents involving patient violence in Adult Mental Health, Older People's Mental Health, Specialised and TQtwentyone services and a slight increase in Learning Disabilities and Integrated Community services by the end of 2012/13.

What we did and future plans

- the roll out of service improvement initiatives such as the Productive Ward programme across Mental Health and Learning Disabilities services in 2012/13 has made a key contribution to reducing numbers of violent incidents within inpatient units, by increasing the time available for staff to care for service users and staff and service users working together to develop and agree plans for their care.

- we have introduced simple effective changes to how we work in order to reduce service user frustration, such as moving the location of the property cupboard in Bluebird House which has reduced the time service users wait for their property to be given to them and has resulted in fewer violent incidents.

- we continue to design training courses to meet the specific needs of a particular service with a clear focus on how to use techniques to de-escalate potential violent situations and to use as little restraint as possible.

- introduction of a tool to assess the potential risk of violent incidents by a service user has meant we can put appropriate plans in place to reduce this risk.

- all local services have designed specific action plans to reduce the number of violent and aggressive incidents. These are monitored through divisional governance forums and by the Management of Violence and Aggression committee.

- we will continue to work on reducing numbers of violent incidents and have included this indicator in our 2013/14 plans for quality improvement.

1.2 100% of medicine reconciliations completed within 72 hours of admission to an inpatient unit

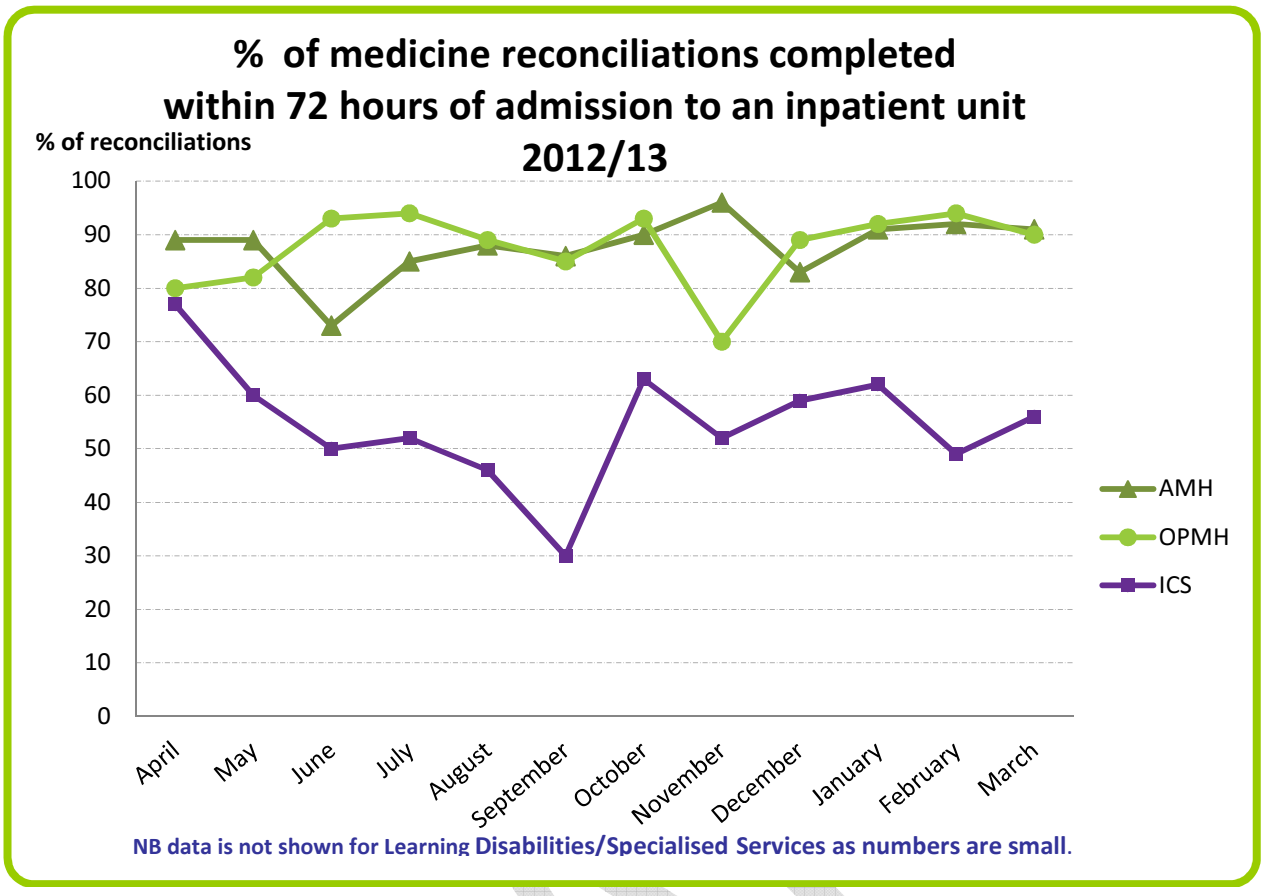
Aim

We aimed to carry out 'medicine reconciliations' for all patients and service users admitted to our inpatient units within 72 hours. This involves our medicines management team checking that patients and service users when admitted are taking the correct medicines prescribed for them. This enhances safe care and reduces any potential harm to patients from taking the wrong medicines. The Trust has a Medicines Reconciliation policy which is based on NICE guidelines.

What we have achieved

We have not achieved this target and know there is more to do to meet medicine reconciliation targets. There were variations between divisions in their ability to meet this indicator as shown in the table and graphs below. The medicines management team do not provide a 24 hour/7 day service and have increased the number of sites they cover when taking over the pharmacy service to our community hospitals from subcontractors in mid 2012 leading to some capacity issues. Figures for Learning Disabilities and Specialised services are not given as the numbers are very small.

Medicine reconciliations completed within 72 hours of admission to inpatient unit	
Trust/Divisions	2012/13
Trust total	74%
Adult Mental Health	91%
Older People's Mental Health	90%
Integrated Community	56%


% of medicine reconciliations completed within 72 hours of admission to an inpatient unit 2012/13
% of reconciliations
100
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70
60
50
40
30
20
10
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April
May
June
July
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September
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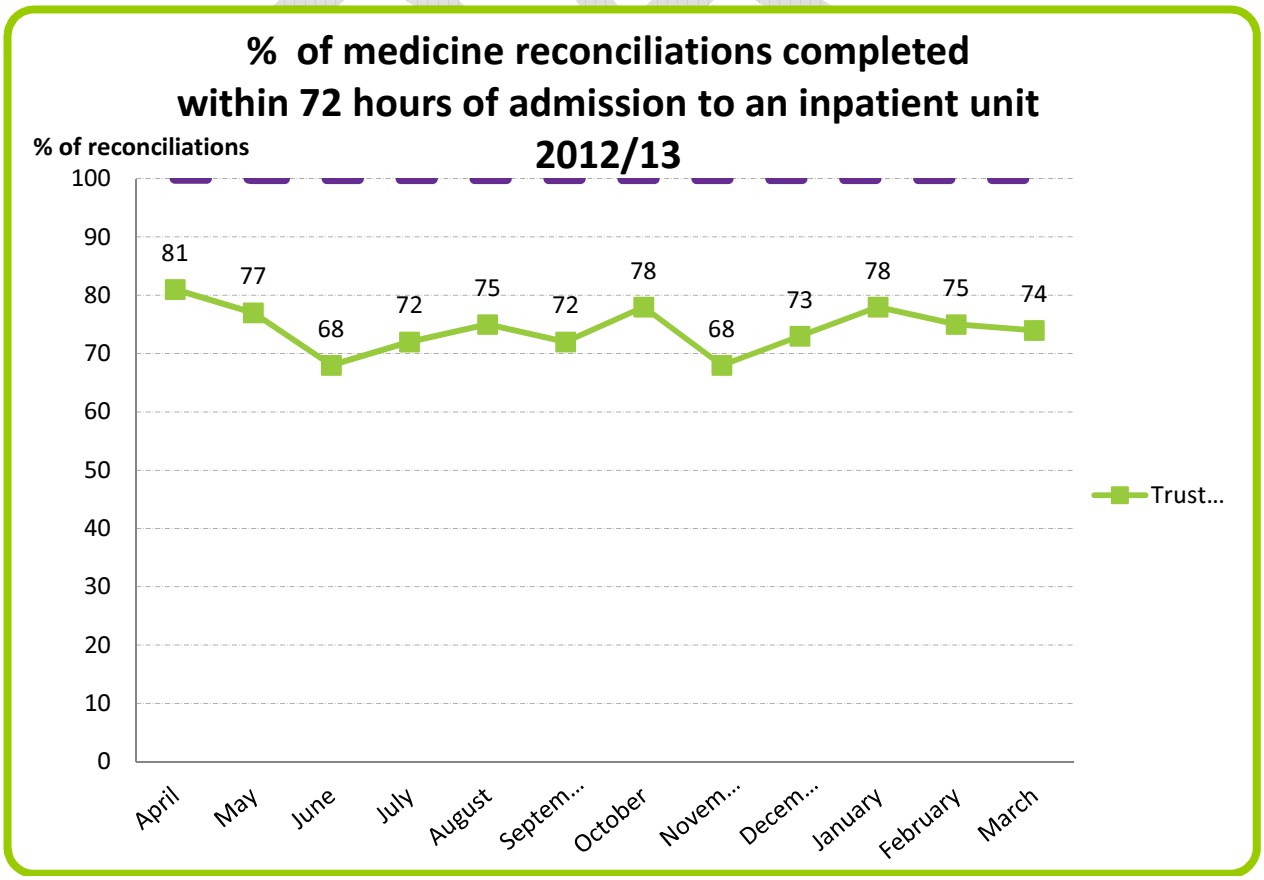
November
December
January
February
March
AMH
OPMH
ICS
NB data is not shown for Learning Disabilities/Specialised Services as numbers are small.


% of medicine reconciliations completed within 72 hours of admission to an inpatient unit 2012/13
% of reconciliations
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January
February
March
Trust...

What we did and future plans

- an online data collection form has been developed for use from April 1 2013 which will make data collection and collation of medicine reconciliation information easier for staff and release time for clinical care.
- the development of 'medicine leads' within nursing teams in inpatient units who would support the work of the pharmacists is in planning stage and would increase capacity to carry out medicine reconciliations.
- investigating the introduction of an electronic medicine management system which would provide robust administration and management of medicines.
- we are investing in the medicines management team and will continue to focus on improvement in medicine reconciliation targets in 2013/14, while recognising it will still be hard to meet these.

1.3 100% of patients where there is appropriate use of an early warning system

Aim

In 2011/12 we recognised that increasing numbers of unwell patients were being cared for in our hospitals and by our community teams. We therefore introduced an early warning system to assist staff in identifying when a patient's condition deteriorates. Early warning systems help staff recognise the early warning signs of possible deterioration in a patient's vital signs so that prompt action can be taken to ensure appropriate treatment is given with a senior clinician being contacted to assess the patient.

We also recognised that our Mental Health and Learning Disabilities divisions needed to be more aware of possible deterioration in the physical health of their service users, with developments in the early warning system ('track and trigger' tools) in 2012/13 being rolled out trust wide regardless of setting.

What we have achieved

We have not achieved this target. Use of an early warning system is new for staff in some divisions and time is needed for use to become embedded in clinical practice.

The results of audits in 2011 and 2013 on the use of an early warning system are shown below:

September 2011: audit in community hospitals showed there was use of an early warning system in 75% of patients audited

March 2013: audit in community care teams, community hospitals, Mental Health, Learning Disabilities services on the use of an early warning system including 'track and trigger' observation charts found:

- 69% of patients and service users audited were assessed using early warning scores.
- 17% of these patients displayed observations outside of the normal limits which triggered an escalation in the frequency of clinical observations for 95% of these patients.
- reasons given for not using an early warning system included: patient was receiving end of life care, baseline observations recorded on RiO, our electronic patient recording system or that assessment indicated the patient did not require use of the early warning system.

Although the results of audit in 2013 showed lower use of an early warning system than the previous audit, the number of services now included is much larger with the Mental Health and Learning Disabilities

services using such a system for the first time. There will need to be time for the use of this new system to become embedded into clinical practice in all services.

What we did and future plans

- developed 'track and trigger' observation charts to monitor patients and service user's vital signs as part of an early warning system to detect clinical deterioration with their use being rolled out across all services throughout the year. The roll out was slower than planned and so some staff had only just started to use the new tools before their use was audited.

- introduced a new Physical Assessment and Monitoring Policy in 2012 which includes use of the track and trigger tools.

- a physical assessment and monitoring training programme is being rolled out so that all staff understand how to use the new observation charts.

- use of the new track and trigger observation charts needs to become embedded into clinical practice with clear guidelines on when it is appropriate to use them. We will re-audit in 2013 and have included a similar indicator in our 2013/14 plans for improvement.

Other safety initiatives implemented to improve patient safety in 2012/13

Patient Safety Thermometer

The Patient Safety Thermometer is a national campaign which measures and seeks to reduce the number of 'harms' that patients suffer. The thermometer measures these 'harms', on a set day each month, which includes the number of falls, blood clots, pressure ulcers and urinary infections associated with catheters in patients on our caseloads. The Patient Safety Thermometer was successfully implemented in all Southern Health's community hospitals in 2011/12 and has been rolled out to community care teams in 2012/13.

We agreed targets with our commissioners that 100% of community hospitals and 55% of community care teams would provide information for the thermometer in 2012/13. We met or over achieved this target with 100% of community hospitals and 75% of community care teams returning information. The results show that on average over 87% of our patients measured on a given day do not have one of the harms listed above.

Our Mental Health and Learning Disability divisions are part of a pilot started in February 2013 to develop a similar Patient Safety Thermometer with proposed measures to include self-harm, falls, risk of violence and aggression/victim of violence, medication omissions.

National Safety Alerts

The Department of Health's Central Alerting System (CAS) enables alerts and urgent patient safety specific guidance to be distributed via a NHS-wide central alerting system. CAS alerts are an important mechanism to help providers learn lessons from each other and to improve the quality and safety of care they provide and they should be actioned rapidly by NHS organisations.

92 alerts were issued nationally during 2012/13. At 31 March 2013:

- **51 alerts were confirmed by Trust services as relevant to Southern Health**

- **28 alerts were confirmed by Trust services as not relevant to Southern Health**

- **13 alerts were waiting confirmation of relevance to Southern Health by Trust services**

The table below summarises the alerts issued in 2012/13:

Type of alert	Number issued	Number actioned or implemented within deadline	Number being actioned	Number actioned or implemented in breach of deadline
Medical device alert	89	78	11	0
Estates alerts	3	1	2	0
Total	92	79	13	0

Southern Health has actioned or implemented all alerts issued within the Department of Health's strict deadlines. The 13 alerts being actioned at 31 March 2013 are not in breach of their implementation deadlines.

NHS Litigation Authority (NHSLA)

The NHS Litigation Authority (NHSLA) works with NHS Trusts to improve their clinical and non-clinical risk management practices. This responsibility, aimed at improving the safety of NHS patients and staff, is met mainly through the provision of risk management standards which are based on the identified causes of claims.

In September 2012, 58 of the Trust's policies and procedures were examined by NHSLA assessors to ensure they met these risk management standards (level 1). We achieved a maximum score of 50/50 and now continue to work on the implementation and monitoring of compliance with these policies and procedures.

Safeguarding

Safeguarding describes Southern Health's responsibility to work in partnership with other agencies to prevent abuse and neglect of vulnerable adults and children and to deal with it effectively if it does occur. The Trust is a member of Local Safeguarding Boards for Children and Adults and follows the Multi Agency procedures.

The Trust is committed to ensuring adequate preventative measures are in place to reduce the risk of abuse. This includes having appropriate policies, staff training, supervision, management and leadership arrangements in place and clearly defined professional boundaries. An appropriately skilled workforce is considered key to reducing risk of abuse or neglect. This year 4716 staff, approximately 50% of our workforce, accessed training to identify those at risk, incidents of abuse and how to report concerns.

All incidents where safeguarding concerns are reported are investigated with the Trust focused on learning and sharing widely any lessons learned thereby reducing future risk.

The Safeguarding team have reviewed and circulated the recommendations from the Winterbourne Review and Savile case to services, requesting each makes sure they meet the recommendations and develop plans to address any shortfalls which are monitored by the Safeguarding Committee.

Infection Prevention and Control

In Southern Health we take the risk of infection very seriously and work hard to maintain our low infection rates. We have our own dedicated infection prevention and control team who work with all staff to ensure the risk of infection is kept as low as possible for all patients and service users.

All staff must undertake regular training in infection prevention, control and hand hygiene. This can be done as 'face to face' training or by completing an assessment on line. There is an extensive audit programme to monitor clinical practice and ensure high standards are maintained.

Southern Health has very low rates of healthcare acquired infection. Our numbers of *Clostridium difficile* infection (inpatients) are reducing year by year as shown below. This is a great achievement and a credit to all staff involved.

Rates of Clostridium Difficile (C.Diff)	
2010-11	27
2011-12	7
2012-13	5

The team also monitors other infections such as MRSA and *Escherichia coli*. These do not happen very often, but when they do occur, we investigate to see if there was anything that could have been done differently to prevent the infection. Any learning from these incidents is shared with staff.

Preventing and learning from serious incidents

The total number of reported serious incidents in 2012/13 is 372. However, following review by clinical staff, 36 of these incidents were downgraded with most concerning pressure ulcers which may have been incorrectly graded, categorised or were not acquired in our care. This gives a final total of 337 which is a decrease of 5% compared to 2011//12 (353).

Serious incidents are rare and unintended events that can cause significant harm or distress. If an incident happens as a result of failure in care or treatment, we want to understand why and how, and to make sure it doesn't happen again. We do this by:

- Ensuring staff know what to do in the event of a serious incident by having policies and procedures in place
- Ensuring investigating officers are fully trained to identify root causes of incidents and plan actions which will make a difference to patient and service user outcomes
- Ensuring that staff involved in serious incidents attend panels with senior managers to discuss root causes, review action plans and share learning in a constructive manner
- Ensuring through our audit of action plans that improvements have been made and learning from incidents has been embedded into practice and shared across the organisation.
- Ensuring that staff are aware of their responsibilities in being open with patients, services users and their carers and discuss openly with them when things may have gone wrong.

The bar chart shows the number and type of serious incidents reported by Southern Health in 2012/2013 compared to 2011/12. From 1 November 2012 it includes serious incidents (1) reported by the former Oxfordshire Learning Disability Trust.

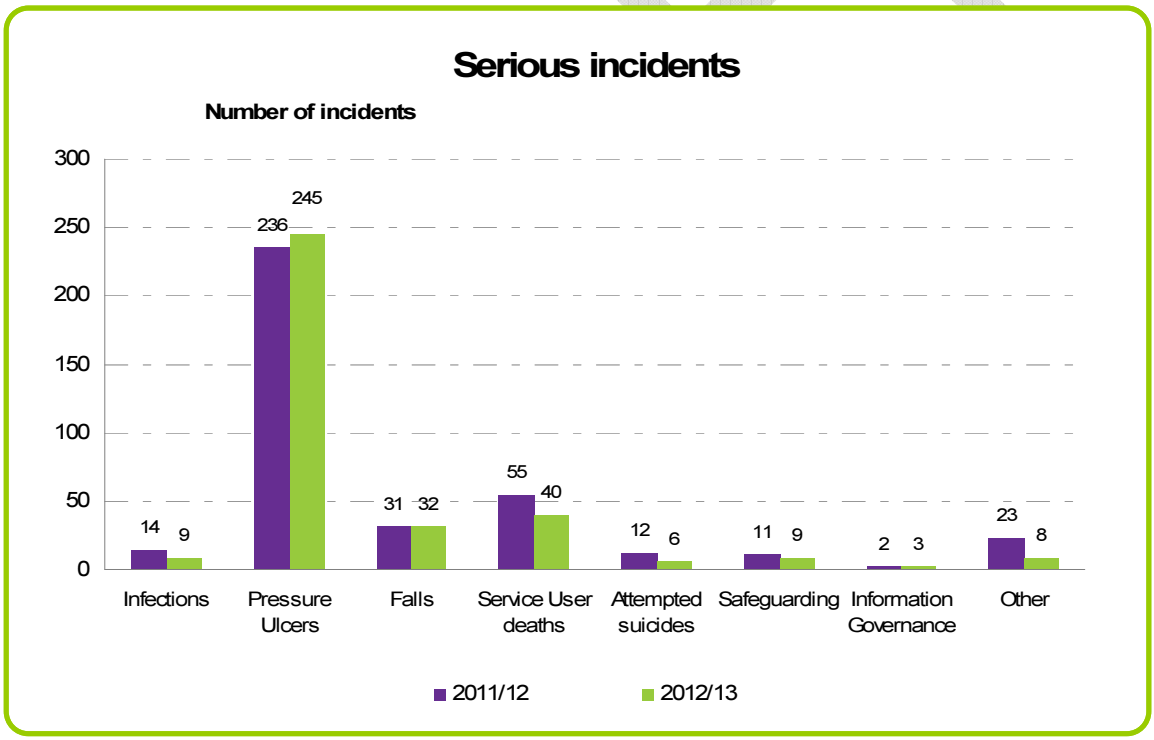
The largest reductions are in 'other' (which includes incidents such as service users absconding from secure

units), service user deaths including suicides, attempted suicides and healthcare acquired infections.

The overall number of unexpected deaths and suicides has decreased in 2012/13 compared to 2011/12. The number of suicides has decreased by 13 (25%) and attempted suicides which result in permanent harm by 6 (50%) in 2012/13.

The number of falls resulting in significant harm has increased by 1 from 2011/12. These incidents have been across a number of sites and do not have a single cause. The falls prevention team has reviewed all falls resulting in serious harm and identified some key learning points with scenario based training on the wards to improve falls prevention being introduced.

There has been an overall increase in pressure ulcers in 2012/13 due to revisions in identification and grading of pressure ulcers acquired in our care. With the agreement of our commissioners, unavoidable pressure ulcers were not consistently reported in the year. Data shows 11% of all pressure ulcers were in community hospitals in 2011/12 with this reducing to 3% in 2012/13. 89% of all pressure ulcers were in community care teams in 2011/12 with this increasing to 97% in 2012/13. Information is given in section 2.1 about some of the work we have undertaken to reduce pressure ulcers.



Never Events

'Never Events' is the term for serious patient safety incidents considered largely preventable if good practice and preventative measures in the NHS had been implemented.

Southern Health had no reported Never Events in 2012/13.

Priority 2: Improving clinical outcomes – how we performed

2.1 100% of patients identified as being at risk of skin damage will have a care plan to reduce the risk of developing a pressure ulcer or other skin damage.

Aim
The management of pressure ulcers and other skin damage continues to be an important area of focus for us, particularly in our integrated community services where there are higher numbers of pressure ulcers due to the nature of the patients seen. A very small number of patients seen by Older People's Mental Health services have pressure ulcers. Information below therefore shows audit results for community hospitals, community care teams and Older People's Mental Health inpatient units and does not include information from other services where the indicator is less applicable.

The numbers of avoidable grade 3 and 4 pressure ulcers acquired in our community hospitals has reduced from 24 in 2011/12 to 18 in 2012/13. However numbers for the same type of pressure ulcer reported by the community care teams has risen from 149 in 2011/12 to 167 in 2012/13. Our aim is to proactively assess any patient at risk of skin damage and put into place appropriate treatment and care plans which will reduce the risk of developing a pressure ulcer so leading to better outcomes for our patients.

What we have achieved
We have not achieved this target and know we need to do more to reduce numbers of pressure ulcers.

Clinical audit results show that a very high percentage of patients have a skin assessment and a pressure ulcer risk assessment on admission but lower numbers have a pressure ulcer prevention care plan in place.

This may be because of changes in care planning being introduced with a move away from individual care plans for each problem to one holistic care plan which includes all the actions that need to be undertaken to make the person better. It may be those completing the audit interpreted the audit question literally and did not include holistic care plans.

In Older People's Mental Health wards the risk of developing a pressure ulcer is small with only two patients having a grade 3 or 4 pressure ulcer at the time of the audit. Both of these had a wound care plan for the pressure ulcer.

Clinical audit on risk assessment and care planning regarding pressure ulcers				
service	audit	skin assessment on admission	pressure ulcer risk assessment on admission	pressure ulcer prevention care plan
Community Hospitals	Oct 2012	99%	89%	67%
Older People's Mental Health inpatient wards	Oct 2012	90%	98%	36%
Community Care Teams	March 2013	97%	98%	71%

Work we have done and future plans
We have implemented recommendations from national reviews and developed a trust wide pressure ulcer action plan including:

- Inviting the whole community team to serious incident review panels chaired by a senior manager so that all staff are involved in understanding the root cause of grade 3 and 4 pressure ulcers and identify good practice to be implemented in the future.
- Tissue viability link nurses have been developed within community teams to provide advice and information and ensure best practice is followed.
- Tissue viability team working closely with community teams and providing a second opinion on the grading of pressure ulcers and whether they were avoidable or unavoidable.
- Tissue viability team providing training to Mental Health services.
- The detailed information about pressure ulcers provided to teams has been revised so that it is easier to identify trends, compare sites and track the impact of service improvements.
- In October 2012 a 'deep dive' into the top and bottom 5 reporting community care teams identified good practice which could be shared and areas which needed addressing, including training of health care support workers, identification and grading of pressure ulcers, initial visits to be by nurse. These have all been added to overall action plan which is reviewed on a monthly basis.
- We want to see a reduction in numbers of grade 3 and 4 pressure ulcers and have included this in our 2013/14 plans for quality improvements. The audits will be repeated in 2013/14 to monitor that improvements have taken place.

2.2 95% of patients identified to be at the end of life (within 1 year) to have an End of Life Care Pathway.

Aim
Southern Health is proud of its track record in supporting individuals to die at home. End of life care is very much core business for our community care teams. We set ourselves a challenging target this year to ensure we were supporting people as early as possible to make the right decisions about their end of life care.

What we have achieved
We have not achieved our target. At year end in 2012/13 68% of patients who we believed were in their last year of life, were on an end of life care pathway. Whilst this was below our target it demonstrated year on year improvement – just 18% in 2010/11 had recordable end of life care plans and 42% in 2011/12. We also continued to support an average 70% of those wishing to die at home to do so – against a national average of 40-50%.

Work we have done and future plans

- End of life care remains a high priority for Southern Health and through 2012/13 we have continued to train our staff in the necessary skills and have continued to work in partnership with primary care and hospices in Hampshire to support the best end of life care practice.

- We have paid attention to the national debate around the use of the Liverpool Care Pathway (LCP) and remain committed to its principles as a tool to support better communication around end of life decisions. We welcome the national review of the LCP by Baroness Julia Neudberger.

- A clinical audit on use of the Liverpool Care Pathway in 2012 found a full explanation of the care plan was given to the patient (40%) or carer (91%). The reason the number of patients is low is that it often was not possible to discuss the LCP as the patient was unconscious.

- We have not included this indicator for 2013/14 but will continue to support people as early as possible to make the right decisions about their end of life care and will re-audit use of the Liverpool Care Pathway in 2013.

2.3 85% of Matrons Walk Round results demonstrate evidence of a structured handover tool

Aim

A structured handover tool provides a framework for effective sharing and communication within teams about a patient or service user's condition and treatment which is key to the provision of safe and effective care. Matron walk rounds, which are well established in our community hospitals, provide assurance that a range of patient safety, quality and outcome measures are in place. We want to extend the use of matron walk rounds to Mental Health, Learning Disabilities divisions and community care teams to provide assurance that structured handover tools are in use.

What we have achieved

We achieved this target. The table shows 100% of matron walk rounds in all services, except community care teams where the matron walk round has only recently been introduced, found a structured handover tool was being used by clinical teams. Comparison figures for 2011/12 are only available for community hospitals and show improvement in the use of a structured handover tool.

Matrons Walk Round results which show a structured handover took place		
	2012/13	2011/12
Trust Total	95%	n/a
Adult Mental Health Services	100%	n/a
Older People's Mental Health Services	100%	n/a
Learning Disabilities Services	100%	n/a
Specialised Services	100%	n/a
Integrated Community Services:Community Hospitals	100%	90.5%
Integrated Community Services: Community Care Teams	85%	n/a

The matron walk round is just what it says – a walk round of sites by the matron or lead nurse who completes a checklist to provide assurance that a wide range of patient safety, quality and outcome measures are in place and includes discussions with patients and service users about their experience and

satisfaction with the care we are providing.

Work we have done and future plans

- The monthly matron walk round has become well established practice within community hospitals with senior managers and Board members joining walk rounds. Their value in providing assurance about quality of care being provided was recognised with the walk round tool being introduced across other clinical services in 2012/13.

- Mental Health and Learning Disabilities services and community care teams have adapted the original tool to meet their own service needs and rolled it out across their services in late 2012/early 2013

- All matron/lead nurse walk round tools are now completed electronically with results being collated by the information team with reports on performance at team/service/division level being shared with senior managers and teams with actions taken to address any issues.

- One of the questions on the matron walk round checks that a structured handover tool is used at handover between staff. The handover tool provides a framework for effective sharing and communication within teams about a patient's condition and treatment which is key to the provision of safe and effective care. Having a structured handover tool ensures no vital information about a patient or service user's needs is overlooked.

- The structured handover tool has become embedded in clinical practice and does not need to be included as a separate quality improvement indicator for 2013/14. However, its use will continue to be monitored by the matron walk round.

Other initiatives to improve clinical outcomes during 2012/13

National Institute for Health and Clinical Excellence (NICE) Guidance

NICE is responsible for providing national guidance on promoting good health and preventing and treating ill health. During 2012/13 NICE issued 87 pieces of guidance, of which 36 were assessed as being relevant to Southern Health and which are being implemented across the Trust.

Implementation and compliance with NICE guidelines has been monitored as part of the clinical audit programme for 2012/13 with some examples of how these have helped us improve the quality of care we provide to patients given below.

CG 92 Venous thromboembolism: Reducing the risk

This guidance is about the care and treatment of people who are at risk of developing deep vein thrombosis (DVT) while in hospital. The results of this audit showed 77% of our patients had a completed VTE risk assessment filed in their records.

CG21 Falls: the assessment and prevention of falls in older people.

This audit has shown improvement in many of the areas identified by NICE as good practice with an increase of 20% in inpatient falls care plans being completed.

Development of Outcome Frameworks in Southern Health

There are many measures used in the NHS to assess the performance of NHS organisations and the impact of care upon patients and service users. At Southern Health we want to move away from just counting activities or processes and focus on what matters to patients, service users and their carers or families. We are therefore looking at how we measure 'outcomes' of care, for example rather than focus on a specific piece of care provided ie a leg ulcer dressing, we want to shift the emphasis to what we want to achieve for that patient, for example rapid healing of ulcers to support maximum function and quality of life for each individual.

Clinical services have identified key outcomes and the factors needed to be in place to achieve them so that we can provide quality care to our patients and service users. These Outcome Frameworks bring together all aspects of service delivery that lead to positive outcomes for patients and service users. They draw on best practice and aim to help us understand how well we are doing and what we need to do to improve outcomes further.

The Outcome Frameworks have attracted a great deal of interest from other parts of the NHS. As a consequence we are sharing our experience and methodology with others, and helping to shape measures that are used to monitor community health services nationally.

At a local level we have been identifying data to populate the Outcome Frameworks, so that we can track changes in the outcome and underlying predictive factors over time. These reports will be used at service level to improve outcomes for patients, and at trust level so that the Board has assurance that its services are working well for patients.

Other initiatives

Community Assessment Lounge We are working with Solent Healthcare and Queen Alexandra Hospital in Portsmouth to prevent avoidable acute admissions by opening a Community Assessment Lounge in the hospital. The service has been designed to provide clinical assessment to anyone admitted to the emergency department and provides the appropriate support and treatment to enable a patient to be discharged safely and in a timely way in the community.	**Fusion Project in Lymington and New Milton** This project focuses on working more closely with care homes and aims to educate care home staff about the services we provide and develop their skills so they can provide quality care to their residents. Over the coming year the project will look at topics such as tissue viability which will help reduce the numbers of pressure sores, how to support those with mental health issues and how multidisciplinary care is provided in the community.
Memory Advisory Service in Southampton A joint Memory Advisory service has been set up in Southampton in partnership with Age Concern to promote inclusion to newly diagnosed patients with dementia or those who are deemed to have significant cognitive impairment by their General	**Older People Partnership in South East** This project sees us working with our colleagues in acute care and with Solent Healthcare to transform the way we collectively care for frail and elderly patients. This includes looking at how people are looked after when they arrive at the Queen Alexandra Hospital,

Practitioners.	and offers training and support to staff.

Priority 3: Improving patient experience - how we performed

3.1 100% of Mental Health and Learning Disabilities inpatients with a physical healthcare assessment

Aim

Service users with mental health and/or learning disabilities can have less emphasis put on physical health needs, even though many with learning disabilities are at higher risk of having physical health problems. In 2011/12 our commissioners identified improving the physical healthcare assessments for mental health service users as a key area for further improvement. We therefore repeated this indicator from 2011/12 to ensure all mental health and learning disabilities inpatients received a physical healthcare assessment on admission to a unit.

What we have achieved

We have not achieved this target. However figures below show an improvement since 2011/12 when clinical audit showed 87% of service users had a physical healthcare assessment. It is challenging to achieve 100% of mental health and learning disabilities inpatients having a physical healthcare assessment on admission as some service users refuse such an assessment.

Inpatients in Mental Health and Learning Disabilities units who have received a physical healthcare assessment	
Trust total	**91%**
Adult Mental Health services	**87%**
Older People's Mental Health services	**96%**
Learning Disabilities services	**96%**
Specialised services	**85%**

Work we have done and future plans

- physical healthcare assessment has been measured via the matron/lead nurse walk round tool which checks a random sample of five service users per visit. The physical healthcare assessment includes baseline observations, such as blood pressure and temperature, which enables service users physical health to be monitored and any physical health difficulties to be identified so that appropriate care can be given.

- annex A reflects the introduction of the matron/lead nurse walk round tool in September 2012 in these services with no walk round taking place in January 2013.

- services have followed guidance and procedures in the new Physical Assessment and Monitoring Policy introduced in 2012 and staff have attended a physical assessment and monitoring training programme.

- weekly health check clinics for service users have been introduced on all Adult Mental Health wards to monitor physical health.

- we are pleased to see these results for inpatients in our Mental Health and Learning Disabilities divisions and will monitor via matron/lead nurse walk rounds that such high levels of physical healthcare assessment are maintained. Rather than repeating this same indicator for 2013/14, we will focus on the identification of physical deterioration in our service users by including an indicator on the use of an early warning system.

3.2 Use of a patient reported outcome measure in all clinical services across the Trust

Aim

This was a new indicator this year with the aim that all clinical services gained patient feedback on the quality and effectiveness of care they received. We are always keen to learn about patient and service user experiences and to know we are meeting their needs. Patient reported outcome measures (PROMs) were originally introduced as a national tool to gain patient feedback on the success of surgery. They focus on quality from the patient perspective and give an insight into patient satisfaction with the care and treatment they have received. We want to understand more about patient satisfaction so we will be able to improve our services to make the most impact on the service user's quality of life.

What we have achieved and future plans

We have not achieved this target; however 9 out of 10 clinical divisions reporting to Quality and Safety Committee in January 2013 provided evidence of using patient reported outcome measures in their services. The exception was the Learning Disabilities division which highlighted that it was hard to use such measures with their service users but they worked hard to gain patient feedback.

Only one national PROM was relevant to our services with the hernia PROM used at Lymington New Forest Hospital to gain patient feedback, with results reviewed by the senior management team and at local governance meetings. An audit is being completed to investigate hernia repair failures so that procedures can be adapted as necessary.

As there were few relevant national patient reported outcome measures, services adapted or developed tools to meet the needs of their patients and service users. Examples included:

- physiotherapy classes ask patients to rate what they could do before attending a series of classes and then to rate the same movements at the end of the classes providing clear information about patient views on the outcome of treatment given.

- specialist nurse services have introduced well-being scores as part of their care, for example, the Minnesota Living with heart failure questionnaire which looks at the patient's quality of life. This is used with patients when first assessed and then repeated at a later date.

- children's services use simple before-after intervention measures to gain feedback from parents on the effectiveness of interventions, for example, parental confidence before and after health promotion advice is given.

- the Warwick-Edinburgh Mental Well-Being Scale which asks patients to rate items on how they are feeling based on their recent experiences is being piloted in Older Peoples Mental Health services.

- Bluebird House introduced the Strengths and Difficulties Questionnaire (SDQ) in 2012 which gathers service user's views on their own difficulties and strengths at various points in the admission process.

- service user evaluation questionnaires are well established in Leigh House and ask questions regarding their views on the impact of the care they have received on their overall well-being.

- introduction of patient reported measures 'Inspire' as part of IMROC programme in Adult Mental Health services.

- we will continue to seek feedback from patients and service users and use it to help shape our services and continually improve the care we provide.

3.3 Use of patient experience surveys to ask 'How would you rate your experience of our service as a whole?'

3.5 Use of patient experience surveys to ask 'were you involved in decisions about your care?'

Aim
We value patient feedback and have used patient experience surveys over many years. We have developed a standard patient experience survey which was introduced across the Trust in May 2012. This was designed to collect patient feedback at regular key points in their care, not just at discharge. A 95% satisfaction target was set by the Trust for most services with a lower target of 75% for Adult Mental Health services reflecting the nature of their service users.

What we have achieved
We have achieved these targets with 95.3% of patients and service users who responded to the survey in 2012/13 showing a high level of satisfaction with services received and 92.9% of patients and service users responding that they had been involved in decisions about their care.

Information for Learning Disabilities and TQtwentyone divisions is not yet available as some modifications to the survey procedures are required.

The dashboard shows results for January – March 2013 for the two questions from the patient experience survey included in this Quality Account.

Patient and Service User Experience : Board summary for the 3 month period ending : March 2013

All percentages are quoted as the number of positive responses given against the total number of responses for that question	ICS - Adults North Hampshire	ICS - Adults Mid Hants	ICS - Adults North East	ICS - Adults South Eastern	ICS - Adults Specialist Nursing	ICS - Adults West	ICS - Children and Families	ICS - Dental	ICS - Scheduled Care	MH &LD - Adult Mental Health	MH &LD - Older Persons Mental Health	MH &LD - Learning Disabilities and Specialised Services	MH &LD - TQ21	Southern Health NHS Foundation Trust
Total number of surveys completed	232	34	33	444	135	268	2440	34	867	351	137	0	0	4975
How many surveys were expected to be returned?(based on a 40% response rate with every patient being given the opportunity)	510	900	330	1050	150	600	1500	1200	1350	900	900	0	0	9390
How would you rate your experience of our service overall?	98.1%	93.8%	100.0%	96.8%	98.5%	96.6%	95.7%	100.0%	96.4%	84.3%	90.4%			95.3%
Customer charter : As an organisation we commit to involve and inform patients and carers/family about their care														
Were you involved in decisions about your care?	93.9%	97.1%	87.1%	93.6%	96.3%	91.7%	93.6%	94.1%	94.5%	86.6%	88.3%			93.1%

Thresholds	
	Main question only (how would you rate your overall experience) : Above 95% (75% for AMH) - Achieving expectations
	Main question only (how would you rate your overall experience) : Below 95% (75% for AMH) - Falling below expected standards
	Supplementary questions only : Outlier (based on 80% confidence limit when compared to the Trust for that question) ; cause for concern
	All questions : Response rate is insufficient (below 20) to obtain statistically relevant results
	Supplementary questions : Question not asked within the survey for that Service

What we have done and future plans

- Services have worked hard to increase the survey response rate since it's introduction.
- Patient experience survey results are discussed at local, divisional and trust level and any learning shared across services.
- We will have a similar indicator for quality improvement in 2013/14 with the Friends and Family Test being reported.

3.4 100% of service users have a care plan that has been developed with them and/or their main carer.

Aim

Care plans ensure that treatment is well planned, appropriate and has clear expected outcomes. The involvement of the patient, service user or their carer in their development puts the service user at the centre of decision making about their own treatment leading to a positive patient experience. We aimed that all patients and service users had a care plan that had been developed with them and/or their main carer.

What we have achieved

We have not achieved this target which has been measured by a series of clinical audits throughout the year with results as follows:

- audit in community hospitals in October 2012 showed 72% of patients audited had a nursing care plan. There has been a move away from separate care plans written for each health need with new documentation paperwork introduced in community hospitals aiming for a holistic approach to the assessment and treatment of the patient. The 'traditional' care plan may have been less obvious thus explaining the relatively low score. On reflection our audit tool may not have captured the care planning process adequately and will be reviewed and adapted as appropriate in the future.
- audit in Adult Mental Health, Older People's Mental Health and Specialised Services in November 2012 showed that 84% of service users audited had a nursing care plan.
- audit in community care teams in March 2013 showed 62% of service users audited had a care plan. Community care teams are using a new electronic patient recording system (RiO) introduced in 2012/13 where the setting out of clinical notes, care plans, assessment forms is different to the original paper notes and may explain the low score. A group is working to develop a core set of care plans which will be available on RiO.
- Patient experience survey results (given in 3.5 below) show a very high percentage of patients and service users were involved in decisions about their care.

What we have done and future plans

- Audit results have been shared with clinical teams and managers and discussed at local governance meetings and action plans implemented to address under-performance.

- Holistic plans of care and treatment are being developed to replace the 'traditional' care plan. Use of plans of care and treatment will be re-audited in 2013/14 with audit tools adjusted to reflect these changes and the introduction of an electronic patient record system in community services in 2012/13.

- Having a plan of care/treatment is essential when providing quality care to a patient or service user. We will continue this indicator in our priorities for improvement in 2013/14 and look at the use of plans of care in targets concerning falls, pressure ulcers and use of the 'track and trigger' early warning system.

Other initiatives implemented to improve patient experience during 2012/13

National patient experience surveys

We had a response rate of 38% to the 2012 NHS Community Mental Health Services User Survey, which was one of the highest rates in the country and compared to the national response rate of 32%. This prompted other Trusts to contact us to discuss how to replicate such a good response. The results of the survey are presented in a different way to previous years with Trust results being rated as 'better', 'the same as' or 'worse' than the majority of the other Trusts who took part. Southern Health results were the same as or better than the majority of other Trusts with 'better' scores for the questions below:

- 'did this person listen carefully to you?'

- 'did this person treat you with respect and dignity?'

The majority of responders rated the care they had received from NHS Mental Health Services in the last 12 months favourably.

Action plans have been developed by Adult Mental Health and Older People's Mental Health divisions to address those areas where it has been identified, alongside input from service users and carers, improvements could be made.

Patient experience surveys

In May 2012 Southern Health introduced a standard patient and service user experience survey across most services in order to measure our performance in meeting patients, service users and their carers' needs and to identify aspects of care where the Trust could improve. By using a number of standard questions the Trust can measure customer service across the range of Trust services. The surveys are designed to capture feedback during treatment rather than just at discharge so that improvements in care can be actioned while the patient/service user is still receiving our care.

A monthly dashboard and report is shared with services and discussed at local and divisional governance meetings. Adult Mental Health services have analysed the free text comments from completed surveys with themes identified and discussed at 'learning out of concerns meetings'. There is an internally set target to achieve a 40% return rate. Services have worked hard to increase response rates with some giving stamped addressed envelopes, involving League of Friends in hospitals giving out surveys, involving service users to collect feedback from other service users in our social care and learning disabilities services.

Service user surveys

In 2012, TQtwentyone's Personalisation Manager along with a working party of team members redesigned the annual Service User Survey so that a larger proportion of people with learning disabilities, particularly those who are not able to verbalise their responses, were able to give genuine indicators of satisfaction. Staff were provided with guidance on how they might support people to complete the survey using 'evidence' to demonstrate an answer. For example, to the question 'Do you get on with the people you live with?' the evidence could be a daily diary entry about an activity that occurred with their co-tenant, where they offered their arm to accompany them to the car and photographs showing them jointly engaging in the activity. The outcomes of the survey will be shared with people supported by TQtwentyone, their families, and Commissioners.

Friends and Family Test

The Friends and Family Test will be included in our patient experience surveys from April 1st 2013 and will be reported as part of our quality improvement targets in 2013/14.

Implementing Recovery through Organisational Change (IMROC)

Our Implementing Recovery through Organisational Change (IMROC) journey has continued this year with the Recovery College opening in April. The Recovery College will provide an educational approach to increasing skills and knowledge around self-management and recovery with all courses being 'co-produced' i.e. developed and delivered by those with 'lived experience' of mental health issues and those whose experience of services is by virtue of their profession or training. Courses will also be co-attended – people who may identify themselves as service user, carer or member of staff setting aside those labels and being united in the shared identity of 'student'. Through this approach we know that the learning experience is enriched for all participants, that we take strides in tackling stigma and discrimination, and that we can transform the lives of individuals and our services.

We are also developing a new role of 'peer support worker' in our acute care pathway skill mix where those who have experienced recovery from mental health issues will be used at the heart of our workforce to help provide environments where hope is evident and recovery expected and supported.

We are very pleased that two of our staff have been asked by the IMROC National Team to join them as consultants in recognition of the contributions they have made and their growing expertise in developing recovery focused cultures and organisations. This will involve them using their experiences to directly support NHS Trusts and other providers who are setting out on their own journey of organisational change and is an exciting opportunity to share the learning and great work that Southern Health staff and service users, working in partnership, have put in again this year in pursuit of developing truly recovery oriented services.

Supporting patients and service users

All patients should be treated with compassion, dignity and respect in a clean, safe and well managed environment. Southern Health views excellent customer service as integral to achieving these standards. The Trust has a dedicated Complaints and Patient Advice and Liaison (PALS) team which is the first point of contact for patients and members of the public who require advice or information about any of our services and manages complaints.

Figures for complaints, concerns and compliments received in 2012/13 are given with 2011/12 figures in brackets. In 2012/13 the Trust received 399(342) complaints, 460(544) concerns and 1491(854) written

compliments and letters of thanks. These figures include 20 complaints received since 1 November 2012 regarding the former Oxfordshire Learning Disabilities Trust.

The majority of compliment letters praised staff attitude and the clinical care provided.

The Complaints and PALS team work closely with clinical services to review complaints and concerns, identify themes, share learning at 'Learning out of Concerns' meetings and improve quality of services.

Some examples are given below:

Complaint	Service Improvement
A service user on a mental health inpatient unit burnt themselves with a lighter	No lighters are now allowed in the unit.
Prescription had been written on incorrect prescription sheets in a nursing home.	Nursing homes now have the correct paperwork for Southern Health.
The right medication was not available during my operation.	New procedures have been put in place so appropriate medicines always available.

69% of complaints received in 2012/13 related to four key categories:

- clinical and nursing care 36.8%
- staff attitude 13.5%
- communication 11.5%
- access to services 7.2%

The top three reflect both the same top categories reported in 2011/12 and the national picture, while access to services has been one area that the Trust monitored in 2012/13 in light of the changes that have been happening with reconfiguration of our services.

Of the complaints related to access to services the majority (69%) were related to Adult Mental Health services. This is not unexpected and is fed back to the division through the learning out of concerns groups.

Of the 399 complaints, the Trust has been made aware of 15 complainants who went on to take their complaint to the Parliamentary and Health Service Ombudsman. Ten have required no further action, one case was returned with a suggestion for further action by the Trust and four remain outstanding.

We are reviewing the recommendations made by the Francis report and will be adapting policies and procedures as required.

Patient Environment Action Team (PEAT)

In addition to the environmental assessment performed during the matron walk rounds, all inpatient Mental Health sites were inspected as part of the Patient Environment Action Team (PEAT) in May 2012 for environment, food, privacy and dignity with 80% of scores being 'excellent' and the remainder 'good'.

Productive Series

The NHS Institute for Innovation and Improvement's Productive Community series helps front line teams improve quality and productivity.

The releasing time to care programme was re-launched in Mental Health and Learning Disabilities divisions in September 2012. So far over 248 staff from community teams and inpatients units have been trained and are implementing the Lean principles to improve patient's safety and experience, enhance quality outcomes and cost effectiveness. Focus has been on processes and systems within wards and teams, increased use of a multi-disciplinary approach and working with teams to understand and plan the most effective ways of delivering their team priorities.

The first wave implementation saw a potential efficiency saving of over £4500 with £21364 predicted savings from medication costs per annum. Feedback from teams has been very positive with the time released being used to communicate more effectively with patients with more time being available for staff to talk and listen to patients.

74% of teams within the division are now implementing the productive series with the remaining teams due to undertake training and start implementation in March/April 2013.

The final wave of implementation of the Productive Series took place in community services with 'Planning our Workload' module leading to efficiency savings in time through changes in working practices that has released time for patient care.

Last October the wound clinic at Andover was nominated for an award at the NHS South of England 'Safe & Productive Care Celebratory conference'. This was for their excellent collaborative work and using Productive Community series to redesign and extend their specialist wound care clinic services to improve the patient experience and meet the needs of the locality.

Care Quality Commission (CQC) inspections

In 2012/13 Southern Health has continued to monitor, through a combination of external review and our own internal monitoring processes, quality of service delivery. Where improvements were required action has been taken to ensure that the quality and safety of services was maintained. During 2012/13 there were 17 unannounced inspections by the Care Quality Commission to Southern Health sites. Fourteen of these inspections found we were fully compliant with the Essential Standards of Quality and Safety set by CQC. Three inspections identified areas where the Trust was not meeting essential standards with three compliance actions issued, reflecting two minor and one moderate concern. The level of concern relates to the potential impact on patients and service users of non-compliance with the standard.

The three compliance actions are shown below, with one being closed when the site was re-inspected in January 2013. The remaining two will remain open until the sites are re-inspected by CQC.

minor concern	recording of medicines to be taken by service users supported by our social care services was not always clear.
minor concern:	care plans were not always completed with information relating to the physical health needs of the service user.
moderate concern	care plans did not adequately reflect the patient's views on their care and treatment and risk assessments were not always included in the care plan to inform staff about the support the service users may need.

This is an improved situation from last year when 14 compliance actions were issued.

The Trust continues work to further strengthen its governance systems. A Quality Assurance and Improvement Programme is in operation reporting to the Assurance Committee and the Board. The programme has focused on:

- the collation and triangulation of a wide range of quality and safety information to ensure early identification of issues and strong performance management
- a programme of unannounced visits by a dedicated inspection team and re-inspections of areas with independent representatives and external experts
- the identification of areas of good practice to share across other services
- the identification of leadership and organisational development requirements
- a review of the governance infrastructure to provide assurance to the Board around quality

Mock CQC inspections

The Trust set up a mock inspection team in December 2011 to provide a comprehensive, unannounced programme of visits to all sites, including community teams, to assess compliance against the CQC Essential Standards of Quality and Safety. The inspection process is based on the format used by CQC for their inspections and has been cited by other trusts as good practice which they would like to adopt.

The core mock inspection team comprises clinicians from a mental health, learning disabilities or community services background. A wider pool of inspectors and observers has been drawn from staff across the Trust and key stakeholders such our commissioners and Governors. Staff were encouraged to take part so they gain the necessary skills to carry out peer review inspections in the future.

The mock inspection programme has been used to identify and celebrate areas of best practice across the Trust as well as highlighting areas which need to be improved. It has been invaluable in assuring the Board and stakeholders that we are meeting the CQC Essential Standards of Quality and Safety and any gaps are being addressed. It has raised awareness of CQC with staff and how patients and service users should be at the centre of everything we do.

By the end of March 2013, 198 inspections had been carried out by the mock inspection team. These covered all service types across the Trust, including former Oxfordshire Learning Disabilities Trust, and represent 56% of all our sites and 354 services.

As a result of the mock CQC inspections the following have been noted:

- Implementation of new care planning standards
- improved documentation of discharge planning meetings and communication with service users
- improved discussions with service users and documentation of choices for end of life
- improved compliance with sharps disposal procedure and drug storage monitoring procedures now in place
- more robust lone working procedures implemented within teams
- increased attendance at essential training with tracking training systems implemented

The Trust's priorities in 2012/13 were based upon:

- What patients and service users told us about our services and where it should focus attention
- What our Governors have told us is important to them
- What staff have told us is important to them
- What has been learnt about the quality of services and where improvements are required

Southern Health and its stakeholders consider that the Trust should continue to seek improvements in the services it provides based upon improving patient safety, clinical outcomes and patient experience. As such they will remain the Trust's priorities in 2013/14 with progress being monitored by Quality Improvement and Development Forum, Quality and Safety Committee and the Board.

After engagement with stakeholders to gain their views on the indicators they consider to be priorities for the coming year the Trust Board has approved the follow indicators (tbc). The Trust will monitor these indicators and report its performance against them in its 2013/14 Quality Account.

2012/13 local indicators to be delivered by April 2014

Priority 1: Improving patient safety	**Priority 2: Improving clinical outcomes**	**Priority 3: Improving patient experience**
To reduce the risk of falls by ensuring 90% of inpatients in Community Hospitals and Older People's Mental Health wards at risk of falling have a falls care plan completed within 6 hours of admission	Improve therapeutic interventions in Mental Health and Learning Disabilities services to reduce patient violent and aggressive incidents by 10%	95% positive response to the question 'did staff give your family/someone close to you, the right support to help care for you?' on our patient experience survey
Avoidable grade 3 and 4 pressure ulcers to reduce by 30% in patients cared for by our community care teams	Prevent patients deteriorating unexpectedly by using the track and trigger tool as an early warning system for 90% of appropriate patients	Achieve 95% excellent in the Friends and Family Test
80% of stage 2 medicines reconciliations will be completed within 24 hours of admission to inpatients units	Five outcome frameworks will be introduced to demonstrate improved clinical outcomes for patients/service users over the year	100% compliance with Duty of Candour obligations for suspected or actual patient safety incidents that result in severe harm or death
	All Community Hospitals and Older People's Mental Health wards will provide dementia friendly environments	

Part 2b - Statements of assurance from the Board

This section contains a number of mandated declarations Southern Health is required to make so that its performance may be directly compared to that of other NHS trusts.

Review of services

During 2012/13 Southern Health provided or sub-contracted 47 NHS services.

Southern Health has reviewed all the data available to it on the quality of care in 47 of these NHS services. The data covered the three dimensions of quality: patient safety; clinical effectiveness; and patient experience.

The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by Southern Health for 2012/13.

Clinical audits and national confidential enquiries

During 2012/13 2 national clinical audits and 3 national confidential enquiries covered relevant health services that Southern Health provides.

During 2012/13 Southern Health participated in 100% national clinical audits and 100% 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 Southern Health was eligible to participate in and participated in during 2012/13 are as follows:

National Audit / Confidential Enquiry	Eligible	Participated
National Audit: Parkinson's Disease	✓	✓
National Audit: Schizophrenia	✓	✓
National Confidential: Patient outcome and death	✓	✓
National Confidential Enquiry: Suicide and homicide in mental health	✓	✓
National Confidential Enquiry: Elective surgery (national PROMS)	✓	✓

As a community Trust we do not always meet the criteria for the national audits and so in 2012/13 adapted the national audit tools for local use for comparative audit of blood transfusion, health promotion in hospital and dementia.

The national clinical audits and national confidential enquiries that Southern Health participated in, and for which data collection was completed during 2012/13 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit/Confidential Enquiry	% of required cases submitted
National Audit: Parkinson's Disease	100%
National Audit: Schizophrenia	100%
National Confidential Enquiry into cardiac arrest	100%
National Confidential Enquiry into suicides and homicides	100%
National Confidential Enquiry: Elective surgery national PROMS (hernia only is relevant)	100%

The reports of 1 national clinical audit and the locally adapted national audits were reviewed by the provider in 2012/13 and Southern Health intends to take the following actions to improve the quality of healthcare provided:

- Blood transfusion and consent policy to be amended to include the recommendations that written consent should be obtained prior to transfusion of blood/blood products.
- All community hospitals to introduce use of the 'this is me' booklet and ensure it is completed for all patients with dementia on admission with the aid of their relatives/carers.
- A lead for dementia care at Lymington New Forest Hospital is to be allocated with dementia champions for each ward.
- A local audit to investigate hernia repair surgery is being completed.

The national audit report on Parkinson's Disease is yet to be published.

The reports of 56 local clinical audits were reviewed by the provider in 2012/13 and Southern Health intends to take the following actions to improve the quality of healthcare provided:

- a review and implementation of the World Health Organisation checklist for theatres.
- ensuring that all patients at initial assessment are asked to complete the information sharing consent form and that the completed form is filed in the records.
- development and implementation of a marketing strategy aimed at increasing the profile of the Memory Assessment and Research Centre amongst the public.
- providing all patients/service users with a copy of their signed consent to treatment form.

Clinical research

Research is a critical component of successful NHS provider organisations, ensuring that clinical practice is based upon the latest evidence. All patients and service users should receive the opportunity to take part in research. It is also a key element of the continuing development of staff, providing stimulating opportunities for professional and personal development.

Southern Health aspires to:

- embed a culture in the organisation that enables every patient the opportunity to participate in research
- embed clinical and health services research, and the use of evidence, into every day clinical practice within Southern Health
- be seen as a leader and to host research relevant to Mental Health, Learning Disabilities and community care practice
- encourage a research culture, studentships and practitioner researchers within Southern Health
- attract national and regional research funding, ensuring the Trust can continue to deliver significant and relevant research for Southern Health into the future

The Research & Development Department supports research in a number of disease areas and is a world leader in research into culturally adapted cognitive behaviour therapy and its feasibility in ethnic minority groups.

The Memory Assessment and Research Centre (MARC) runs national and international clinical trials in dementia. The majority of these trials are investigating how effective new drug treatments are, although some trials look at other aspects associated with Alzheimer's such as depression and sickness behaviour.

MARC is one of the leading centres in Europe for dementia research. South Coast DeNDRoN is one of seven local research networks which are placed throughout the UK, and is hosted by Southern Health NHS Foundation Trust.

Southern Health hosted 96 clinical research studies (57 Portfolio and 39 Non-portfolio) during 2012/13. The number of patients receiving NHS services provided or sub-contracted by Southern Health NHS Foundation Trust that were recruited during that period to participate in research, approved by a research ethics committee, was approximately 670. The department has robust governance processes that approve and monitor the studies hosted by the trust.

Increasing patient and public involvement (PPI) is central to the Southern Health research business plan and in 2012/13 actively engaged 3 Service User Representatives. The vision is that patients are at the centre of decision making. Southern Health PPI initiative aims to:

- Provide every patient the opportunity to participate in research
- Give patients the opportunity to be involved in research studies at the start
- Involve patients in the selection of the types of studies relevant to their care needs
- Improve knowledge for patients and carers about national research processes in the NHS

Involving patients and the public in developing research offers a better chance that researchers and clinicians will ask questions that are relevant to patients.

Commissioning for Quality and Innovation framework (CQUIN)

A proportion of Southern Health income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between Southern Health 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 payment framework.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at: *http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275*

In 2012/13 income totaling £5,446,826 million was conditional upon the Trust achieving quality improvement and innovation goals. In 2011/12 income totaling £0.886 million was conditional upon the Trust achieving quality improvement and innovation goals, of which payment of £0.772 million was received.

The following table lists the CQUIN schemes for 2012/13:

Commissioner	Service Area	Scheme	Available £
Hampshire	Childrens Services	Children's Services	£350,000
Hampshire	Integrated Community Services	Patient Safety Thermometer	£2,483,775
		Patient Experience	
		VTE - Risk Assessments & Medication	
		Piloting the use of Telehealth	
		Reducing Frequent Attenders to SGH	
		Joint working to reduce non-elective admissions to Acute Hospitals	
Hampshire & Southampton	Mental Health & Learning Disabilities	Patient Safety Thermometer	£1,850,464
		Patient Experience	
		Improving Dementia Diagnosis Rates in Primary Care	
		Development of Psychiatric Liaison model in acute hospitals	
		Undertaking physical health screening for admitted patients	
		Developing Mental Health Payment by Results	
		Reviewing placements	
		Reviewing use of IAPT services for people with Long Term Conditions	
Buckinghamshire	Learning Disabilities	Improving access to general healthcare for adults with learning disabilities	£83,442
		Reviewing placements	
		Ensuring Dignity in Care	
Oxfordshire	Learning Disabilities	Improving access to general healthcare for adults with learning disabilities	£153,974
		Service User Involvement	
		Prison Liaison	
		Dysphasia	
Specialised Commissioning	Mental Health & Learning Disabilities	Development of Clinical Pathways	£525,171
		Optimising Length of Stay	
		Implementing Clinical Dashboards for Specialised Services	
		Service User Defined CPA Standards	
		CAMHS - Education & Training	
		CAMHS - Eating Disorders Network Development	
		Access to specialised mental health services	
		TOTAL	**£5,446,826**

Care Quality Commission registration and actions
Southern Health is required to register with the Care Quality Commission and its current registration status is registered in full with no conditions. The Care Quality Commission has not taken enforcement action against Southern Health during 2012/13.

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

Quality of data
Southern Health submitted records during 2012/13 to the 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 (with 2011/12 figures given in brackets):

which included the patient's valid NHS Number was:
- 99.8% *(99.5%) for admitted patient care
- 99.8% * (99.8%) for outpatient care
- 90.3% * (93.1%) for accident and emergency care

which included the patient's valid General Practitioner Registration Code was:
- 100% *(100%) for admitted patient care
- 100% *(100%) for outpatient care
- 100% *(100%) for accident and emergency care
  (* year end figures to be confirmed mid May)

In 2012/13 the Trust's performance in respect of the quality of data exceeded national targets (tbc mid May)

Southern Health Information Governance Assessment Report overall score for 2012/13 was 75% and was graded satisfactory green level 2. This shows a slight improvement on the 2011/12 overall score of 73% which was also graded green.
Southern Health was not subject to a Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Mandated Requirements for Foundation Trusts

This year there is a mandatory requirement for all Foundation Trusts to provide information on a set of mandated requirements appropriate to the Trust and to include national comparison data where made available to the Trust by the Health and Social Care Information Centre. The latter has not made any comparison data available to Southern Health.

The table below shows performance against the mandated requirements.

Prescribed information	2012-13 YTD	Target
100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital	96.2%	100%
The number of delayed transfers of care per 100,000 inpatient population (All adults aged 18 plus)	0.06	-
The proportion of inpatient admissions gatekept by the crisis resolution home treatment teams.	97.4%	95%
Patient safety incidents reported to the National Reporting and Learning Service*	5106	-
Safety incidents involving severe harm or death	1.8%	-

* - All Mental Health teams report all unexpected deaths as Patient Safety Incidents with a actual impact grading of Catastrophic until further investigation reveals that there were no shortcomings in care which may have contributed to the death.

Part 3 - Southern Health's approach to quality

Southern Health's approach to quality supports the Trust's overall aim of providing high quality, safe services which improve the health, well-being and independence of the people we serve. We are committed to meeting essential standards and also to using robust evidence as the basis of improving care. Our work on customer standards and experience has given us robust feedback on our care from those who use our services. In addition we have used research, evidence based care and a focus on outcomes to improve the effectiveness of our services.

In order to deliver safe care, improved clinical outcomes and a better experience for service users we have developed an approach to quality that ensures robust systems and processes are in place, there is a strong culture of innovation and learning and our workforce has the right knowledge and expertise to deliver high quality care. Our approach to quality is led from the Board.

Board leadership

The Board's vision for quality is aligned with the Trust's strategic vision, core values and business strategy. At each Board meeting Directors review measures which indicate how the organisation is performing in relation to quality, safety, clinical performance, finance and workforce. At each Board meeting held in 2012/13 the quality and safety indicators set out in Annex B were discussed and the Trust's performance scrutinised.

All Non-Executive Directors take an active and challenging role at the Board and Board Committees. During 2012/13 the Trust has reviewed its corporate governance structure, to ensure that the Board has appropriate oversight on key matters. This has led to the introduction of a number of reconfigured Committees, including the Quality & Safety Committee, which will oversee clinical governance, including quality and safety; and the Service Performance & Transformation Committee, which will monitor the Trust's strategic action plan, and consider the quality impact of various proposed initiatives. In addition, the Audit, Assurance & Risk Committee has oversight of reports from internal and external audit, and is charged with providing the Board with assurance on the Trust's system of internal control. The Board has been clear throughout the year that any examples of poor quality or performance must be tackled swiftly and purposefully.

Assurance and governance

The Trust has continued the process of standardising and strengthening the infrastructure, systems and procedures across the Trust following the merger between Hampshire Partnership NHS Foundation Trust and Hampshire Community Health Care on 1 April 2011. This has included external and internal reviews of risk management, assurance and governance as well as inspections of our clinical services.

The Trust completed a detailed quality of care review of former Oxfordshire Learning Disabilities Trust services with all inpatient sites visited prior to acquisition on 1 November 2012. Recommendations made by the review are being and will continue to be implemented in 2013/14. The former Oxfordshire Learning Disabilities Trust is now managed within Southern Health Learning Disabilities and TQtwentyone (social care) divisions with a process of standardising and strengthening the infrastructure, systems and processes under way.

Workforce development

We remain mindful of the impact that effective staff engagement and workforce development has upon the quality of patient experience and outcomes. For this reason, we continue to invest in both these elements.

One key component of our staff engagement programme is the competency-based appraisal process with a new scheme launched in April 2012 and significant emphasis placed on this becoming fully embedded as it not only underpins the business planning process and enables staff members to appreciate their contribution

to the organisation's overall strategic priorities but also provides the mechanism by which personal development plans are agreed. The annual staff survey is another key engagement tool with results showing 91% of our workforce have had an appraisal in the past 12 months, with 72% having clear, planned goals and objectives for their job.

Achievements and innovation on the part of our workforce, both individual staff members and teams, continue to be recognised and rewarded through the course of daily activities and then more formally at the annual Star Awards event.

Our development programmes ensure we support staff to deliver high quality care and develop strong leadership skills. The Trust ensures its staff are equipped with the core skills and knowledge they need to deliver high quality care through a comprehensive staff training programme which incorporates essential (statutory and mandatory) training, clinical competency based courses and developmental opportunities. We have a strong development in our bands 1-4 healthcare support workers and administrative staff with diplomas, apprenticeships, foundation degrees and internal course all available. We will be continuing this training and development and reviewing this in the light of the Francis report and its implications on these core workers within our Trust.

Compliance with essential training is monitored regularly and a monthly report submitted to the Board for assurance purposes. Any emergent areas on non-compliance are addressed swiftly and the necessary remedial action taken to ensure the training programmes remain both accessible and relevant to our workforce.

We consider developing our staff, leaders and managers to be a high priority and continue to invest in leadership development with 600 staff completing the 'Going Viral' leadership programme by December 2013 and a talent management programme launched in 2012; this will ensure that individuals are supported to maximise their potential and there is an effective system in place to support succession planning within the organisation.

Organisational learning

Southern Health recognises the importance of organisational learning in developing safe effective services and the sharing of good practice. In 2012 a new post 'Head of Quality and Organisational Learning' was created to lead on this. An outline Organisational Learning strategy has been developed and will be rolled out across the Trust in the coming year.

Southern Health has implemented a programme of work to ensure we learn from all information and feedback about our services, including complaints, incidents, clinical audits, CQC and mock CQC inspections and performance indicators. These have influenced the selection of some of our quality indicators for 2013/14.

Information has been triangulated to identify themes where action may be needed and shared with clinical services and managers. The sharing of learning and good practice across the Trust is encouraged, for example, the falls prevention team used key learning points from a review of all falls resulting in serious harm to develop scenario based training on the wards to improve falls prevention.

Measuring quality

The Board cannot rely on an annual account of quality as its sole mechanism for assuring itself about the quality of services provided within the Trust. Therefore at each Board meeting a broad set of quality indicators is reviewed and monitored via the Integrated Quality, Finance and Performance dashboards shown in Annex B. These indicators are made publicly available as part of the published Board papers and are on our website (www.southernhealth.nhs.uk).

Annexes to the Quality Account

Annex A: dashboard showing Trust wide results for local indicators

Annex A - Southern Health NHS Foundation Trust Quality Indicators for 2012-2013

Southern Health NHS Foundation Trust

The following report summarises quarter 1, quarter 2, quarter 3 and quarter 4 data that outlines SHFTs progress against the Quality Account (2012 - 2013).

Report period From Apr-12 to Mar-13 **Month of issue:** Apr-13

Data source: Modern Matron Walk Around tool, Safeguard, SHFT Patient Experience report

Version: 2
Version Date: 29/04/2013
Author: JS

All indicators to be achieved by April 2013

Indicator	Quarter 1				Quarter 2				Quarter 3				Quarter 4				End of Year
	April	May	June	Q1 summary	July	August	September	Q2 summary	October	November	December	Q3 summary	January	February	March	Q4 summary	
Improving Patient Safety																	
1. Incidents involving patient violence resulting in physical injury to reduce by 10% (excluding former Ridgeway Partnership) *Data source: Ulysses Safeguard*	79	68	39	186	49	61	56	166	31	53	52	136	48	45	46	139	-14.8%
2. 100% of medicines reconciliations completed within 72 hours of admission to an inpatient unit *Data Source: SHFT Pharmacists*	81%	77%	68%	76%	72%	75%	72%	73%	78%	68%	73%	73%	78%	75%	67%	73%	74%
3. 100% of patients where there was an appropriate use of an early warning system *Data Source: Clinical Audit*															69%		See individual audit scores
Participating divisions															Trust Wide		
Improving clinical outcomes																	
4. 100% of patients identified as being at risk of skin damage will have a care plan to reduce the risk of developing a pressure ulcer or other skin damage *Data Source: Clinical Audit*									ICS CH: 67% OPMH: 34%						ICS CCTs: 94%		See individual audit scores
5A. 95% of patients identified to be at the end of life (within 1 year) to have an End of Life Care Pathway* *Source: CIDS/RIO*	67%	72%	60%	68%	66%	60%	64%	57%	73%	61%	67%	63%	67%	60%	100%	61%	68%
5B. Proportion of patients dying in Hampshire on an End of Life Care Pathway ** *Source: CIDS/RIO*	57%	57%	50%	55%	54%	48%	43%	47%	38%	33%	31%	31%	31%	24%	0%	18%	39%
6. 85% of Matrons Walk Round results can demonstrate evidence of a structured handover tool in the service area *Data source: Modern Matron Walk Round Tool*	100%	100%	100%	100%	100%	100%	100%	100%	95%	97%	95%	96%	57%	100%	100%	94%	95%
Participating divisions	ICS CH	ICS CH	ICS CH	ICS CH	ICS CH	ICS CH	ICS CH & MHLD	ICS CH & MHLD	ICS CH & MHLD	ICS CH & MHLD	ICS CH & MHLD	ICS CH & MHLD	ICS CH, CCTs & MHLD	ICS CH, CCTs & MHLD	ICS CH, CCTs & MHLD	ICS CH, CCTs & MHLD	ICS CH, CCTs & MHLD
Improving Patient Experience																	
7. 100% of in-patients with a physical healthcare assessment (MHLD only) *Data source: Modern Matron Walk Round Tool*	Tool under development						81%	81%	99%	79%	89%	89%	No data collected	97%	98%	97%	91%
8A. Use of a patient reported outcome measure in all services across the Trust *Data Source: Divisional Reports*	Provided as a narrative by divisional report in the Quality and Safety Committee - January 2013												90%				90%
8B - Use of patient experience surveys to ask 'How would you rate your experience of our service as a whole? *Data source: Patient Experience Report*	Survey launched in May	97.2%	93.4%	95.1%	96.5%	97.0%	93.7%	95.9%	96.5%	93.7%	94.9%	94.9%	94.4%	94.4%	96.4%	95.3%	95.3%
9A. 100% of service users have a care plan that has been developed with them and/or their main carer Data Source: Divisional Reports									72%	84%						62%	See individual audit scores
Participating divisions									ICS CH	AMH, OPMH & SS						ICS CCTs	
9B. Use of patient experience surveys to ask 'were you involved in decisions about your care? *Data source: Patient Experience Report*	Survey launched in May	95.5%	89.6%	92.2%	94.2%	94.7%	93.2%	94.1%	92.9%	92.0%	91.3%	92.0%	93.2%	91.8%	94.0%	93.1%	92.9%

Rag ratings:

< 60%	60 - 84%	85 - 100%

Clinical Audit in March 2013, not RAG rated.

Clinical Audits in October 2012 and March 2013, not RAG rated.

< 50%	50 - 79%	80 - 100%

< 75%	75 - 84%	85 - 100%

< 75%	75 - 84%	85 - 100%

< 95%	> = 95%

As these scores are dependant on the Standard Deviation of other scores in the Patient Experience Survey, it is not possible to RAG rate these scores without the wider context.

* - This is the number of patients known to the Trust that are on an End of Life Care Pathway (Either GSF or LCP). Other pathways are used but are their use is not currently captured on a system so are not reported.
** - This looks at the wider perspective of End of Life care, and shows the proportion of patients dying in Hampshire with a long term condition that are on an EOL pathway with SHFT.

Report produced by SHFT Information Team

Annex B – Progress against strategic objectives - March

Trust Strategic Key Performance Indicators Version 1.0

To ensure we meet our quality & safety, operational performance and financial obligations

		Target	11/12 outturn	Mar-13	Trend Dec	Trend Jan	Trend Feb	YTD 12/13
Safety / Quality	C Difficile year to date infections (quoted against in year target)	<8	7/10	5/10	3/7	4/8	5/9	5/10
	SIRI Suicides (quoted against monthly rolling 2 year average)	up/down	3.58	-11.5%	-5.6%	-3.4%	-5.6%	-11.5%
	Injurious falls (quoted against monthly rolling 2 year average)	up/down	2.5	3.2%	5.2%	5.2%	5.2%	3.2%
	Grade 3 and 4 Pressure Ulcers (quoted against monthly rolling 2 year average)	up/down	17.58	8.3%	8.8%	8.3%	9.0%	8.3%
Financial	Financial risk rating	>= 3	3	3	3	3	3	3
	Income v Expenditure margin (Financial YTD)	>= 1.3%	1.5%	1.5%	1.5%	1.9%	1.9%	1.5%
	Recurrent CIP achievement (Financial YTD)	>= 90%	68.5%	76.0%	72.0%	72.0%	74.0%	76.0%
Regulator	% Monitor indicators compliant (Financial YTD)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Patient experience	% Patients rating service as good or excellent	>= 95%		96.4%	94.9%	94.4%	94.8%	95.2%

Transforming our services

		Target	11/12 outturn	Mar-13	Trend Dec	Trend Jan	Trend Feb	YTD 12/13
ICS Adults	% Appropriate ICS Community Care delivered in clinic setting	>= 75%	new	Unable to currently report due to validity of available data				
ICS Adults	% of CCTs conducting Multi Disciplinary caseload review meetings (i.e. Primary Care, Social Care etc)	>= 90%	new	Unable to currently report due to validity of available data				
ICS Child	Call to action Health Visiting recruitment (quoted as % against plan)	100.0%	98.8%	100.1%	105.1%	106.1%	103.1%	100.1%
AMH	AMH bed utilisation	>=85%	new	94.0%	91.6%	92.4%	95.6%	93.2%
	AMH Service re-design (quoted as % beds against plan)	>= 90%	new	100.0%	100.0%	100.0%	100.0%	100.0%
OPMH	OPMH bed utilisation	50-80%	63.3%	74.7%	66.9%	72.7%	64.1%	67.6%
	OPMH Service re-design (quoted as % beds against plan)	>= 90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TQ21	YTD TQTwentyOne growth of service (quarterly)	>= 9%	new	8.6%	7.9%	8.6%	8.6%	8.6%
LD	Learning Disabilities progress to transaction plan	G	G	G	G	G	G	G

Developing our people and their leadership capability and capacity

		Target	11/12 outturn	Mar-13	Trend Dec	Trend Jan	Trend Feb	YTD 12/13
Workforce	Vacant posts (excluding TQ21)	<= 5%	7.5%	6.4%	7.6%	6.9%	7.0%	6.4%
	% Turnover with less than 12 months service (rolling year)	<=2.5%	1.7%	2.0%	1.9%	1.9%	2.0%	2.0%
	% agency and bank (rolling year excluding TQ21)	<= 3.5%	7.3%	7.7%	7.9%	7.9%	7.9%	7.7%
	% sickness absence	<= 3.5%	4.3%	4.3%	5.3%	5.4%	4.9%	4.6%
	% being managed through formal HR process	up/down	1.9%	2.6%	3.1%	2.9%	2.7%	2.7%
	% appraisal within 12 months	>=95%		85.7%	86.9%	86.3%	86.2%	85.7%
Rostering	Safety (Utilising 2 individual indicators, assigning a score of 0 - Red, 2 - Amber, 3 - Green to each one)	>=4	0.5	0	0	2	0	0
	Effectiveness (Utilising 4 individual indicators, assigning a score of 0 - Red, 2 - Amber, 3 - Green)	>10	9.75	10	10	10	10	10
LEAD	% Band 7 & 8 leaders & Medical Workforce in leadership development (quoted as % against plan)	>= 90%	new	93.3%	95.0%	94.8%	92.8%	93.3%
	% Staff with specified statutory training up to date	>= 90%		46.3%	49.2%	50.4%	50.6%	46.3%

Developing our organisation

		Target	11/12 outturn	Mar-13	Trend Dec	Trend Jan	Trend Feb	YTD 12/13
Research	% Patients recruited for research studies (quoted as % against plan, quarterly and in arrears)	>= 90%	109.0%	134.8%	110.1%	110.1%	110.1%	134.8%
Engagem't	% Positive media coverage	>=55%	new	60.0%	66.0%	69.0%	89.0%	60.0%
Business	Successful strategically aligned bids in the last 12 months	>= 60%	new	92.0%	92.0%	92.0%	92.0%	92.0%
Estates	Estate rationalisation (Income per m^2) quoted against 4% year end reduction	>=4%	new	4.7%	3.3%	3.3%	3.3%	4.7%
	Overall % of critical aspects of the estate that is at the required standard (6 facet survey)	>= 90%	new	83.0%	83.0%	83.0%	83.0%	83.0%
Health Technology	% of sites enabled to support flexible working (wirelessly enabled, quoted as % against plan)	>= 90%	100.0%	168.0%	146.0%	149.0%	152.0%	168.0%
	% of appropriate staff able to work remotely (quoted as % against plan)	>= 90%	100.0%	98.5%	71.0%	83.2%	92.1%	98.5%
Data Quality	Mental Health Minimum Data Set : Identifiers	>= 99%	99.5%	99.7%	99.6%	99.6%	99.7%	99.7%
	Mental Health Minimum Data Set : Outcomes compliance	>= 50%	82.8%	83.1%	81.4%	83.0%	79.6%	84.5%
	Community Data Set compliance	>= 50%	89.3%	94.3%	93.8%	92.8%	93.3%	92.9%

Achieving stretch | Achieving target | Failing target

Monitor Dashboard

March 2013 — Version 1.0

Performance Corporate Indicators : Monitor Quality Outcomes

	Target	YTD Act	YTD Vol	3 month actual	Trend	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
% of patients experiencing a delayed transfer of care within a Mental Health Inpatient facility	5.0% 7.5%	3.0%	5,139	2.8%	▼	●	●	●	●	●	●	●	●	●	●	●	●
% of patients receiving a 7 day follow up	97% 95%	97.5%	1,651	96.5%	▲	●	●	●	●	●	●	●	●	●	●	●	●
% of patients receiving a 12 month review	97% 95%	97.3%	32,214	96.7%	▼	●	●	●	●	●	●	●	●	●	●	●	●
% gatekeeping compliance for inpatient admissions	97% 95%	97.5%	1,085	97.5%	▼	●	●	●	●	●	●	●	●	●	●	●	●
EIP new referrals	100% n/a	130.9%	201	148.4%	▼	●	●	●	●	●	●	●	●	●	●	●	●
Mental Health Minimum Data Set - Identifiers	99.5% 97.0%	99.7%	1,585,125	99.6%	▲	●	●	●	●	●	●	●	●	●	●	●	●
Mental Health MInimum Data Set - Outcomes	60% 50%	84.5%	126,559	81.8%	▲	●	●	●	●	●	●	●	●	●	●	●	●
Community Data Set compliance	60% 50%	92.9%	6,324,313	93.5%	▲	new	●	●	●	●	●	●	●	●	●	●	●
Infection Control (Community C Difficile)	10 n/a	5	n/a	2	◀	●	●	●	●	●	●	●	●	●	●	●	●
Access to Care : Learning Disabilities	n/a n/a	G	n/a	G	n/a	●	●	●	●	●	●	●	●	●	●	●	●
Access to Care : Admitted 18 week wait	94% 92%	96.4%	5,918	97.1%	▲	●	●	●	●	●	●	●	●	●	●	●	●
Access to Care : Non admitted 18 week wait	97% 95%	99.8%	24,582	99.7%	▼	●	●	●	●	●	●	●	●	●	●	●	●
Access to Care : Incomplete pathways within 18 weeks	94% 92%	99.7%	49,437	99.7%	▼	new	●	●	●	●	●	●	●	●	●	●	●
A&E attendances completed within 4 hours	97% 95%	99.6%	22,489	99.5%	▼	●	●	●	●	●	●	●	●	●	●	●	●

Achieving target | Achieving Monitor compliance | Failing Monitor compliance

Annex C: The Oxfordshire Learning Disability Trust (Ridgeway Partnership) Priorities for Improvement 2012/13

The Priorities for Improvement 2012-13 for Ridgeway Partnership were identified through consultation and involvement with service users, carers, staff and other key stakeholders as well as responding to national priorities for learning disability services. Planning for the merger with Southern Health NHS Foundation Trust provided opportunity to meet with different groups of stakeholders to discuss what improvements people considered were a priority for the next year and these were translated into the Priorities for Improvement 2012-13 which were signed off by the Ridgeway Partnership Trust Board in May 2012. The Quality Accounts were published by 30th June 2012 and the monitoring of the Priorities for Improvement was reported to Trust Board in July and October 2012 as part of the quarterly quality report. Ongoing reporting has occurred in January and April 2013 as part of the overall trustwide Quality Report for Southern Health and service lines have been implementing the priorities as part of their development plans.

The Priorities were felt to be achievable at the start of the year and overall there has been good progress made. Some areas have been impacted by the work required for the merger and the new Learning Disability Divisional Management Group is working with teams to support the continued implementation of development plans and the priorities.

1. Safety

Priority	Rationale	Monitoring	Outcome	Progress
1. To continue to deliver high quality services that safeguard essential standards for service users	To ensure that services are built on the development of therapeutic relationships between staff and service users.	**1A. Dignity in Care:** Q1: Dignity Champion to be established in each area of the service within Bucks– A&T; AOT/ Intensive Support/ LDT's (North & South). Q2: To undertake The Dignity Challenge (SCIE Dignity in Care Practice Guide) in each area of service. Q3: Appropriate Dignity in Care training to be identified and rolled out across all areas of service. 80% of all staff to be trained. Q4: Undertake an annual survey of patients/ service users asking about dignity, quality of care/treatment.	The ethos and objectives of the national Dignity in Care campaign are embedded across all areas of the service	All actions were implemented within the specified timescales. Report to be completed April – June 2013

	To ensure that practice is based on the best available evidence. To ensure that staff are provided with the appropriate knowledge to support service users with this complex health need.	**1B. Dysphagia Awareness** • Speech and Language Therapists (SALT) to review Trust Dysphagia guidelines in line with NPSA recommendations and present these to the Research and Development Committee for approval. • SALT to lead the development of Information sheets and guidelines re: planning menus and foods to avoid when managing risks around dysphagia and choking. • To increase the number of staff attending training in Dysphagia, led by SALTs. To be monitored through an audit of training figures. • Guidelines on supporting people with Dysphagia within ELPs to be reviewed by Professionals at a maximum of 3 yearly intervals. Monitoring to be built into the clinical audit plan 2012-13.	Good practice guidelines re: supporting service users with Dysphagia are approved in line with national best practice and embedded across the Trust.	• Guidelines re: risks of Dysphagia have been written and are in place for Social Care. • Posters re: raising awareness of early warning signs for dysphagia are in place across Social Care. • Following assessment, and confirmed diagnosis / level of dysphagia, guidelines and menus are provided. • A priority Training list has been identified. Social Care training weeks now include a refresher course. Training figures demonstrate that attendance has increased. • Reviews are now to be triggered by Care Service Leaders when a 3 year review is required and a referral to SALT is made. • Auditing of reviews to be included in Audit of Person Centred Plans
	To promote the importance of policies, procedures and training in relation to Safeguarding across the Trust, following the Internal Review of Quality and Safety in	**1C: Safeguarding** • Managers to incorporate discussions around safeguarding scenarios into regular supervisions sessions • Audit of safeguarding training to be extended to senior managers. • Re-audit of safeguarding training to be undertaken in 6 months. Comparison of data will identify if areas in need of development have improved.	Staff will demonstrate increased awareness and understanding of safeguarding policies and procedures.	• Safeguarding Scenarios have been incorporated into regular supervision sessions within Social Care. • The Re-Audit of Safeguarding was reviewed in light of the Merger with Southern Health. It was felt that the value of the audit would be limited due to the change in Policy from the Ridgeway Partnership to Southern Health. These changes would need to be embedded in practice before an

	response to the Winterbourne View revelations.			audit was undertaken. Assurance has been provided by Health and Social Care Service Managers that the recommendations made in the Safeguarding Audit Report have been implemented. Safeguarding is part of the Southern Health Audit Plan and will be undertaken in the future via SNAP, managed by the Audit Team.

2. Effectiveness

Priority	Rationale	Monitoring	Outcomes	Reporting
2.To improve the effectiveness of assessment and care planning processes across services	To maintain the continuity of effective assessment, care planning and review processes in the transition from paper to electronic records. The need to streamline processes and reduce duplication of paperwork in order to ensure that all service users receive care based	**2A. Core Standards for Assessments and Care Planning** • To define core standards re: the documentation of assessments, risk assessments and care planning for service users receiving health services. • To re-audit Assessments, Risk Assessments, Care Plans and CPA across in-patient services. To compare data with audit undertaken in 2011-12 in order to measure progress against agreed action plan and identify where further action is required. • To audit Assessments, Risk Assessments, Care Plans and CPA across LDTs.	• For service areas to clearly define core standards re: assessment and care planning processes that will inform the development of the Service User Care Pathway. • Greater consistency in service user's journey through services. • All service users to have all relevant assessments, risk assessments, care	• Standard Operating Procedures for documenting assessments, risk assessments and care plans on RiO have been reviewed and updated for In-Patient Services. • The Re-audit for In-Patient Services has been completed. Data has been analysed comparing results with the audit undertaken in 2011-12. Final reports have been written and will be discussed with Team Members to develop action plans. The Final Reports and agreed action plans will be taken to the Specialist Health Services Managers Committee and the LD Service Board for approval,

	on identified needs and that all service users are offered the same pathway through services.	• To audit Person Centred Risk Assessments and Person Centred Plans against national benchmarks across Social Care.	plans and CPA management processes documented on RIO (Health Services only). • For Person Centred Risk Assessments and Plans to be in line with National Benchmarks.	ensuring actions link with Trust wide developments re: RiO and CPA processes. • The Audit across LDTs has been put on hold following the merger with Southern Health. The audit tool is to be revised for use of SNAP and integrated with existing Southern Health Audits.
	Within the Forensic Service, there is a need to ensure that service users are accessing the right facilities with the right level of security to support reduced length of stay (QUIPP Target)	**2B. Reduced Length of Stay** To audit the number and outcome of gatekeeping assessments completed the length of stay for all individuals and delayed discharges waiting list.	Data will demonstrate that overall length of stay has been reduced.	• Feedback to Quality Priorities Forum, Divisional Heads meetings, TME and Trust Board. • Commissioners are assured that the processes that are in place are working effectively to ensure that periods of admission are appropriate to the needs of the patient. At this stage it is not possible to determine if the Gateway Assessments are having a direct impact on length of admission.

3. Service User Experience

Priority	Rationale	Monitoring	Outcomes	Reporting
3.To increase recorded	To ensure that the broad range of	**3A. Documented evidence from Service Users** • Establish a baseline of existing documented	• An increase in the	• The Annual Service User

evidence of service user's experience and involvement in their own care	approaches used on a daily basis to involve service users in their care are captured in a meaningful way and documented within their care records.	evidence of service user experience by end of May 2012. To review evidence base in 6 months to measure if this has increased. • Audit the Implementation of a Decision Making Matrix for service users across Social Care in October 2012. • Service user survey for Oxfordshire LDT's reviewed in terms of content and purpose. Data to be analysed once revised form introduced. Findings will be used to influence practice. • Essence Climate audit to be completed in Forensic Services to monitor service user's feelings of safety within the environment. • To explore new opportunities for service user engagement in service development.	documented evidence of service user involvement in their own care. • Development of clear processes for the recording of service user experiences, how these are collated and applying learning from feedback. • Questionnaire implemented by LDTs that is meaningful for service users, carers and providers and influences changes to practice.	Experience Report was taken to Trust Board in June 2012 providing an overview of existing documented evidence. The evidence base was not formally reviewed and reported following the merger with Southern Health. Re- Audit of Assessments, Risk Assessments and Care Plans has been completed. Audit of Decisions Making Matrix and Service user survey for Oxfordshire LDTs being completed on a regular basis. •The opportunities for further developing service user engagement across the new LD Division form part of the Development Plan.

Annex D Feedback received form our Commissioners and Governors

Feedback from Southampton Healthwatch

"Southampton Healthwatch public engagement Steering Group is pleased to be given the opportunity to comment on the Quality Accounts of the Trust. The trust provides mental health services in Southampton and has a major inpatient treatment unit at Antelope house with many other services provided just outside the City boundary but accessed by its residents as required.

Whilst supporting the local indicators for 2012/13, we were pleased to see the two additional measures included for patient satisfaction.

The report is comprehensive and as far as we can judge covers all necessary aspects with no obvious omissions. Overall, fair and good progress has been made on the previous year's figures in most areas with the average risk rating meeting its target; we are particularly pleased that progress has been made in the Productive Ward programme and reducing the number of patient-violent incidents. The 25% drop in the number of suicides and the 50% drop in attempted suicides were especially pleasing results. However, there is still room for improvement and we hope will be pursued in the coming year. We are pleased that the trust has acknowledged the challenge of medicine reconciliation within 72 hours of admission to inpatient care and hope that it will achieve the target for 2013/14.

It is disappointing that the clinical audit of Old People's Mental Health showed that only 34% of those at risk of pressure ulcers had a pressure ulcer prevention plan. We hope the Trust strives to achieve its target in 2013/14.

A response rate of 38% to the 2012 NHS Community Mental Health Services User Survey, and one of highest rates in the country, is very good and it is pleasing that the majority of responders rated the care they had received favourably.

We are pleased that the Trust maintains a dedicated Complaints and Patient Advice and Liaison (PALS) team and seeks to learn from concerns and complaints. It is however disappointing that 36 % of complaints were about clinical and nursing care.

Unfortunately Southampton LINk was not asked to participate in the PEAT inspections so find it difficult to comment on the reported scores. We fully support the 'mini CQC inspection' process and had hoped to be included by providing at least one independent person on some of the visits. Regrettably, although we attended the original session, this was not followed up we understand due to staff changes. We hope Southampton Healthwatch will be involved in PLACE inspection of Antelope House and other sites involving Southampton residents.

We support the Quality Improvement targets for 2013/14 and wish the Trust well in their efforts to achieve them."

Hampshire Healthwatch

Responded they were unable to comment on the 2012/13 Quality Account as they were only newly formed.

Hampshire Overview and Scrutiny Panel

Responded that they did not contribute to the Quality Account of any of the NHS bodies it works with.

Annex E: Statement of directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - *Board minutes and papers for the period April 2012 to June 2013*
    - *Papers relating to Quality reported to the Board over the period April 2012 to June 2013*
    - *Feedback from the commissioners dated xxxxxxxxxx*
    - *Feedback from governors dated xxxxxxx*
    - *Feedback from local Healthwatch organisations dated xxxxxxxx*
    - *The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xxxxxxxx*
    - *The (latest) national patient survey xxxxxxx*
    - *The (latest) national staff survey xxxxxxxx*
    - *The Head of Internal Audit's annual opinion over the trust's control environment dated xxxxxx*
    - *CQC quality and risk profiles dated xxxxxxxx*

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to proper scrutiny and review; and the Quality Report has been prepared in accordance with Monitors annual reporting guidance (which incorporates the Quality Account regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board

NB: sign and date in any colour except black

……Date ……Chairman

……Date ……Chief Executive

Annex F

Glossary

AMH - Adult Mental Health – a directorate within the Trust that delivers services to working age adults.

CAS - Department of Health's Central Alerting System.

CCGs - Clinical Commissioning Groups - groups of GPs that will, from April 2013, be responsible for designing local health services In England.

Commissioners - organisations that fund local health and social care.

CQC - Care Quality Commission – the regulator for health and adult social care services in England.

CQUIN - Commissioning for Quality and Innovation - a mechanism for encouraging quality improvement via incentives.

DeNDRoN - Dementias & Neurodegenerative Diseases Research Network.

DoH - Department of Health.

HCHC - Hampshire Community Health Care - now the Integrated Community Services (ICS) part of the Southern Health NHS Foundation Trust.

HPFT - Hampshire Partnership NHS Foundation Trust - now the Mental Health, Learning Disability and Social Care part of the Southern Health NHS Foundation Trust.

HoNOS - Health of the Nation Outcome Scale – a tool to measure if the treatments and therapies we provide make a positive difference to service users lives.

HoNOSCA - The Health of the Nation Outcome Scales for Children and Adolescents.

Hospital at home - is a team which works closely with the acute inpatient service, which together will form the acute care pathway.

HOSC - Health Overview & Scrutiny Committee – a committee of elected members of the local authority who have responsibility for scrutinizing and approving proposals for change in health service provision.

ICS - Integrated Community Services - the part of Southern Health NHS Foundation Trust which was formerly Hampshire Community Health Care.

IMROC - Implementing Recovery Through Organisational Change.

LD - Learning Disabilities.

LINks - Local Involvement Networks – an independent organisation with responsibility to represent service users, carers and the local population.

MARC - Memory Assessment & Research Centre.

MEWS - Modified Early Warning Scores.

MH - Mental Health services - a part of Southern Health NHS Foundation Trust.

Monitor - Monitor is the independent regulator of foundation trusts.
It authorises and regulates NHS foundation trusts and supports their development, ensuring they are well- governed and financially robust.

Never Events - the term for serious patient safety incidents considered largely preventable if good practice and preventative measures available in the NHS had been implemented.

NICE - National Institute of Health and Clinical Excellence – an independent organisation that provides national guidance on the promotion of good health and the prevention and treatment of ill health.

National Institute for Health Research - an independent organisation with responsibility for research in the NHS.

NHS - National Health Service.

NHS Protect - the NHS organisation that leads on a wide range of work to protect NHS staff and resources from crime.

OLDT - Oxfordshire Learning Disability

NHS Trust.

OPMH - Older People's Mental Health services, a part of the Southern Health NHS Foundation Trust that delivers services to people aged 65+.

PALS - Patient Advice & Liaison.

PCT - Primary Care Trust - a type of NHS trust which may commission primary, community and secondary care from providers.

RIDDOR - Reporting of Incidences, Diseases and Dangerous Occurrences Regulations -RIDDOR places duties on the Trust as an employer (the Responsible Person) to report serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses).

RiO - Southern Health's electronic patient records system.

SBAR - Situation, Background Assessment Recommendation.

Service redesign or transformation – changing how we provide our health and social care services.

SHA - Strategic Health Authority – the main purpose of a SHA is to ensure both that there is a continuing improvement in the health of the local population and that local healthcare services are directed to meet its needs.

SHIP - Southampton City, Hampshire, Isle of Wight and Portsmouth City PCT cluster.

SIRI - Serious Incident Requiring Investigation – such as unexpected death, medication, errors, grade 4 pressure ulcers.

Southern Health - Southern Health NHS Foundation Trust.

The Trust - Southern Health NHS Foundation Trust.

TQtwentyone – the name of the Trust's social care service that provides services for people with learning disabilities and people with mental health needs.

Annex G – Feedback and involvement form

Quality Account Feedback Form 2012/13

Use this form to tell us what you think about this report and what you would like us to include in our report next year.

1. Who are you?

Member of staff ☐ Patient or family member/carer ☐ Governor/ Member of the Trust ☐

Other please specify: _____

2. What did you like about this report?

3. What could we improve?

4. What would you like us to include in next year's report?

5. Are there any other comments you would like to make?

6. Are you interested in becoming a member of Southern Health NHS Foundation Trust? If so please provide your name and address:

Thank you for taking the time to read this report and give us your comments.

Please post this form to:

Associate Director of Governance,
Southern Health NHS Foundation Trust,
Maples, Tatchbury Mount,
Calmore, Southampton,
Hampshire SO40 2RZ

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOLENT NHS TRUST: DRAFT QUALITY ACCOUNT 2012/13		
DATE OF DECISION:		23 MAY 2013		
REPORT OF:		INTERIM CHIEF EXECUTIVE		
CONTACT DETAILS				
AUTHOR:	**Name:**	Dorota Goble	Tel:	023 8083 3317
	E-mail:	dorota.goble@southampton.gov.uk		
Director	**Name:**	Dawn Baxendale	Tel:	023 8083 2966
	E-mail:	dawn.baxendale@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

This paper provides an update on activities at Solent NH Trust and the draft Quality Account for Solent NHS Trust 2012/13.

RECOMMENDATIONS:

(i) That the Panel notes the content of the report and provides feedback and comments on its content to the Solent NHS Trust.

REASONS FOR REPORT RECOMMENDATIONS

1. To understand the activity, issues and priorities of the Solent NHS Trust.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. The Chief Executive of the Solent NHS Trust has written to the Panel with an update on activities at the Trust. The letter is attached at Appendix 1.

4. This report also provides the latest version of the Trust's Quality Account. The purpose of the Quality Account is to share information about the quality of services and plans to improve even further with patients, their families and carers. The Draft Solent NHS Trust Quality Account for 2013/14 is attached at Appendix 2.

5. In producing the Quality Account the Trust has engaged with staff, patients, Trust members, commissioners, carers groups and Local Involvement

Networks (Healthwatch) to ensure that it gives an insight into the organisation and reflects the priorities that are important to us all.

6. The Solent NHS Trust's three key areas for quality improvement are:

Patient Safety This means ensuring that the environment is clean and safe at all times and that harmful events are avoided.

Patient Experience This is the term used to describe those aspects of healthcare that do not relate directly to the treatment of an illness or injury, but can make all the difference to whether patients feel that they have been looked after properly.

Effectiveness of Care This is ensuring that the most appropriate treatments, interventions, support and services will be provided at the right time to those patients who will benefit.

7. The Panel are invited to note and discuss the content of this report, in order to provide any comments or feedback to the Trust on its Quality Account.

RESOURCE IMPLICATIONS

Capital/Revenue

8. None

Property/Other

9. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

10. None

Other Legal Implications:

11. None

POLICY FRAMEWORK IMPLICATIONS

12. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	N/A

SUPPORTING DOCUMENTATION

Appendices

1.	Update from Solent NHS Trust: Letter from the Chief Executive
2.	Solent NHS Trust: Quality Account 2012/13

Documents In Members' Rooms

1.	
2.	

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

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Solent NHS Trust

Councillor Andrew Pope (Chair)
Chair, Health Overview & Scrutiny Panel
c/o Members' Services
Southampton City Council
Civic Centre
Southampton
SO14 7LY

Chief Executive
Solent NHS Trust Headquarters
Adelaide Health Centre
William MacLeod Way
Southampton
SO16 4XE

Tel: 023 8060 8815
Fax: 023 8053 8740
www.solent.nhs.uk

10th May 2013

Dear Councillor Pope,

Re: Update letter from Solent NHS Trust

Please find to follow an update on activities at Solent NHS Trust ahead of the HOSP meeting on 23 May.

Foundation Trust status
Solent NHS Trust started the new financial year in a strong position reporting compliance with quality requirements, contracts and finances. We are also pleased to be nearing the final stages of our journey to be licensed as a Foundation Trust (FT).

We are hoping the Trust Development Authority will give final assurances on our preparations to become a Foundation Trust at the end of May and we will then be referred to Monitor for its assessment. The Monitor assessment can take 3-5 months and will check our readiness to be a Foundation Trust. At the end of that process there will be a final Board to Board session between Solent NHS Trust and Monitor after which they will decide if we are ready to be licensed. We hope to be licensed as a Foundation Trust in the autumn of this year.

Mental Health Awareness Week: 13-17 May
Solent NHS Trust will be holding a range of events and activities for the communities it serves and its' staff to mark Mental Health Awareness Week from 13th – 17th May.

This year, the focus is on physical activity and how it can positively impact on good mental health and wellbeing, and will include wellness checks, ways to identify strengths in yourself and others and an opportunity to join Solent NHS Trust's Choir. To see a full list of the events we are holding, please visit our website www.solent.nhs.uk and click on the Mental Health Awareness Week banner.

Fall in teenage pregnancy rates
One of the key targets for Solent NHS Trust's Sexual Health Services is to reduce the teenage conception rate, and we are delighted that in 2012/13 the rates fell in Southampton by 6%, and were complemented by a 4% fall in Hampshire and 15% in Portsmouth.

The Solent NHS Trust teams have worked hard to make the marketing and accessibility of the contraceptive services relevant to young people. This includes a revamped website, prioritisation of young people in busy clinics, and an increase in use of long acting reversible contraception (LARC). Clearly many other agencies also have a role to play in reducing

teenage pregnancy, but we are proud to have played our role in improving the position on this important public health goal. The focus will continue into 2013/14.

Commissioning for Quality and Innovation
The Trust has achieved 98% of the targets set under the Commissioning for Quality and Innovation framework (CQUIN) during 2012/13. These are additional initiatives often just for a year at a time, based around areas where commissioners would like to see some specific progress. In 2012/13 areas included better follow-up for dementia patients, reduced attendances at Emergency Departments and increased use of teleconferencing and Apps. One area where as a Trust we did particularly well was in the Portsmouth CAMHS service. The CQUIN was to provide training to foster carers and residential home staff to improve skills and confidence in looking after children with mental health issues. The target was to train 90 people and the team trained over 200 people as the training sessions were enthusiastically oversubscribed. The aim of the training was to enhance the carer's skills which would improve the children's health and wellbeing and reduce the need for interventions from primary care or other agencies.

Special and Occasional Care Dental Services
The tender specification for Special and Occasional Care Dental Services issued to Solent NHS Trust by SHIP included a preference for a reduced number of clinics.

In accordance with this specification, we have closed 3 clinics across the Southampton area. We selected sites on the basis of local demographics and the specific area knowledge of incumbent providers. The priority was to minimise disruption and prioritise access for service users, while maintaining the highest level of quality care. We informed all active service users in advance, through direct correspondence and clear signage at affected clinics. A schedule of both retained and closed clinics is shown below:-

Special and Occasional Care Dental Services in Southampton from 1st April 2013:

Full Name and address of each site
Hythe Dental Clinic, The Medical Centre, Beaulieu Road, Hythe, SO45 4ZD
Romsey Dental Clinic, Rumsey Hospital, Winchester Road, Rumsey, SO51 8ZA
Bitterne Dental Clinic, Bitterne Health Centre, Commercial Street, Bitterne, Southampton, SO18 6BT
Millbrook Dental Clinic, Pickles Coppice Healthy Living Centre, 65 Windermere Avenue, Millbrook, Southampton, SO16 9QX
Dental Dept, Fanshawe Wing, Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
Community Dental Clinic, Eastleigh Health Centre, Newtown Road, Eastleigh, SO50 9AG

All registered 'active' patients (i.e. those who have had an appointment in the last two years) were contacted by letter and informed of the changes. Posters were clearly displayed at each affected clinic.

Single Point of Access - making our services easier to contact
The Trust is pleased to update you on our vision to create a Single Point of Access (SPA) for

our services. Over time the SPA will become the primary way that most healthcare professionals, patients, and members of the public contact us.

Through SPA, telephone calls, emails, and other communications will be managed effectively to improve access to our services. This means patients will be routed to the most appropriate care, giving clinicians a timely response while maximising our clinical time with patients. The SPA represents the way Solent NHS Trust intends to place local patient care at the centre of what we do.

The intention is that SPA will provide a 24/7 point of contact for most of our services.

Solent NHS Trust's Podiatry Services in Southampton are currently in the process of moving to SPA. To help ensure podiatry's transition to SPA runs smoothly, we taking a two-phased approach:

- From Tuesday 28 May 2013, all patients will book their appointments via SPA on 0300 300 2012.
- All referrers enquiring about patients or services can use the dedicated health professionals phone number 0300 300 2011.

Please note, all referrals will still be required to be addressed and/or faxed to the existing Podiatry address and secure fax number until further notice.

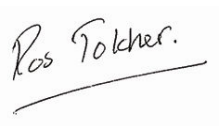
It is envisaged that by November 2013, all aspects of podiatry administrative procedures including referral management and appointment bookings will be run by SPA.

Membership
At the end of March 2013, the Trust met its target to recruit 6,000 members. We are now aiming to recruit a further 300 members across the region by the end of June.

Governorship
As part of becoming a Foundation Trust, Solent NHS Trust needs to establish a Council of Governors and is looking for people to stand for election at our forthcoming elections to be held in summer 2013. Governors help set the strategic direction of the Trust and work with the Board of Directors to ensure that the Trust behaves in a way that is consistent with its constitution and objectives. They should engage with their members to ensure their views are taken into account. Candidates do not have to have a public sector or NHS background.

If you have any questions regarding any of the issues mentioned in this correspondence, please contact Kirstie Henry on 023 8060 8889 or email kirstie.henry@solent.nhs.uk or contact me direct as above

Yours sincerely,



Dr Ros Tolcher
Chief Executive

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Solent NHS
NHS Trust

DRAFT

QUALITY ACCOUNT 2012/13

(With our priorities for Quality Improvement in 2013/14)

Our Quality Promise aims to ensure that:

- *our services are safe*
- *people have a good experience of our services*
- *we use best practice to ensure better outcomes for our patients*
- *we meet national standards*

Version 1	Marion Wood	Submitted to Patient Experience & Public Involvement Group for comment	25/2/13
Version 2	Marion Wood	Submitted to Patient Experience & Public Involvement Group for comment	26/3/13
Version 3	Marion Wood	Submitted to Assurance Committee for approval and comment	16/4/13
Version 4	Marion Wood		29/4/13

CONTENTS

Introduction

This is the third annual Quality Account which Solent NHS Trust has produced.

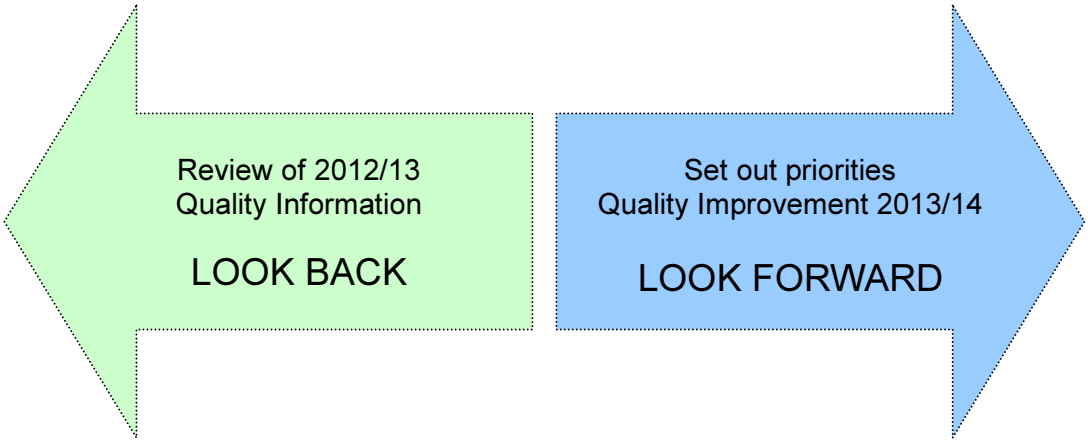
Why are we producing a Quality Account?

Following the publication of the *Next Stage Review in 2008 which developed a vision of how the NHS would continue to serve the needs of the public in the 21st century*), all NHS Trusts have been required to publish an annual Quality Account, in addition to their financial accounts.

The purpose of the Quality Account is to share information about the quality of services and plans to improve even further with patients their families and carers. The public and patients can also view quality across NHS organisations by viewing the Quality Accounts on the NHS Choices website: www.nhs.uk

The dual functions of a Quality Account are:

1. To reflect on the past year and
2. Highlight improvement for the future



What are the required elements of a Quality Account?

The National Health Service (Quality Accounts) Regulations 2010 specify the requirements for Quality Accounts. We have used these requirements as a template around which our Account has been built.

This Quality Account is presented in three parts:

Part 1	Part 2	Part 3
Message from our Chief Executive and Chairman, Statement of Assurance	Review of our quality performance in 2012/13	Outline of quality priorities for 2013/14

How did we produce our Quality Account?

In addition to ensuring that we have included all of the mandatory elements of the Quality Account, we have engaged with staff, patients, Trust members, commissioners, carers groups and our Local Involvement Networks (Healthwatch) to ensure that the Account gives an insight into the organisation and reflects the priorities that are important to us all.

The Quality Account Project Group liaised with each of the Trust's three divisions (Adults and Older People, Children and Families, Mental Health) to discuss what

quality initiatives they would be working on in the year ahead. The Project Group reviewed each potential improvement priority by assessing whether these were:

- areas that patients had told us were important through complaints or surveys.
- improvements that would have a significant impact on the quality and safety of the services provided.
- Improvements that were feasible with the resources available to the Division.

As a result, we have identified specific and measurable improvement initiatives in each of our priority areas.

In line with the Department of Health report "*High Quality Care for All*" (2008) our three key areas for quality improvement are:

Patient Safety — This means ensuring that the environment is clean and safe at all times and that harmful events are avoided.

Patient Experience — This is the term used to describe those aspects of healthcare that do not relate directly to the treatment of an illness or injury, but can make all the difference to whether patients feel that they have been looked after properly.

Effectiveness of Care — This is ensuring that the most appropriate treatments, interventions, support and services will be provided at the right time to those patients who will benefit.

We appreciate that some of the language used may be difficult to understand if you do not work in healthcare so we have included a glossary at the end of our Quality Account to explain some of the words that we use every day.

PART 1

1.1 Message from our Chief Executive and Chairman

Welcome to Solent NHS Trust's Quality Account, which confirms our continued commitment to improving the quality and safety of the care which we provide.

The Board of the Trust has pledged an unwavering focus on the quality of care and the safety and wellbeing of our service users remains our highest priority. This is what we would want for our own families and what we strive to provide for our patients and their families.

This report is written for a wide audience, but it is principally for people who rely upon our services and their families and carers. We hope that the information in this Quality Account is clear and meaningful and that it demonstrates how the Trust continually strives to provide the best care possible. We hope that it will also be of interest to partner organisations, staff and commissioners.

The Quality Account provides a summary of the progress we have made on the quality goals which were set last year, which focused on patient safety, the effectiveness of services and the experience of people using our services. In part 3 of the report our quality priorities for the coming year are also outlined.

As mentioned above, these priorities are based on feedback from staff and service users and discussions with key external stakeholders, such as Local Involvement Networks (Healthwatch) and commissioners. Progress is monitored by the Trust's Patient Experience and Public Involvement Group, the Assurance Committee, the Audit Committee and ultimately the Trust Board. The indicators used to demonstrate achievement and compliance are supported by validated information provided by the services and triangulated through regular performance reports. These are supplemented by regular surveys of front line staff and safety data obtained by frequent visits to services and formal 'Board to Floor' walkabouts.

As with all Trusts across the country, we are considering carefully the recommendations within the Francis Report into care failures at the Mid Staffordshire Hospital, which was published in February 2013. Whilst there is no suggestion that the types of failings found at Mid Staffordshire NHS Foundation Trust exist within Solent NHS Trust, we can all learn from the report to ensure patient care is better safeguarded in the future.

Our vision is to lead the way in local care; by placing the people who use our services at the heart of everything we do and by working in partnership to deliver better healthcare. We believe that by living the Trust's INSPIRE values, service users will experience safe and compassionate care and, despite the unprecedented financial challenges facing NHS providers, we will retain our unwavering focus on quality as we deliver these priorities over the year ahead. We believe that being open, honest and transparent is the best way to ensure the concerns of patients, their carers and staff are listened to and acted on.

Declaration
To the best of our knowledge and belief, the Trust has properly discharged its responsibilities for the quality and safety of care and the information presented in the Quality Account is accurate.

Dr Ros Tolcher	Alistair Stokes
Chief Executive	**Chairman**

1.2 STATEMENTS OF ASSURANCE

This section includes statements which are mandated by the Department of Health to be included in the Quality Account. The aim of this nationally requested content is to give information to the public that is common to Quality Accounts across all Trusts.

1.3 Review of Services

We are a specialist provider of community and mental health services with an annual revenue of £192m for 2012/3, with a workforce in excess of 3800 staff and delivering over 1.5 million service user contacts per annum.

A wide range of community and mental health services are provided to over a million people living in Southampton, Portsmouth and wider Hampshire. Services are provided from over 100 different locations, including community hospitals and day

hospitals, as well as numerous outpatient and other settings within the community such as health centres, children's centres and within service users' homes.

We operate primarily within the local market area of Portsmouth, Southampton and wider Hampshire.

The Trust is currently working towards becoming an NHS Foundation Trust. We believe that this will bring important benefits to the communities we serve and allow us to be more innovative and provide even better services to the public. Although we will still be part of the NHS and meet the same national standards for things like cleanliness and quality of care, as a Foundation Trust we will have more freedom to provide the services which meet the needs of local people. We encourage people from our local communities to become members and governors of the Trust to allow them to have a greater say in how things are run and to help us shape the future of the Trust.

Our quality priorities are continuously monitored through each of the Clinical Divisions within the Trust. Our services are grouped into three clinical divisions: Adults and Older Persons, Child and Family and Mental Health.

Solent NHS Trust provides the following services across Southampton, Portsmouth and Hampshire.

Luke producing list/diagram….

1.4 Participation in Clinical Audits

Clinical audit is used to aid improvements in the delivery and quality of patient care and should be viewed as a simple tool to facilitate continuous improvement. The key component of clinical audit is that performance is reviewed to ensure that what *should* be done is *being* done and, if not, it provides a framework to enable improvements to be made to the quality of patient care and treatment.

National Audits, National Service Improvement Projects and National Confidential Enquiries

During 2012/13, there were 3 national clinical audits and 1 national confidential enquiry which were relevant to services that Solent NHS Trust provides.

The Trust participated in 2 of the national clinical audits (67%) and the national confidential enquiry (100%) in which it was eligible to participate.

The relevant national clinical audits and a summary of our participation is given in the table below:

Title	Summary of participation
National Clinical Audit: Epilepsy 12	Undertaken jointly with Portsmouth Hospitals NHS Trust. 42 patient records submitted.
National Parkinson's Disease Audit	Undertaken jointly with University Hospital Southampton NHS Foundation Trust. Data currently being collated.
Prescribing Observatory Mental Health Clinical Audits	Did not participate; registered for participation 2013/14
National Confidential Enquiry in Suicide and Homicide in Mental Health	*Data is submitted via the Trust on an on going basis as incidents occur - 100% of eligible cases submitted.*

Solent NHS Trust is committed to 100% participation in relevant national audits in the forthcoming year. There are currently nine national audits which are relevant to Solent NHS Trust.

During 2012/13 Solent NHS Trust also participated in several other national service improvement projects:

- National Chlamydia Screening Programme
- Medicines in Prisons survey
- UNICEF Baby Friendly Initiative
- British HIV Association case note audit of patient outcomes and survey of provision of psychological care and adherence support
- British Association for Sexual Health and HIV
    - Partner notification audit
    - Asymptomatic screening audit

Local Clinical Audit

Solent NHS Trust completed 100% (26) of the clinical audits requested by our commissioners. We also carried out a further 57 clinical audit projects across the services. Each of these led to actions aimed at improving the quality of the services that we deliver.

MRSA Screening Results	MRSA screening improved from 84% in June to 95% in December
Re-audit of the uptake of HIV testing following introduction of Electronic Paper Records prompting	The introduction of Electronic Paper Records with a prompt for HIV testing has improved uptake of testing. The re-audit showed that100% of patients seen in April were offered testing and that the acceptance of testing increased from 78.1% to 86.6%
Audit of Lithium Therapy	This was audited twice this year. The first audit showed an increase in compliance of 20% on the previous year. The re-audit showed that the high standard of compliance had been maintained throughout the year. This improvement was achieved by promoting the use of information booklets and Solent NHS Trust guidelines on Safer Lithium Therapy
Re-audit of patient assessment within a podiatric rheumatology (PR) service	The documentation of patient assessment was audited following the implementation of a proforma and was found to be markedly improved, achieving good adherence to nationally recommended guidelines. Assessment of both cardiovascular risk and foot health status improved from 0 to 100% adherence. Assessment of lifestyle/social factors & neurovascular examination did not achieve 100%.
Adherence to NICE guidelines in the treatment of young people with OCD in CAMHS	This re-audit was carried out to check compliance after an audit in June 2010 showed compliance with 41 of the guidelines, partial adherence to 9 and non-adherence to 3 (4 guidelines were not applicable). The re-audit has shown that now compliant with all relevant parts of NICE CG 31

A full summary of local audit projects we have completed, and the resulting actions can be found on the Trust's website.

Plans for Clinical Audit

Our key aims for next year are to:

1. Participate in all applicable national audits and confidential enquiries.
2. Increase clinical audit activity across all services, and ensure a robust programme of re-audit and evidence of quality improvement
3. To make training programmes available to all staff, to include on-line training and workshops run by national agencies such as National Institute for Clinical Excellence and Healthcare Quality Improvement Partnership
4. Roll out the implementation of audit software to allow for real time reporting and a link to improved patient outcomes
5. Ensure involvement of patients and service users in clinical audit activity

More details of the audits which were carried out and their outcomes, can be found on the Trust's website www.solent.nhs.uk

1.5 Participation in Clinical Research

Solent NHS Trust is currently the second most research active community / care Trust in England and at the end of March 2013 were the second highest recruiting (patients into clinical trials) Trust in the Hampshire and Isle of Wight region. Despite being a young organisation, the Trust has made substantial improvements in its research portfolio and is committed to ensuring that all patients have the chance to participate in clinical research. We are also committed to supporting our staff to stay abreast of latest treatment possibilities which has a direct effect on improving the services that we offer and our patient outcomes.

The number of patients receiving NHS services provided or sub-contracted by Solent NHS Trust in 2012/13 (that were recruited during that period to participate in research approved by a research ethics committee) was 3639. We have opened 57 new studies across the Trust this year (compared to a total of 24 in 2011/12) and are currently collaborating in 122 active studies across a range of services.

Our key achievements in 2012/13 were:

1. Being named as the second most active community Trust in the country by the National Institute for Health Research
2. Increasing the number of patients recruited into clinical trials by over 300%
3. Almost doubling the number of new studies opened across the Trust
4. Investing in a number of research nurse/therapist posts across the Trust to support staff and patients to be involved in research
5. Investing in a clinical academic training scheme to support staff in post-graduate and post-doctoral research and clinical roles in collaboration with the University of Southampton
6. Investing in a patient and public involvement facilitator
7. Decreasing the time it takes to get a research study approved and open in the Trust from an average of 36 calendar days to 11 calendar days
8. Launching our research website, which outlines all of our studies in more detail – www.solent.nhs.uk/research

Summary of achievements in key performance indicators, 2011/12 and 2012/13

	2011/12	2012/13	% improvement
Number of patients recruited into clinical research	846	3639	330%

Number of new studies opened	31	57	84%
Number of open studies	83	122	47%
Median days to grant approval for research studies	36	11	69%

Below are only a few examples of how our research has made a difference to patients. Please visit our website for more details of all of our research and advice on how to get involved in research - www.solent.nhs.uk/research.

Case study - Research into a parenting programme for parents/carers of children with challenging behaviour: *In collaboration with the University of Southampton, the NEW FOREST PARENTING PROGRAMME is being trialled locally and internationally as an intervention for coping with Attention Deficit Hyperactivity Disorder. This has led to specialist clinics being established in Southampton and Portsmouth and home based care being delivered to families of young children.*

Case Study - Reconceptualising 'Did not Attend' to 'Was Not Brought' for children and young people's missed health care appointments*: This study looked at the widespread use of 'Did Not Attend' to record the missed appointments of children and adolescents. It suggested instead that the term 'Was Not Brought' would encourage positive interventions to safeguard and promote the welfare of children, a recommendation that has been incorporated into Trust policy and a number of national publications.*

Case study - The Preservation of Self-Identity in Dementia (A Pilot Study): *This project is developing both a specialised approach to taking consent from patients with dementia, and will developing clinical guidelines which will promote positive physical and mental well-being for older adults in hospital, in order to preserve self-identity and attachments to people and society.*

1.6 Quality of Data Collection

Solent NHS Trust has completed the Information Governance Toolkit Assessment as a Mental Health Trust for the period April 2012 - March 2013 and is compliant with all 45 requirements, having attained the 80% target score which was set for us to achieve.

All organisations that have either direct or indirect access to NHS services must complete an annual Information Governance Toolkit Assessment and agree to additional terms and conditions. Where the Information Governance Toolkit standards are not met to an appropriate standard (Minimum level 2), an action plan for making the necessary improvements must be agreed with the Department of Health Information Governance Policy team or with an alternative body designated by the Department of Health (e.g. a commissioning organisation).

What is Information Governance (IG)?

Information Governance is to do with the way organisations 'process' or handle information. It covers personal information (i.e. that relates to patients/service users and employees) and corporate information (e.g. financial and accounting records).

IG provides a way for employees to deal consistently with the many different rules about how information is handled, including those set out in:

- The Data Protection Act 1998.
- The common law duty of confidentiality
- The Confidentiality NHS Code of Practice
- The NHS Care Record Guarantee for England
- The Social Care Record Guarantee for England
- The international information security standard: ISO/IEC 27002: 2005
- The Information Security NHS Code of Practice
- The Records Management NHS Code of Practice
- The Freedom of Information Act 2000

What is the IG Toolkit?

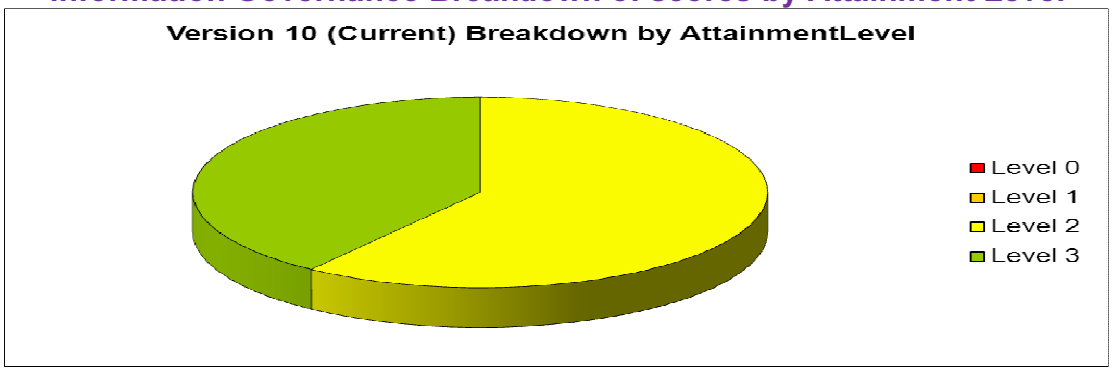
The Information Governance Toolkit is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance set out above and presents them in one place as a set of information governance requirements. The organisations described below are required to carry out self-assessments of their compliance against the IG requirements. Solent NHS Trust was established on 1 April 2011 and provides Community Healthcare for Southampton and Portsmouth.

This year has seen a marked improvement in scoring for the Trust as detailed below.

Information Governance Toolkit V10 Summary Report for 2012/13

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score
Version 10 (2012/13)	Current	0	0	27	18	45	80%
Version 9 (2011/12)	Published	1	4	38	2	45	63%

Information Governance Breakdown of scores by Attainment Level



Solent NHS Trust was created on 01 April 2011 by the merger of provider services from Southampton City PCT (SCPCT) and Portsmouth City Teaching PCT (PCTPCT).

Information Governance Toolkit Scores Table					
Year	Version	Score	Organisation	Score	Organisation
2012/13	V10	80%	Solent NHS Trust		
2011/12	V9	63%	Solent NHS Trust		
2010/11	V8	81%	SCPCT	55%	PCTPCT

2009/10	V7	83%	SCPCT	72%	PCTPCT
2008/09	V6	76%	SCPCT	77%	PCTPCT
2007/08	V5	72%	SCPCT	78%	PCTPCT
2006/07	V4	59%	SCPCT	65%	PCTPCT
2005/06	V3	73%	SCPCT	62%	PCTPCT
2004/05	V2	59%	SCPCT	43%	PCTPCT

What are the IG requirements?

There are different sets of IG requirements for different organisational types. However all organisations have to assess themselves against requirements for:

- management structures and responsibilities (e.g. assigning responsibility for carrying out the IG assessment, providing staff training etc)
- confidentiality and data protection
- information security

Solent NHS Trust has to submit a wealth of anonymised information to SUS (Secondary Users Service) which has to comply with national standards of data quality. Below are examples of the data items in the latest submission:

NHS Number	This is the percentage of records in the dataset that has a valid NHS number recorded, a low figure could mean users are not checking for NHS numbers or GPs are not supplying it when referring a patient to us.
Our score was:	**99.6 % for admitted patient care** **99.8% for outpatients**

Valid GP Practice	This is the percentage of records in the dataset that has a valid GP practice recorded. Where possible the GP practice should be checked with the patient at every contact they have with the Trust, failure to do so may result in the wrong commissioner being recorded against the activity
Our score was:	**99% for admitted patient care** **100% for outpatients**

Valid Postcode	This is the percentage of records in the dataset that has a valid postcode recorded. Where possible the postcode should be checked with the patient at every contact they have with the Trust, failure to do so may result in the wrong commissioner being recorded against the activity
Our score was:	**99.5% for admitted patient care** **100% for outpatients**

Clinical Coding: Each year the Trust has to undertake an external clinical coding audit. Clinical coding is the translation of written medical terminology into codes. Each code is a set of characters that classify a given entity. Clinical Coders extract the relevant information from a source document and assign the appropriate codes that represent the complete picture of a spell in hospital, the yearly audit is carried out to ensure the clinical coders are coding to national standards.

Year	Primary Diagnosis	Secondary Diagnosis
2009/10	81%	53%
2010/11	93%	80%
2011/12	96%	91%
2012/13	98%	95%

Freedom of Information (FOI) requests 2012/13

The Freedom of Information Act 2000 is part of the Government's commitment to greater openness and accountability in the public sector, creating a climate of transparency, a commitment supported by Solent NHS Trust.

The Trust is required under IG Requirement 603 to annually monitor and review compliance with the Freedom of Information Act 2000 and how it meets the standards.

Scope:

The aim of this review is to assess Trust compliance for 2012/13 in;

- Ensuring all requests relating to Solent were responded to within 20 working days
- Ensuring adequate policies and procedures are in place
- Ensuring all staff are aware of the FOI Act 2000 and their responsibilities
- Ensuring all requests are acknowledged within 2 working days
- Ensuring requestors are satisfied with how their request was undertaken and the outcome of the request
- Ensuring the organisation has an up-to-date and effective Publication Scheme

Responding to FOIs

In 2012/13 (April 2012 – March 2013) Solent NHS Trust received a total of 101 FOI requests which contained a total of 442 questions. The time frame for responding to FOI requests is 20 working days.

Subject Access Requests/Access to Records requests 2012/13

Solent NHS Trust under Section 7 of the Data Protection Act 1998 is required to monitor compliance with an individual's rights to access their personal information, including requests for deceased patient records (to whom the Data Protection Act does not apply) under the Access to Health Records Act 1990.

The Trust should endeavour to respond to all requests within 21 days (but no later than 40 days – inclusive of weekends and bank holidays) from receipt of all information e.g. ID check and fee.

Requests for information can be received by (but not limited to) the following;

- Patients
- Patient representatives e.g. Solicitors, Advocates, etc
- Parents of children under 18 years
- Relatives of deceased patients
- Police
- Department of Work and Pensions
- Other Health Care Provides
- Mental Health Tribunals

During April 2012 to February 2013 Solent NHS Trust received and complied with 758 requests to access information from the categories above.

1.7 Goals agreed with Commissioners

A proportion of Solent NHS Trust's income in 2012/13 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.

The CQUIN Framework was launched in 2009 following recommendations made in the report '*High Quality Care for All*'. The Framework aims to embed quality improvement and innovation at the heart of service provision and commissioner-provider discussions. It also ensures that local quality improvement priorities are discussed and agreed at Board level in all organisations. It enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
The table below shows the resource available to the Trust from the CQUIN scheme.

Indicator Name	Description	Status
Community Services		
Venous Thrombo-embolism (VTE)	Reduce avoidable death, disability and chronic ill health from VTE	On target
Patient experience	Composite indicator on responsiveness to personal needs	On target
Dementia	Improve awareness and diagnosis of dementia, using risk assessment, in community teams	On target
NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE	On target
Innovations	To enhance the delivery of care to patients through effective use of Tele-health	On target
Right care in the right place at the right time (admissions avoidance) - **Southampton**	• To ensure effective integrated working across the health economy (primary, community, secondary, mental health, ambulance) to deliver care in the most appropriate place; • To ensure that there are appropriate care pathways which minimise none emergency admissions to hospital and demonstrate organisational compliance with those pathways; • To ensure improving quality of care for service users;	On target

	• To reduce hospital admissions and improve case management in the community	
Right care in the right place at the right time (admissions avoidance) - **Portsmouth**	To see an absolute reduction of 10% of over 65 year old non- elective admissions (to reduce 600 spells from the pre-defined cohort of Healthcare Resource Groups (HRGs) – appendix I) based on 2011/12 performance year end performance	On target 
Health Promotion - **Southampton**	• To improve assessment/screening, brief advice and signposting and onward referral in three priority public health domains (as set out in the Healthy Lives, Healthy People publication) • To increase awareness about the harm caused by smoking, obesity and alcohol • To provide patient information that will encourage behaviour change and improve health To increase appropriate action including referrals of patients to support services e.g. local NHS Stop Smoking Services, weight management pathway, alcohol specialist services, where appropriate	On target 
Frequent Attenders to Emergency Department - Southampton	The aim of this CQUIN which is a system wide CQUIN across SW Hampshire providers (UHSFT, Solent and Southern) is to identify and provide community follow up for frequent attendees to UHSFT emergency services with a view to reducing future repeat attendances.	On target 
Mental Health Services		
NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE	On target 
Patient Experience	Composite indicator on responsiveness to personal needs	On target 
Dementia	• Develop a comprehensive dementia pathway across primary care, secondary care, community care and the third sector • Monitor progress against the Dementia Strategy, recommending remedial action as required • Update the Dementia Strategy and recommend appropriate future actions as appropriate • Work collaboratively across the dementia community, sharing good practice and acting on an advisory basis to support organisations involved in delivering the dementia agenda • Ensure appropriate involvement of service users,	On target 

	families, carers and advocates • Opportunities for Third Sector funding to be identified and proposed	
Physical Healthcare	Physical healthcare for people with severe mental illness (including adults, older people and children) and substance misuse problems	On target 
Improving Access to Psychological Therapies - Older People	The proportion of older people that enter treatment against the level of need in the local population, i.e. the proportion of older people who have depression and/or anxiety disorders who receive psychological therapies. To support achievement it is expected that the provider will use all relevant guidance, e.g. Older People Positive Practice Guide.	Under negotiation 
Improving Access to Psychological Therapies – BME (black and ethnic minority groups)	The proportion of people from black and ethnic minority groups that enter treatment against the level of need in the BME population, (i.e. the proportion of people from BME groups who have depression and/or anxiety disorders who receive psychological therapies)	On target 
Child and Adolescent Mental Health (CAMHS)	Child and Adolescent Mental Health (CAMHS) and CAMHS Learning Disability (CAMHS LD) therapeutic skill enhancement training for foster carers and residential children's home staff in Portsmouth City	On target 
Dual Diagnosis	Lead the development of a pathway for all people with dual diagnosis issues (mental health & substance misuse / alcohol); involving all stakeholders: primary care, secondary care, acute and third sector providers to address the issues of people falling through the gap of eligibility criteria and failing to get a service, people being batted backwards and forwards between services, an unclear referral pathway for primary care and a reluctance to look for dual diagnosis.	Under negotiation 

1.8 Registration with the Care Quality Commission (CQC)

Solent NHS Trust has remained fully authorised to deliver care and regulated activities against all 16 Essential Standards for quality and safety during 2012/13.

The Trust is required to register with the Care Quality Commission for a number of Regulated Activities and is currently registered without any conditions or warnings from the creation of the Trust on the 1 April 2011.

We are registered to provide the following regulated activities:

- Accommodation for persons who require nursing or personal care

- Accommodation for persons who require treatment for substance misuse
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Nursing care
- Personal care
- Surgical procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

The Care Quality Commission has not taken enforcement action against the Trust.

The Board and the Assurance Committee receive quarterly corporate reports against compliance with Essential Standards; this information is also compared with a range of other data available within the Trust. The Assurance Committee is a Trust Board Committee charged with the overseeing of the safety and quality of our services.

The Trust is subject to periodic reviews and unannounced inspections by the Care Quality Commission, under their normal inspection framework. The following visits have taken place:

Adult Mental Health Service

In September 2012 the CQC carried out an inspection of the Mental Health Services in St.James' Hospital, Portsmouth. They focused on 6 outcomes under their Essential Standards framework and their formal report concluded that 5 out of the 6 outcomes were being fully met.

Although the report contained some very positive comments, the inspectors felt that as the service was not meeting all the requirements, a judgment of non-compliance was made but assessed as having a minor impact on the people who use the service.

The areas where the CQC had some concerns included:

- Physical health – having reviewed the care records for 15 people across the three wards at the hospital, they found 3 patients had information restricted only to the management of their mental health.
- Ligature points – although the inspectors observed risk assessments in place for the management of self harm, they felt that the risk assessments did not adequately cover some other potential ligature points.
- Section 17 leave risk assessment – the inspectors found that there were variations in the approach for undertaking risk assessment by nursing staff for section 17 leave.

As a result of these three points, the Trust developed a comprehensive action plan which was submitted to the CQC shortly after their inspection. The service was re-inspected in February 2013, via an unannounced visit, and a subsequent report from the CQC demonstrated that the Service is now fully compliant.

The CQC also regularly inspects (outside of its normal inspections for Essential Standards) under their duty to ensure that we are meeting the key areas of the Mental Health Act. No significant issues have been raised in regard to these visits.

Healthcare Service at HMP Winchester

Following an announced combined Prison Ombudsman visit to HMP Winchester which took place in October 2012, the Trust received a report from the CQC which was positive in relation to the majority of areas considered, but did highlight one 'area of improvement' with regard to 'Care and Welfare of people who use the service'.

This involved the possibility that patient care and treatment may be compromised due to interruptions or delays in the dispensing of medication. This directly related to the implementation of the new national Prison IT system and manual processes that have been immediately reinstated in the area of medicines management until the IT system issue is resolved. Since receiving this report in December 2012, the Trust has had notification from the national team of the short comings of the system and immediate changes have been implemented to address this area, which has been shared with the CQC.

Portsmouth Rehabilitation & Re-enablement Team (PRRT) (a joint Health and Social Care Team)

In February 2013, the CQC carried out an unannounced visit of the Portsmouth Rehabilitation and Re-enablement Team (PRRT). The inspection focused on 5 key areas of their Essential Standards Framework and involved speaking to local staff, patients and the Safeguarding Lead for Adults Services. The inspectors reviewed considerable amount of information including care plans, specific case records, safeguarding incidents, local governance arrangements, patient surveys and feedback loops to staff, including team minutes of meetings.

The CQC report summary found that there were arrangements in place to ensure that people using the service felt respected and involved in decisions about their care as well as the methods of delivery of the service. This included the methods in place for receiving referrals for the service delivery in terms of content, frequency, preferences, staff status and review process.

Service users reported that they were happy with the quality of the service they received from the team, that their care was regularly reviewed and they knew how to raise concerns if needed and were responded to readily.

The report confirmed that the 6 staff files which were reviewed had highlighted the need for improvements in supporting staff in relation to supervision, appraisal and development. As a result of these gaps, the Trust was assessed as non-compliant at a minor level for Outcome 14 "Supporting workers".

The Trust has now provided the CQC with evidence of the proposed management structures which will lead to improvements in providing support to our staff.

Sexual Health Service – Crown Heights, Basingstoke

In January 2013, Solent NHS Sexual Health Service opened a new site operating a range of integrated sexual health services. As this was a new 'location', the CQC carried out an inspection prior to the unit becoming operational and approved the opening, having no significant issues.

Further information regarding the Care Quality Commission can be found on: http://www.cqc.org.uk/public

1.9 Quality Indicators

The data made available to the NHS Trust by the Health and Social Care Information Centre	Solent NHS Trust (%)	Highest (%)	Lowest (%)	National average (%)	Related NHS Outcomes Framework Domain
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during this reporting period	**Q3: 99%** **Q2: 100%**	Q3: 100% Q2:100%	Q3: 95.2% Q2: 89.8%	Q3: 97.6% Q2:97.2%	*1. Preventing people from dying prematurely* *2. Enhancing quality of life for people with long-term conditions*
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	**Q3: 100%** **Q2: 100%**	Q3:100% Q2:100%	Q3: 90.7% Q2: 84.4%	Q3:98.4% Q2:98.1%	*2. Enhancing quality of life for people with long-term conditions*
The percentage of patients aged (1) *0-14 years (not applicable)* (ii) 15 or over, Readmitted to a mental health hospital (which forms part of the Trust) within 28 days of being discharged from a hospital during the reporting period. *Solent NHS Trust considers that this data is as described for the following reasons: The Crisis Teams, day Treatment and Acute admission wards act as a continuous flexible Acute Care Pathway, with a very high threshold for use of inpatient beds. Therefore inpatient treatment and community treatment may form part of the same episode. Moving "up" and "down" the Acute Care Pathway, may involve at times more than one spell of inpatient treatment during the same episode.* *In an effort to improve this score and ensure the quality of its services the Trust has reviewed all instances where patients had to be re-admitted over a 12 month period and modified care plans to ensure that crisis treatment could be better tailored to their needs, based on the experience of the previous admission. We believe, however that the very high threshold for admission and low bed numbers per 1000 population (and subsequent high complexity of CRHT caseloads), will mean that this figure will probably remain appropriately above national average.*	**2011: 14.4%**	2011: 66.7%	2011: 0%	2011: 11.5%	*3. Helping people to recover from episodes of ill health following injury*
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends *Solent NHS Trust considers that this data is as described for the following reasons*	**2011: 59%**	2011: 77%	2011: 56%	2011: 65%	*4. Ensuring that people have a positive experience of care*

(insert) *The Trust (has taken / intends to take) the following actions to improve this score and so the quality of its services by (describe actions)*					
The Trust's 'Patient experience of community mental health services' indicator score with regard to a patients' experience of contact with a health and social care worker during the reporting period	**2011: 87.23** **2010: N/A**	2011: 88.22 2010: 88.39	2011: 81.87 2010: 85.39	2011: 86.79 2010: 87.25	*2. Enhancing quality of life for people with long-term conditions.* *4. Ensuring that people have a positive experience of care*
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death *Solent NHS Trust considers that this data is as described for the following reasons (insert)* *The Trust (has taken / intends to take) the following actions to improve this score and so the quality of its services by (describe actions)*	**Apr-Sept 2011:** **1,246 (22.09)** **Oct 2011-Mar 2012: 1,148 (20.35)**	Apr-Sept 2011: Highest Count – 8,461 Highest Rate – 141.85 Oct 2011-Mar 2012: Highest Count – 8,778 Highest Rate – 157.41	Apr-Sept 2011: Lowest Count – 88 Lowest Rate – 2.13 Oct 2011-Mar 2012: Lowest Count – 66 Lowest Rate – 0.94	Apr-Sept 2011: Avg Count – 2,377.6 Avg Rate – 13.89 Oct 2011-Mar 2012: Avg Count – 2,497.7 Avg Rate – 14.55	*5. Treating and caring for people in a safe environment and protecting them from avoidable harm*

PART 2

2.1 Review of last year's Quality improvements

The priorities identified for 2011/12 are on target and have continuously been monitored through each of the Clinical Divisions within the Trust through their monthly Divisional Governance Group meetings.

Patient Safety

PRIORITY 1: Continue to ensure patients are safe from infections

Why did we make this a priority? Although the Trust has performed well at achieving its vision for avoidable Healthcare Associated Infections (HCAI), this remains a key indicator of clinical quality and patients and the public continue to require assurance that we keep infection prevention and control high on the agenda. The reduction of MRSA (Methicillin-resistant Staphylococcus aureus) bacteraemias and Clostridium Difficile infections have remained a national priority for many years with all such infections reported and fully investigated.

What did we do?

- Carried out internal surveillance of infection rates
- MRSA admission screening compliance was audited every quarter
- Hand hygiene observational audits were carried out twice during the year
- Carried out a full investigations for each reportable infection and identified actions for learning in line with Department of Health guidance
- Actions for learning were monitored through the Infection Prevention and Control Committee
- Audited the use of urinary catheters each quarter with the emphasis on ensuring that all such devices were appropriate and avoided wherever possible

Our achievements so far: 

- Only 1 case of Clostridium Difficile infection to date
- Only 1 case of MRSA Bacteraemia attributed to our organisation to date
- Surveillance of other relevant infections is encouragingly low with no evidence of onward transmission
- MRSA admission screening compliance has increased by 12% this year compared to last
- At 96% hand hygiene compliance (against recommendations made by the World Health Organisation) remains encouragingly high.

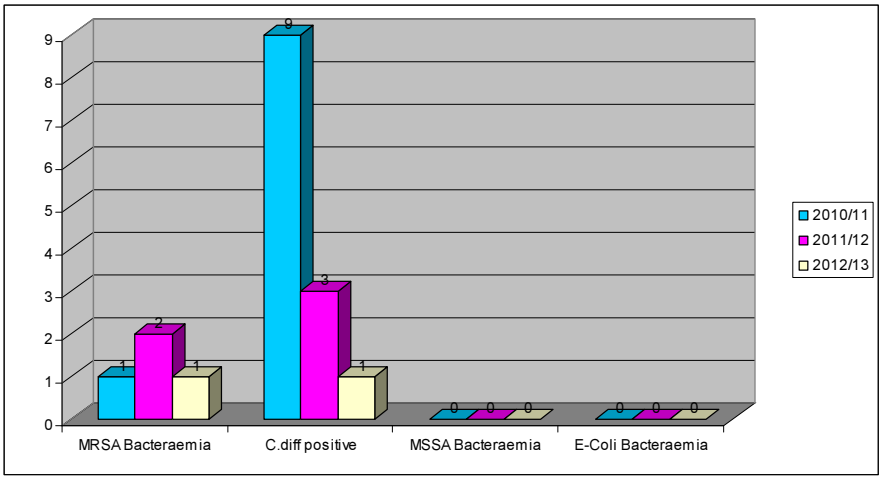
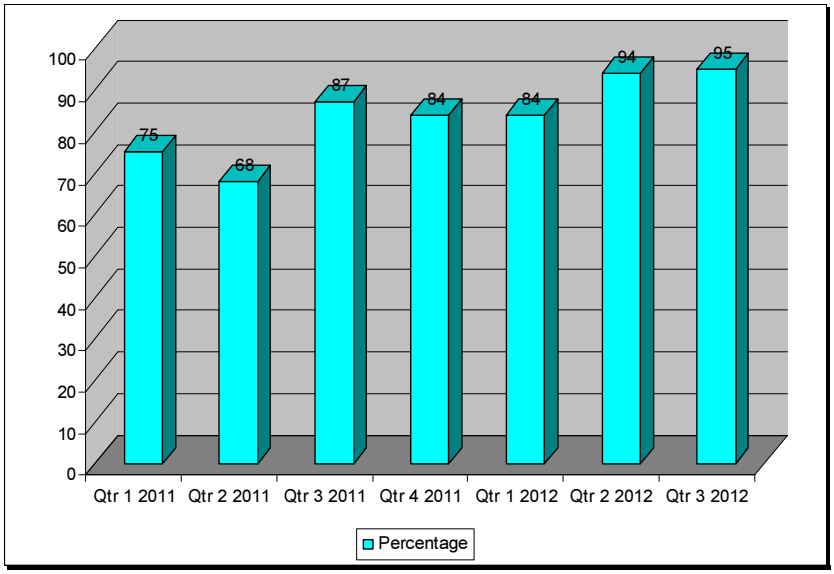


Figure 1 *– Reportable infection rates within our organisation (please note at the time of composing the Quality Accounts figures shown are those available until the end of January 2013)*

The control of MRSA is an important factor in the provision of safe patient care and our current policy outlines measures needed to prevent the acquisition and spread of MRSA. The Trust requires that all patients admitted to any of our inpatient areas are screened for the presence of MRSA. This allows the appropriate treatment to be offered to those individuals found to be positive and relevant alerts placed on medical records for future safety. In order to measure compliance with this process an audit is conducted four times per year.

Figure 2 *– Results of MRSA screening audits*



Comments: Levels of HCAI remain encouragingly low within our organisation. However there is no room for complacency and constant surveillance allows us to identify problems or hot spots at the earliest opportunity and apply the appropriate precautions as swiftly as possible.

The Trust's Infection Prevention and Control Link Advisors continue to provide an important and supportive role across the organisation. To date there are approximately 135 Link Advisors across Solent NHS Trust. This includes 32 who

attended the two day training course during the last year. This valued group of staff assist with maintaining high standards of infection control practice within their clinical areas and carry out infection control audits, monitoring hand hygiene compliance and improving staff skills.

PRIORITY 2: Continue to reduce incidents of falls in inpatient areas

Why did we make this a priority? The National Patient Safety Agency (NPSA) identified that there were 257,679 falls reported in the year ending March 2009. They estimate that about 1,000 patient falls a year result in fractures. A significant number of falls result in death or severe/moderate injury, at an estimated cost of £15m per annum for immediate healthcare treatment alone. We made this a priority as we recognise that the vulnerable patients we care for in our elderly rehabilitation and elderly mental health wards can be more at risk of falling and sustaining a serious injury whilst under our care.

What did we do?

- Falls training for registered staff nurses was made a key part of their annual Clinical Update Day. The Trust's Falls Lead is now working with individual Falls Link staff to complete root cause analysis work on falls patterns on their wards. All wards have access to falls prevention socks which are designed to be less slippery. Fall alarm systems are in use or being trialled in all our older person's rehab or elderly mental health wards.
- At our Falls Service in Portsmouth (Community) a new system is in place for triage of referrals. Funding has been agreed for one falls co-ordinator who will co-ordinate the assessment and interventions for all patients who are seen in the local Emergency Department or call an ambulance due to falls. The co-ordinator will work in one locality team and will compare the results for the locality and other teams without a falls co-ordinator.

The NPSA recommend that falls rate per 1000 occupied bed days (OBDs) is used to measure falls incidence in inpatient services rather than numbers of falls. Nationally, in acute hospitals the mean rate is 5.6 per 1000 OBDs, in community hospitals it is 8.6 and in Mental Health units it is 3.8. There is no benchmark available for an organisation such as Solent NHS Trust where the majority of its inpatient bed base focuses around rehabilitation and people with acute mental health needs / severe dementia. The NPSA acknowledges that falls rates are likely to be higher than those cited above in organisations such as Solent where its inpatient care focuses on those with high falls risk.

Our achievements so far: 

Solent NHS Trust was not in a position in 2011/2012 (due to legacy issues obtaining accurate OBD (occupied bed days) data following the merger of its two predecessor organisations) to provide falls rates per 1000 OBDs. However we now have this data and will use 2012/13 data as a benchmark for 2013/14. This data will also enable real-time identification of individual ward areas experiencing peaks in fall rates which will allow us to intervene where needed quickly.

Data for 2012/2013 shows that overall the Trust's rate is 9 per 1,000 OBDs which is favourable given that NPSA guidance above suggests it might be higher given our inpatient case-mix.

Other achievements in 2012/2013

- Inpatient Falls Care Package introduced which is in keeping with national guidance (due for audit in April 2013).
- Written guidance issued to all medical staff to improve identification of hip fracture post fall in inpatient settings
- Basic level training for OPMH doctors provided at induction twice yearly.
- Audits presented to commissioners indicate that patients passing through elderly rehabilitation units are receiving bone health assessments and interventions to reduce fracture rate reliably.
- A one hour falls prevention session has been included on Clinical Update Days attended by all registered nursing staff (with the exception of Adult Mental Health staff).
- Bespoke training has been delivered on Adult Mental Health wards and Older Person's Rehab, Specialist Palliative Care, and a whole day of bespoke intensive falls training day was delivered in January for staff on the acute dementia ward that has the highest rate of falls across the Trust.
- Trials of Tele-care solutions have taken place in:
    - Spinnaker Ward (unit now has 6 falls detector systems operational which is sufficient to meet current need)
    - Jubilee House (unit now has 4 falls detector systems operational which is sufficient to meet current need)
    - Lower Brambles / Fanshawe (inpatient elderly rehabilitation) - decision awaited following one final trial due in March as to which system will be chosen and used.
    - OPMH – decision expected at next OPMH Falls Meeting re how many more falls detector systems are needed in that setting.
- Crash mats (more detail) already in use on OPMH settings and now also on Spinnaker and in Jubilee House

PRIORITY 3: Continue to improve the nutritional status of our patients whilst they are under our care

Why did we make this a priority? Feeding our patients appropriately and making sure they have enough to drink is an essential component of good, quality care and is vital for a speedy recovery. This is particularly important for our most vulnerable patients and links to our ongoing work to provide high quality care for the vulnerable and elderly including those with dementia and patients who are at the end of their life.

What did we do? Staff have worked extremely well on this priority have worked extremely well on this priority over the last year. A few examples of the improvements include:

- The production of a training leaflet which will help staff to recognise the signs of malnutrition. This was approved by our Dieticians and will be available to all inpatient staff.
- Our Learning and Development Service now include this leaflet with all new staff's induction packs and it is also available on the Trust's intranet Nutrition page for staff to access.
- The PEG (Percutaneous Endoscopic Gastrostomy – tube feeding directly into the stomach sack) Project continues and a six month interim project report was circulated to Commissioners of the service.
- A successful PEG project study day was held on 15 October 2012.
- For the national Nutrition Awareness week 15 to 21 October 2012 displays were arranged in the restaurants at RSH, Western Community Hospital, St

James` Hospital and St Mary's Community Hospital campus; the theme was 'Mood and Food'.

- The Nutrition and Hydration Policy has been updated to reflect the Good Practice Guidelines which resulted from Hampshire Adult Safeguarding Board's multiagency review of five cases in Hampshire where a person with learning disability had died as a result of choking.
- In the Portsmouth area we are involved in an educational drive to try to reduce obesity within Adult Mental Health. A Health Living day was arranged at the Orchard Centre in Hospital. As a result of the comments received from patients and staff we have made some changes including having protected mealtimes, changes to menus with healthier meal choices, giving ratings to food choices by a traffic light system and there are plans to bring health trainers onto the wards for staff and patient education sessions.

Our achievements so far: 

We carried out an audit of MUST (Malnutrition Universal Screening Tool) in November 2012 and below is a summary of the findings:

Areas of good practice identified:

- Screening of patients' nutritional status has been maintained at a high level.
- Full compliance with implementing care plans that are in place.

We also were able to identify a few areas for improvement which will be discussed and addressed via the Nutrition and Hydration Strategy Group:

- Adherence to the 24 hour standard for initial screening needs to be improved.
- Initial screening of patients living in their own homes is variable.
- Repeat screening should be carried out at the required frequency and clearly documented.

PRIORITY 4: To ensure all new patients referred to the Child and Adolescent Mental Health Service receive as much information as possible while waiting for appointments

Why did we make this a priority? Having a child referred to the Child and Adolescent Mental Health Service (CAMHS) can be a stressful time for the child and their families. The Trust wanted to make sure that while children wait to be seen by a specialist, they and their families feel as informed and supported as possible.

What did we do? Before we made any changes we asked our clients to take part in a survey to help us understand from their perspective what needs to be on leaflets and our new website to help them. Young people came up with a number of ideas for the website. The most common suggestions were pictures of staff, videos and descriptions of what happens at CAMHS. Generally the young people were in favour of quite a fun looking website with pictures and bright colours.

Parents were also keen for pictures of staff to be on the website. The other common suggestions were advice for parents, links to other resources and outline of services provided. Parents also suggested making the website child friendly, which would involve clear and concise language and not being too overloaded.

The response from young people and parents concerning a video for the website was good. Both parents and young people said they would like to know about a young person's feelings about attended CAMHS. They also suggested that it would be

helpful to see the rooms of the building and show the areas that may help children relax and enjoy themselves such as the garden and x-box.

Our achievements so far:
With the help of our young patients and parents we have now put together the first draft of the design form for the website and are looking at what information needs to be there to allow service users to feel informed and supported.

All service users and carers' information leaflets have been updated following consultation and review from young people, children and carers from the CAMHS service. These updated and reviewed leaflets will be available on the new website.

Patient Experience

PRIORITY 5: To improve our communication and support for carers of the people who use our services

Why did we make this a priority? We recognise that being a carer can have a profound impact upon a person's life and many carers need support from our services to enable them, not only to continue to care for someone, but also to help maintain their own health and wellbeing.

What did we do? In an effort to support our carers (particularly those caring for a person with a physical or mental illness or learning disability) we have produced a three year strategy to improve our carers' experience and ensure that they will be supported in their caring role.

As well as providing further training and support for our Carers Champions within our inpatient units, the Trust is also pleased to be supporting the Carers Strategies for our local authorities to improve the range of support and advice we can offer to carers.

Our achievements so far:
Within our Adult Mental Health Unit there are a number of initiatives being discussed through the Acute Care Forum which is attended by staff, carers themselves and Local Authority staff who work for the Carers Centre in Portsmouth. This relationship is long standing and has contributed to many successful carers initiatives over the years.

The current focus of the work is the development of the Carers Resource Pack which is now available on our inpatient wards at The Orchards. These packs can be given to carers of our patients whilst they are visiting their friends/family members. The packs contain a wealth of information relating to support for carers in the community, referral forms for carers, information about the care and treatment provided at The Orchards and a copy of the Trust's Carers Strategy.

The second initiative is the introduction of a Carers Clinic on The Orchards. This is a joint collaboration with Health and Social Care (via the Carers Centre). The purpose is for staff from The Orchards and from the Carers Centre to work together to provide some protected time for carers to visit the unit to speak to staff about the treatment being provided in the hospital and for them to seek support for themselves as carers

as we recognise how vital it is for them to be supported to stay mentally and physically well, and be treated with dignity and respect.

There is also ongoing support of carers to be part of the Care Programme Approach (CPA) process and being invited to care planning and CPA meetings - as well as having the opportunity to meet with staff members (such as named nurses, doctors and managers) and this remains a core part of our service delivery.

We are currently developing Carers Resource Packs for all services and these will available very soon.

PRIORITY 6: To increase the number of satisfaction surveys across the Trust to inform service improvement

Why did we make this a priority? As part of our Patient Experience Strategy 2012 -15, we focussed more on the importance of good patient experience as highlighted by Care Quality Commission and other national bodies. It was also a requirement of our NHS contract with commissioners to demonstrate areas of improvements as reported by our service users. In order to identify any areas for improvement, we needed to gain more feedback from patients and carers.

Although satisfaction surveys were already being carried out locally in some services using paper surveys, this needed to be extended to cover all services, standardised to cover key areas, and to offer a wider variety of methods of capturing feedback to suit different needs.

What did we do? We set up a survey programme covering key areas of the organisation focusing on the key areas required by commissioners which include:

- Involvement in decisions about treatment/care
- Staff being available to talk about worries/concerns
- Privacy when discussing condition/treatment
- Being informed about side-effects of medication
- Being informed who to contact if worried about condition after leaving hospital/community care

In addition to these questions, services were also asking for feedback on issues related to their specific service area.

Many services, including inpatient areas and community are now offering the survey to all patients on discharge from the service. Others offer the survey for limited periods of time to all current users of their service.

Friends and Family: Patients are being asked how likely they would be to recommend a service to friends and family. A pilot is currently being run across specific services.

Services have increasingly adopted electronic methods for completing surveys including the use of tablets and standalone kiosks within public areas.

Alternative methods have been trialled to capture feedback from vulnerable groups and those unable to use standards methods. e.g. focus groups in Homeless Health, pictorial versions for those with dementia and learning disabilities, carers' discussions

in palliative care, and visual scoring scales and spoken surveys in areas where reading or English language is a challenge.

These methods together with monitoring social media feedback, unannounced inspections together with patient and voluntary groups and complaints give a rounded picture of the experience that patients have within Solent NHS Trust services.

Our achievements so far: 

- We have increased the number of surveys carried out over the year, from 959 in 2011/12 to 3,289 in 2012/13.
- This was an increase from 20 services to 56 services.
- The overall percentage of positive answers in the 5 key areas (e.g. dignity, privacy and involvement) was 94% and to other questions was 67%.
- The Friends and Family Question from Community wards and the Minor Injuries Unit was reported as 75% over a six month period and with the planned promotion of this question we expect this score to rise even further in the months ahead.
- These surveys are helping us to pick up any areas that need some improvement. Discharge and Rapid Response Teams are producing patient information leaflets and training staff to ensure that patients and carers fully understand what is being arranged for their return home and who to contact for support and our elderly inpatient areas are introducing visual aid menus

PRIORITY 7: To demonstrate improvements in recovery and support mental health patients to regain their place in the community and improve partnership working

Why did we make this a priority? The recovery focus of the Adult Mental Health Service ensures that all aspects of service, work to the common aim of promoting a life worth living even where there are ongoing symptoms of mental illness. Supporting people to take increasing control in aspects of their care and develop social roles / activities they value has a close relationship with wellbeing.

What did we do? We have completed a number of exercises in order to:

- measure how the service is currently performing against a number of recovery-underpinning statements
- explore the level of recovery-focussed care planning carried out
- identify suitable ways to increase self assessment of recovery, to ensure that our service-users' own perspective is key to our interventions

We have developed and provided folders for all service users to store copies of their care plans and information relating to their recovery. We have continued to develop volunteer roles for people who have accessed our service, this enables the service and people accessing it to learn from their expertise of living with a mental health condition and promotes opportunity for people to share their personal skills.

We have carried out a thorough review and refinement of the purpose of Oakdene Unit to enhance the recovery and rehabilitation of people accessing this part of the service.

We developed three Recovery Principles which 81 staff to date have committed to make visible in their work. In collaboration with carers and service-user volunteers, we have used this information, to develop a 5 year strategy to implement changes required to increase our recovery-focus as a service.

We continue to build effective and innovative relationships with our partners working in education, commissioned mental health providers and mainstream community providers.

Our achievements so far: 

Recovery-Focussed Care Planning: Audited from clinical notes; 72% of service users' notes, indicate recovery-focussed interventions and 27% record more advanced stage of recovery (i.e. feeling well / taking responsibility for recovery.

In a study asking people about their own care plans and experience, 75% felt their strengths and abilities were included to promote their recovery and 63% felt their goals and aspirations were reflected in their care plan.

Over the last year we have supported 17 service-user volunteer opportunities ranging from co-researcher to providing creative art activities. Of these at least two have used this experience to complete related further study and one has been helped to gain employment.

In our work with Highbury College we have 39 students who have completed the Back on Track Programme (*this has been developed to meet the specific needs of younger people with mental health issues and disrupted education*). 50% have progressed to further education or employment and 25% progress to study at a higher level. The quality of outcomes achieved through this partnership working have received international recognition as 'best practice'.

In 2012 the lead from our service received a College of Occupational Therapy Merit Award to celebrate national recognition for excellence. These outcomes are in addition to those achieved through referral and joint working with our partner agencies.

CLINICAL EFFECTIVENESS

PRIORITY 8: To improve foot care and reduce amputations in people with diabetes in our community

Why did we make this a priority? A recent report published by NHS Diabetes set out the high cost to both patients and the NHS of poor quality diabetic foot care. Portsmouth was shown to have the highest amputation rate in England and Southampton was not far behind.

What did we do? Reviewed the provision of a Multi-Disciplinary team in the management of the diabetic foot; ongoing education and raising awareness. Increase the access to podiatry for patients with diabetes in the Portsmouth area.

Our achievements so far:
This has been a major achievement for the Trust's Podiatry Team who has worked with NHS Diabetes on a Quality Improvement Framework for the whole of the Health Authority.

We are delighted to say that in February 2013 a 25% reduction in major amputations in Portsmouth was reported (from 48 in 2010/11 to 36 in 2011/12). New statistics also reveal that there has been a large reduction in the number of diabetic patients needing major amputations in the last 3 years.

Our Podiatry Service redesigned its diabetes pathway with a focus on prevention and the rewards of this pathway are now coming to fruition. Patients are receiving care from the right people in a timely fashion since the introduction of the diabetic foot score. We would encourage all patients with diabetes to find out their foot score at their annual diabetes assessment with their GP practice.

Other areas of improvement…….

2.2 Learning from our staff

Solent NHS Trust is committed to being an excellent employer and a healthy organisation where learning remains at our core. We believe that our staff are our greatest asset and we will strive to enable them to feel valued, involved and proud, creating a culture which ensures excellent services, excellent staff, and excellence in all that we do to deliver the very best patient and staff experience.

Our annual Staff Survey has been undertaken by Pickers Institute Europe for the last three years to generate historical data with which to benchmark our progress. This survey enables us to gain feedback from our staff in terms of understanding their concerns and also how we can as an organisation, to improve both the working conditions for staff and our culture to support continuous improvement.

Our 2012 Staff Survey is an objective indicator and was carried out during the months of October and November 2012.

1652 staff out of 3195 eligible staff returned their completed questionnaire giving a response rate of 51.7% (compared to last year's response rate of 56%). The national average response rate of the survey was 54.6%.

The overall survey shows that not withstanding the significant organisational change prevalent at the time of conducting the survey progress continues to be made year on year particularly in areas such as communication between senior managers and

staff, consulting with staff regarding changes and providing training in delivering good patient/service user experience and in Equality & Diversity.

The staff survey results were broadly similar to those of other community trusts. In some areas the Trust is doing slightly better than other trusts and in some areas we are doing less well. An area of concern was the extent to which staff are feeling under pressure and in some areas a feeling that they do not always have enough time to do their job to the standard they would wish.

	2010/11		2011/12		Trust Improvement
Top 4 Ranking Scores	Solent Trust	National Average	Solent Trust	National Average	
No training in how to deliver a good patient / service user experience	37%	38%	20%	24%	17% improvement
Not able to do my job to a standard am pleased with	25%	23%	16%	13%	9% improvement
In last 3 months, have come to work despite not feeling well enough to perform duties	62%	60%	53%	58%	9% improvement
Communication between senior management and staff is not effective	40%	39%	32%	31%	8% improvement

	2010/11		2011/12		Trust Deterioration
Bottom 4 Ranking Scores	Solent Trust	National Average	Solent Trust	National Average	
Senior managers do not act on staff feedback	23%	23%	31%	31%	8% deterioration
Felt pressure from manager to come to work despite not feeling well enough	22%	23%	30%	29%	8% deterioration
Felt unwell due to work related stress in last 12 months	36%	32%	43%	40%	7% deterioration
Not enough staff at Trust to do their job properly	50%	45%	52%	49%	2% deterioration

(Results above are taken from Pickers Survey 2012)

In response to the staff survey, the Human Resources Department has, together with service lead managers, analysed key areas for improvement and devised a set of locally targeted action plans which has informed the overall consolidated engagement plan for Solent NHS Trust. Key priorities are correlated to areas where the Trust's score is lower than average and performance has slipped or deteriorated since 2011-12 survey.

Our focus for 2013/14 is on:

- Keeping the patient at the centre and our quality of care
- Releasing time to care through our Community Productive Series
- Workforce Health & Wellbeing implementing key areas of activity to promote wellbeing
- Making is easy to raise a concern so as to foster an open culture
- Staff involvement, engagement and communication to improve the staff experience
- Ensure everyone has clear planned goals and objectives through the introduction of a new Performance Management Appraisal model
- Cultural development though our core values

Our overall objective is to enhance staff morale and staff engagement through continuous improvement and year on year we ensure that we measure the changes identified within the Staff Survey as it provides structured, evidence based, way for us to engage with our staff and respond to their feedback.

The Employee Engagement indicator is a key performance indicator for Solent NHS Trust and an improvement target has been set in the annual operating plan of 3.75 from its current indicator of 3.64.

Our Core Values

I N S P I R E

2.3 Learning from you…..

Was there anything particularly good about your treatment?

Royal South Hants Hospital (Sexual Health Service): *"Without exaggeration the visit was an absolute pleasure. The doctor and nurses were excellent by being friendly, respectful and knowledgeable"*

Physiotherapy, Queen Alexandra Hospital*: "I wanted to write to let you know of the absolutely outstanding care being delivered in hospital by your physiotherapy team. My father was diagnosed with cancer and his physiotherapist worked with him to get him up and moving again after two weeks unconscious. The physiotherapist has been gentle and encouraging and compassionate. Thank you."*

Adult Mental Health*: "Thank you so much for giving me hope to start the day treatment and showing me I have the power to be strong and assertive. I cannot thank you enough, you are amazing."*

Was there anything we could have done better?

"You need a serious review of how your department is being run, and an urgent training session on how to treat patients"

"If you can't be bothered to staff the appointment system, then at least let the referring GP make the appointment or indeed the patient"

You said, we did

As a result of the feedback we have received in the last year we have carried out the following improvements across our services:

Podiatry Service – A large number of our Reception staff have been re-trained and provided with guidance on how to confirm which type of clinical appointment is required for patients. The signage at the Podiatry Clinic in Gosport War Memorial Hospital has been improved to make it clearer to visitors what clinics are running and the directions to the waiting area.

Specialist School Nursing Service – All staff who escort children to their homes have now received appropriate training for when oxygen is required to be transported with the patient. The Service will make every effort to be clear and precise as to the nature of the child's changes to support the family in making appropriate provision when transporting the child home.

Adult Mental Health Service (Crisis Resolution Home Treatment Team): Staff will now contact patients if any delay in home visits is expected to avoid any distress or confusion for patients.

Adult Mental Health – Psychological Therapies: Due to poor accessibility, the Service plans to relocate to other premises which provide more facilities for disabled clients.

Physiotherapy Service: In future Physiotherapists will inform the Reception staff of any delays, so that patients can be kept informed at all times.

The Physiotherapy Service has now made a change of practice for patients within Intensive Therapy Unit who need to spend some time sitting out of their bed. It is now clearly documented and displayed on a whiteboard for staff and patients to be aware of the time recommended that a patient should be sat out of bed for.

Rapid Response (Community Nursing Service): Following a breakdown in procedure which caused delay in providing information, the Rapid Response Service has now introduced electronic fax transmissions rather than relying on manual faxing.

Wheelchair Service: The Service has recently started a sub store, which will enable patients to gain access to a basic wheelchair whilst they are waiting for their own specialist chair to be ordered.

Sexual Health Service: The Service has recently introduced a number of changes to protect patient confidentiality at the St.Mary's Campus in Portsmouth. New registration forms, designated receptionist for client who have booked appointments and separate waiting areas. All staff are fully trained in customer care and confidentiality. Also in future patients who consent to having their results via a text message will only receive a brief message with no details of the sender.

PART 3

3.1 Priorities for Quality Improvement in 2013/14

In drawing up our priorities for improvement in 2013/14, we have taken into consideration our progress against last year's priorities, and also considered the local, regional and national picture, our overall performance and the views of patients, our governors, commissioners and patient representatives from our Local Involvement Networks (Healthwatch).

The following priorities have been endorsed by the Trust Board. In addition, there is a good deal of other work to improve the quality of patient care and the patient experience which is also reported upon at Trust Board.

PATIENT SAFETY

PRIORITY 1: To reduce the number of pressure ulcers that following investigation are deemed to be acquired within Solent NHS Trust's care by 35%

Why have we chosen this priority? Pressure ulcers develop when a large amount of pressure is applied to an area of skin over a short period of time, or they can occur when less force is applied but over a longer period of time.

Treating and caring for people in a safe environment and protecting them from avoidable harm is a key priority for Solent NHS Trust therefore, preventing the incidence of newly acquired pressure ulcers continues to be a key focus for improvement.

The Trust acknowledges that, whilst at times we care for a very complex and vulnerable patient group, we must do everything we can to prevent a newly acquired pressure ulcer occurring while a patient is under our care, whether that be on our inpatient wards or for a patient who is at home and receiving care from our Community / District Nurse Teams.

We also acknowledge that many of our patients move throughout different healthcare environments (such as the acute hospitals, to rehabilitation wards and then to their own home or to a Care Home). It is therefore essential that our Nursing staff communicate clearly and effectively with other Nursing or Care Teams to ensure that the correct equipment and support is available at all times.

How will we improve? The Trust has a clear process for the reporting and recording of all pressure ulcers. However, whilst this system works well we think we can improve further.

Within the year we intend to introduce a new Pressure Ulcer Panel. This will be an expert panel that will review any pressure ulcer within our care with the Nursing Team that care for the patient. This will follow and review the investigation process that has taken place and will help the team to identify key learning and actions to be taken. This will be monitored through the Trust's Governance and Risk strategies through out Assurance Committee.

We will then ensure that the results from our Pressure Ulcer Panel are available for external review and scrutiny by our Commissioning Body.

There are key national and local agendas that we will continue to develop within the Trust to inform our practice and improve patient safety and experience such as the Safety Thermometer, Your Skin Matters and NICE Guidance.

We know key areas of improvement are ensuring:

- Early identification of patients at risk of developing pressure ulcers
- Prompt assessment and delivery of essential equipment
- Monitoring pressure ulcers already acquired and preventing deterioration.

How will we measure our improvement? Through the Pressure Ulcer Panel we will monitor our compliance against the key standards for the prevention and reduction of pressure ulcers. This will also provide a monthly report for the Trust Board and will monitor and track sustained improvement. This will also give us the ability to identify areas of concern and to monitor their improvement.

The learning and actions from the Pressure Ulcer Panel will be monitored at both Trust and Local level, within individual teams being accountable for their learning development.

Continued training and education throughout the organisation will be maintained and we will ensure that nurses and care staff joining our organisation receive the correct education and are fully competent to assess and care for patients with pressure ulcers prior to be allowed to work independently.

What will our targets be for next year? In the year ahead we aim to reduce the number of pressure ulcers that following investigation are deemed to be acquired within Solent NHS Trust's care by 35%

We will work alongside our partners to develop a whole systems approach regarding the prevention and management of pressure ulcers. This will ensure that our most vulnerable patients who are at risk of developing (or have developed) a pressure ulcer can be monitored and reviewed wherever they are in the healthcare system.

How will we monitor and report our improvement? Solent NHS Trust is committed to sustained improvement and therefore the Nursing and Quality Corporate teams will work in liaison with the Pressure Ulcer Panel to ensure robust reporting and recording of all pressure ulcers acquired either within or external to our

care.

In turn this will continue to form part of the monthly Board Report and will also be monitored through the local and Trust Governance agendas.

PRIORITY 2: Improve the detection and management of medically deteriorating patients in our care (reduction in incidents)

Why did we make this a priority? Identification and management of patients whose medical condition is deteriorating is an important part of ensuring that people have the best possible outcome and a good experience of care. We know that the outcome for the patient is better if any deterioration is recognised promptly and measures are taken to treat the illness by well trained staff and sufficient senior staff.

By using robust and reliable early warning systems and standard ways of communicating concerns about a patient who is deteriorating, we are treating our patients more effectively.

What will our targets be for next year? For 2013/14 we will continue with this work, focussing very much on early identification and action for these patients. We know that our staff are good at timely and accurate observations, and also good at recording the early warning scores.

Our focus in the year ahead will be to ensure that once a patient 'triggers' (i.e. has a warning score which indicates that they will be in trouble) the correct processes for calling senior staff are followed. This includes calling an ambulance, where necessary, and that call comes from nurses, if necessary, rather than waiting to go through a hierarchy of doctors. All inpatient units will use an early warning system along with SBAR (Situation, Background, Assessment, Recommendation and Reply) communication tool.

How will we monitor and report our improvement? By carrying out regular audits throughout the year and reporting to the Divisional Governance Groups. In order to measure performance, key performance indicators have been identified as follows:

Measure	Source of Data	Frequency of Collection	Data collected and Reported by
Month by month improvement in the compliance with early warning score	Inpatient audits	Monthly	Quality Team
Number of SIRIs relating to failure to rescue deteriorating patients	Risk Team	Monthly	Quality Team
Appropriate escalation following triggering as laid out in the early warning score policy	Inpatient audits	Monthly	Quality Team
Appropriate action taken by senior staff when consulted as a result of escalation	Inpatient audits	Monthly	Quality Team
The use of the SBAR (Situation,Background,Assessment,Recommendation and Reply) communication tool	Inpatient audits	Monthly	Quality Team

PATIENT EXPERIENCE

PRIORITY 3: Incrementally roll out real time capture of patient experience

Why have we chosen this priority? It is essential that we are able to understand how our patients feel about the experience that they have in our care in order to improve services. During the past year we have been able to greatly increase the amount of feedback we have obtained from the users of our services and make improvements.

During this time we have been developing our survey methods, including increasing the use of electronic tablets and other devices which will allow the results to be reported back to services in real time enabling rapid changes and improvements to be made to services.

These methods will be spread to cover all services increasing the amount of reporting available in real time.

An improvement priority in our operating plan Corporate objectives 1 and 3 and within the NHS Outcomes framework domain 4.

How will we improve? Our aim is for 100% of services to capture user feedback on a regular basis throughout the year and to develop improvements as a result of the feedback.

How will we measure our improvement? All services' plans for patient surveys will be closely monitored and achievements and progress reported on a monthly basis.

What will our targets be for next year? We aim to increase the amount of real time reporting of user feedback with a target of 25% of services within the year.

How will we monitor and report our improvement? Patient experience service will collate survey activity and results for the organisation's cumulative percentage of services carrying out surveys within the year.

CLINICAL EFFECTIVENESS

PRIORITY 4: Reduce number of amputations in patients with diabetes

Why have we chosen this priority? Building on the excellent work carried out over the last year, we plan to continue to reduce amputation rates working with other providers of NHS care to achieve a 50% reduction by 2017.

How will we improve? We will continue to improve access for patients to podiatry care with a skilled and highly competent workforce. We will play an increasing role in the diabetes care pathway.

How will we measure our improvement? By measuring the reduction rates in amputations; monitoring the reduction in referral to treatment waiting times; access to new ways of managing foot ulceration; audit of outcomes.

What will our targets be for next year? The continual reduction in amputation rates throughout our regions.

How will we monitor and report our improvement? Annual performance linked to clinical outcomes; reduction in late referrals to the Podiatry Service.

PRIORITY 5: Improve the physical health of adult mental health service users
Why have we chosen this priority? Building on the excellent work carried out and acknowledged by the CQC visits to adult mental health in patient units, we will continue make care planning for long term physical health conditions in mental health a priority.
How will we improve? We will improve our management of, and our care planning for, patients with long term physical health conditions. Regular training sessions for all levels of clinical staff will be undertaken.
How will we measure our improvement? By auditing the care plans in the Adult Mental Health; monitoring the quality of care planning by monthly auditing and monitoring action plans at the Adult Mental Health Divisional Governance Group meetings.
What will our targets be for next year? All Adult Mental Health patients will have completed care plans with their identified physical health needs.
How will we monitor and report our improvement? We will monitor all care plans and update these on a regular basis and carry out regular audits throughout the year and report our improvement to the Divisional Governance Groups.

PRIORITY 6: Increase the coverage of the Health Child Programme (Health visiting and school nursing)
Why have we chosen this priority? We want to be able show what difference we are making to the mental health of children and young people in our care.
How will we improve? We will have pre and post outcome measures in place for all teams and for 100% of clients who are willing to take part.
How will we measure our improvement? Through a range of validated outcome tools.
What will our targets be for next year? We aim to have 80% of completed episodes of care show improvements.
How will we monitor and report our improvement? By producing annual outcomes report we will be able to monitor our progress in this area.

PRIORITY 7: Ensure Appropriate Staffing Levels
Why have we chosen this priority? There is a need to transform services to ensure that the best services can be provided within the resources available. This has led to changes to staffing levels.
How will we improve? All service areas will have a staffing establishment which has been agreed and signed off by the Division's Medical Lead, Nursing and Allied Health Professions leads as being safe and effective.
How will we measure our improvement? To benchmark against national benchmarks where they exist or against self determined benchmarks.
How will we monitor and report our improvement? Progress towards this target will be reported quarterly through our Divisional Governance Forums.

3.2 How will we monitor the progress of our quality priorities throughout the coming year?

We have a dedicated committee focussed on reviewing the safety, quality and effectiveness of our services. This committee (known as the Assurance Committee) will monitor our progress throughout the year.

Comms - STRUCTURE CHART TO BE INSERTED

Statements from our Stakeholders

To be inserted following consultation…..

GLOSSARY

BME - Black and Minority Ethnic people
The Department of Health has published *'Delivering Race Equality in Mental Health Care'*, a five year action plan for tackling discrimination and achieving equality in services for black and minority ethnic patients and communities.
CAMHS - Child and Adolescent Mental Health Services
NHS provided services for young people with mental health disorders.
CPA - Care Programme Approach
The system or framework by which care is arranged and managed. It remains at the centre of current Mental Health policy, supporting individuals who experience severe and enduring Mental Health problems to ensure that their needs and choices remain central in what, are often, complex systems of care.
CCG - Clinical Commissioning Groups
Previously these were Primary Care Trusts. They commission hospital and Mental Health services from appropriate NHS Trusts or from the private sector.

CDW - Community Development Worker
Work with and support communities including the Black and Minority Ethnic (BME) voluntary sector and ensure the views of the minority communities are taken into account during planning and delivery of services.
Clinical Pathway
One of the main tools used to manage the quality in healthcare concerning the standardisation of care processes. It has been proven that their use reduces the changes in clinical practice and improves patient outcomes.
CQC - Care Quality Commission
The independent regulator of health and social care in England, aiming to make sure better care is provided for everyone in hospitals, care homes and people's own homes. www.cqc.org.uk
CQUIN - Commissioning for Quality and Innovation
Measures whether trusts achieve quality goals or an element of the quality goal. The achievements are on the basis of which CQUIN payments are made.
CRHT - Crisis Resolution Home Treatment Teams
Provide intensive support for people in mental health crises in their own home: they stay involved until the problem is resolved. Designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers.
HQIP - Healthcare Quality Improvement Partnership
Promotes quality in healthcare through clinical audit.
LINk - Local Involvement Network
Previously networks of local people and community groups who want to improve social care and healthcare in their local area.
LTC - Long term condition
Long term conditions (also called chronic conditions) are health problems that require ongoing management over a period of years or decades. They include a wide range of health conditions including diabetes, chronic obstructive pulmonary disease and cardiovascular disease.
MDT – Multi disciplinary Team
Multi disciplinary teams are groups of professionals from different areas who come together to provide comprehensive assessment and consultation.
Monitor - Independent Regulator of NHS Foundation Trusts.
www.monitor-nhsft.gov.uk

MRSA - Methicillin-resistant Staphylococcus aureus
A bacterium responsible for several difficult-to-treat infections in humans.
MUST – Malnutrition Universal Screening Tool
A five step screening tool to identify patients who are malnourished, at risk of

malnutrition or obese. It also includes management guidelines which can be used to develop a care plan.

NAS - National Audit of Schizophrenia

This enables clinicians who treat people with schizophrenia in the community to assess the quality of their prescribing of antipsychotic drugs and of their monitoring of service users' physical health. It also supports them to monitor service users' experience of treatment and its outcomes, plus carers' satisfaction with information and support.

NICE - The National Institute of Health and Clinical Excellence

Provides guidance and support to healthcare professionals and others to ensure that the care provided is of the best possible quality and offers the best value for money. They also provide independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

NIHR - National institute for Health Research

Commissions and funds research. www.nihr.ac.uk

NPSA - National Patient Safety Agency

Established in 2001 with a mandate to identify patient safety issues and find appropriate solutions.

OFSTED - Office for Standards in Education

OFSTED is the Office for Standards in Education, Children's Services and Skills. It reports directly to Parliament and is independent and impartial.

OBD – Occupied bed day

An occupied bed day is defined as a hospital bed which has been used for at least one day case admission during the day.

PLACE - Patient Lead Assessment of the Care Environment

An annual assessment of food and cleanliness of inpatient healthcare sites in England that have more than 10 beds.

SPA - Single Point of Access

The Single Point of Access (SPA) service provides a first point of contact for people accessing our community services.

TeleHealth

The use of technology to deliver health and/or social care at a distance and the remote monitoring of a patient's medical condition in their own homes, i.e. blood pressure, ECG or weight.

UKROC - UK specialist Rehabilitation Outcomes Collaborative

UTI - Urinary Tract Infection

A urinary tract infection is an infection that can happen anywhere along the urinary tract, i.e. bladder, kidneys, ureters and urethra.

VTE - Venous Thromboembolism

A blood clot that forms within a vein. Thrombosis is a medical term for a blood clot occurring inside a blood vessel. A classic venous thrombosis is deep vein thrombosis (DVT), which can break off and become a life-threatening pulmonary embolism (PE). The conditions of DVT and PE are referred to collectively with the term venous thromboembolism.

Voluntary Sector - Is a term used to describe those organisations that focus on wider public benefit as opposed to statutory service delivery or profit.

Publishing our Quality Account

Our Quality Account is published on NHS Choices and can be downloaded from our own website on **www.solent.nhs.uk.** We are also planning to produce an "easy to read" version of this Quality Account and this can be obtained by contacting our Communications Team – details below.

GET INVOLVED AND JOIN US AS A MEMBER TO HAVE YOUR SAY IN THE FUTURE OF THE TRUST

As we become an NHS Foundation Trust we are building up a thriving membership list made up of local people and staff. If you would like to work with us and have a say in the decisions made about our healthcare services, please get in touch with our Communications Team on **e-mail: communications@solent.nhs.uk or telephone: 023 8060 8937**

Or write to our Chief Executive, Dr Ros Tolcher, Solent NHS Trust, Adelaide Health Centre, William Macleod Way, Southampton SO16 4XE

YOUR FEEDBACK IS IMPORTANT TO US

We are keen to ensure that the Quality Account is a useful document which helps patients, families and the public to understand our priorities for delivering quality care to our patients.

Although the Department of Health tell us some of the content we have to include, and all NHS Trusts have to do this, the Quality Account also gives us an opportunity to include local quality initiatives and your feedback on these is important to us.

Please tell us what you think about our Quality Account by simply filling in the evaluation form below, tear from this document, fold and stick along the gummed edges - then pop into a post box. No postage is required.

THANK YOU FOR YOUR TIME

Evaluation form

Did you find the Quality Account (tick all that apply)

Easy to read	□
Easy to understand	□
Informative	□
Helpful	□
Interesting	□

Other (please specify below)

.....

What best describes you?
Please delete as appropriate: Patient / Carer / Public / Staff / Other (please specify):

.....

Which sections stood out for you?

.....

Why did they stand out?

.....

Would you like to receive the Quality Account?

by email	□
by post	□

Please state your email or postal address:

.....

How can we improve future Quality Accounts?

.....
.....
.....

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST: QUALITY ACCOUNT 2012/13		
DATE OF DECISION:		23 MAY 2013		
REPORT OF:		UHS, DIRECTOR OF NURSING		
CONTACT DETAILS				
AUTHOR:	**Name:**	Judy Gillow	Tel:	023 8079 4953
	E-mail:	Judy.Gillow@uhs.nhs.uk		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This is a draft of the UHS quality account for 2012/13 which will be published in June of this year. The account reports on progress in meeting the targets set for the year 2012/13 as well as looking ahead to set priorities for the year 2013/14.

Members are invited to review the priorities for 2013/14 and comment on them as well as noting the progress made during 2012/13. Members should note that due to the current availability of data, some items of information particularly in relation to clinical audit are missing and will be added in before publication.

RECOMMENDATIONS:

(i) That the Panel notes the information set out in this report

REASONS FOR REPORT RECOMMENDATIONS

1. To give the Panel an update on the plans and priorities for the University Hospital Southampton Trust

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2 None

DETAIL (Including consultation carried out)

3. The University Hospital Southampton (UHS) Draft Quality Account and Quality Report for 2012/13 is attached at Appendix 1. The draft of this report has been shared widely with staff, commissioners, community partners and other key stakeholders

4. The priorities identified by the UHS for 2013/14 are:

Patient Improvement Framework:

Priority 1

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

Priority 2

To improve the trust's performance in the measures that are included in the

national safety thermometer which is part of the strategy for harm free care

Priority 3

To improve the care of UHS patients with diabetes

Patient experience priorities

Priority 1

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

Priority 2

To improve the experience women have of our maternity services

Priority 3

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

Priorities for outcomes and clinical effectiveness

Priority 1

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

Priority 2

Improve outcomes for deteriorating patients in hospital which contributes to mortality rate

Priority 3

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

5. The Panel is invited to note the priorities and issues outlined in the draft Quality Account attached at Appendix 1 and feedback their comments to the University Hospital Southampton Trust.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None

Property/Other

7. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. None

Other Legal Implications:

9. None

POLICY FRAMEWORK IMPLICATIONS

10. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	University Hospital Southampton NHS Foundation Trust Draft Quality Account & Quality Report 2012/13

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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APPENDIX 1

University Hospital Southampton NHS Foundation Trust

Our Quality Account & Quality Report 2012 13

DRAFT for comment

High quality care for our patients

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

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

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

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

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

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

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

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

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

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

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

Mark Hackett
CEO

(sign and date)

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

Provides: hospital services for people with acute health problems.

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

Delivers: the regional specialist hospital services for central Southern England

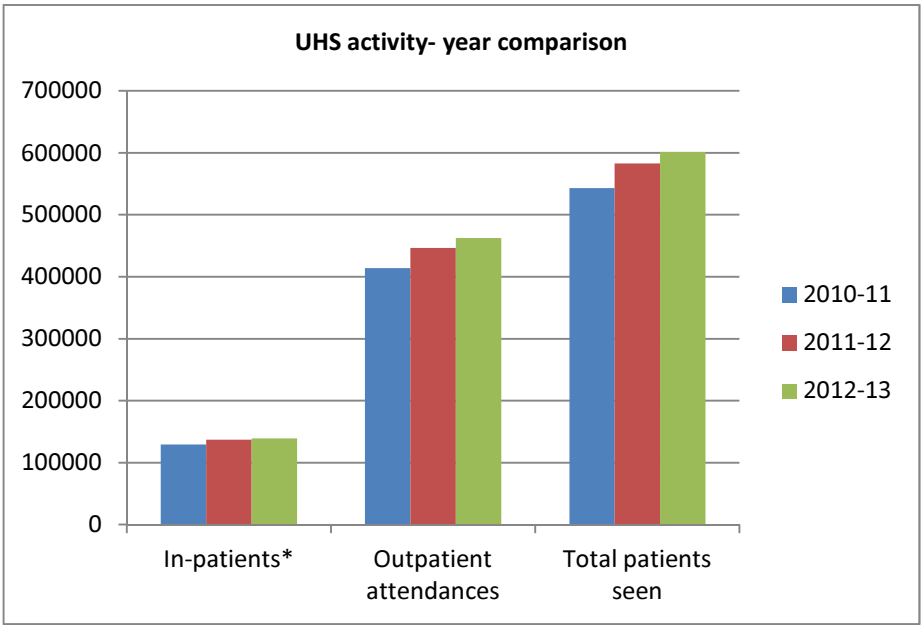
major research programmes to develop the treatments of tomorrow

training and education of the next generation of hospital staff

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

<in a box> Activity levels during 2012/13

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



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

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

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

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

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

<Section heading> Our priorities for improving quality

Developing **our priorities for 2013/14**

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

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

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

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

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

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

We assessed each potential improvement priority by asking;

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

A review of our performance for clinical quality

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

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

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

Clinical incidents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority 3
To improve the care of UHS patients with diabetes

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

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

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

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

Patient experience priorities

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

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

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

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

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

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

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

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

Priority 3

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

Why it's important

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

Our Aim 2013/2014

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

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

Priorities for outcomes and clinical effectiveness

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

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

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

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

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

To improve coding accuracy.

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

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

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

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

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

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

Statements of Assurance from the Trust Board

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

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

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

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

Participation in clinical audits:

Clinical audit statements

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

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

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

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

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

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

The national clinical audits and national confidential enquiries that UHS participated in, and for which data collection was completed during 2012/13, are listed below in Table A alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. (column 1 of Table A) and percentages (column 5 of Table A)

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

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

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

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

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

Table B: Local clinical audits, and actions

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

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

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

Table C

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

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

Research:

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

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

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

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

Our goals agreed with the commissioners

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

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

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

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

UHS; Our CQUIN priorities for 2012/13

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

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

What others say about University Hospital Southampton NHS Foundation Trust

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our data quality:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our standard core indicators of quality

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

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

a) the national average for the same; and

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

Our hospital mortality rating

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

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

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

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

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

Below, our SHMI rating falls within the nationally expected range

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Below, our PROMS rating falls within the nationally expected range

PROMS (iii) hip replacement surgery

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

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

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

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

PROMS (iv) knee replacement surgery

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

Our readmissions rate for children and adults

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

(i) 0 to 14; and

(ii) 15 or over,

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

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

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

Readmissions within 28 days <16

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

Readmissions within 28 days 16+

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

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

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

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

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

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

Responsiveness to Personal Needs of patients

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 3 - Review of our services in 2012/13

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

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

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

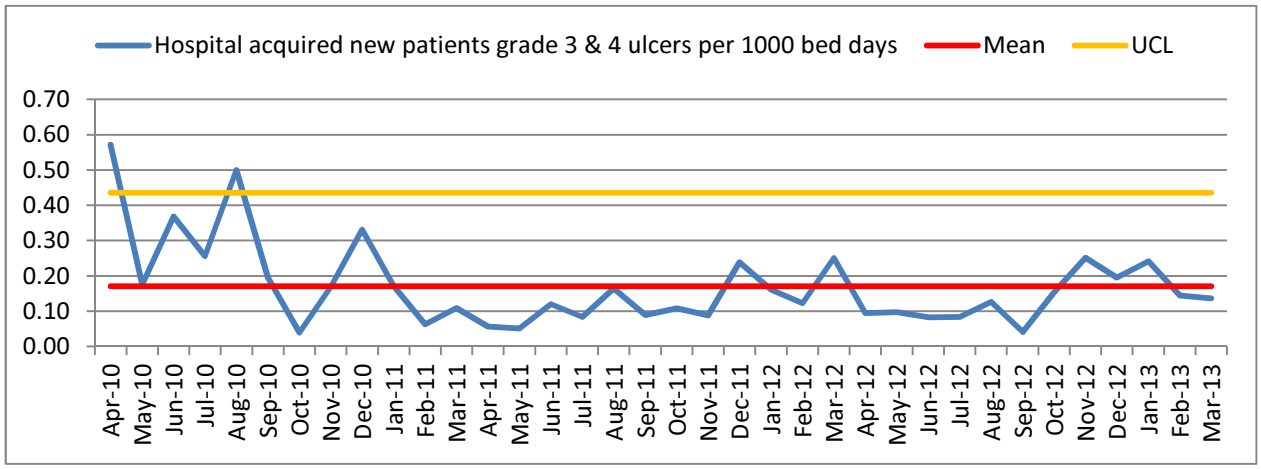
Patient safety priorities: Our 2012 13 progress

Pressure Ulcers

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

Our results for 2012 13 were:

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



What we did

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

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

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

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

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

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

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

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

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

Implementation of regular safety walkabouts

Reviewing how safety information is communicated.

To Improve Diabetes Care:

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

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

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

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

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

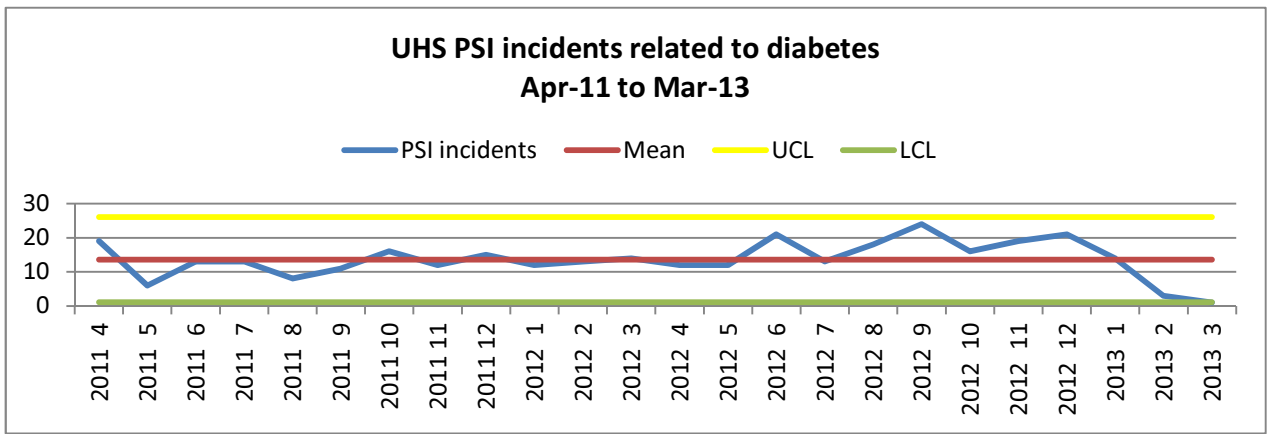
The application has had over 1300 downloads nationally and internationally from the Apple iPhone App Store since its launch, and is rated five stars in reviews.

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

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

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

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

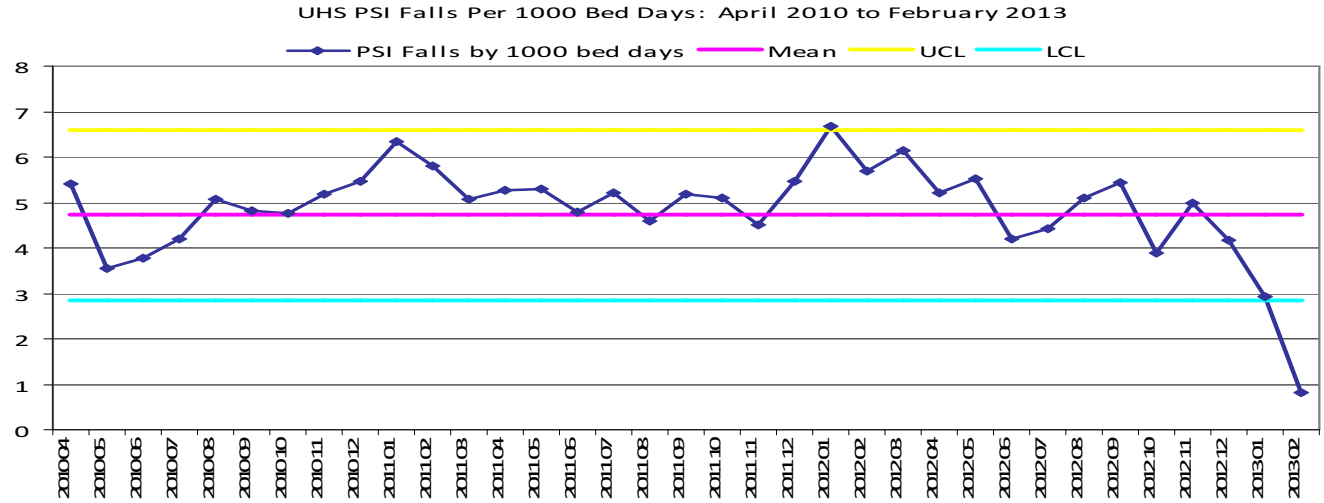


There has been an increase incident reporting related to diabetes however this should be seen as part of an improvement journey with the first step being to improve reporting and reliability of future measurement. The incidents are analysed and shared with ward teams to support understanding and learning.

Falls

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

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



What we did

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

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

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

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

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

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

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

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

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

Patient Experience priorities: Our 2012 13 progress

Nutrition & Hydration

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

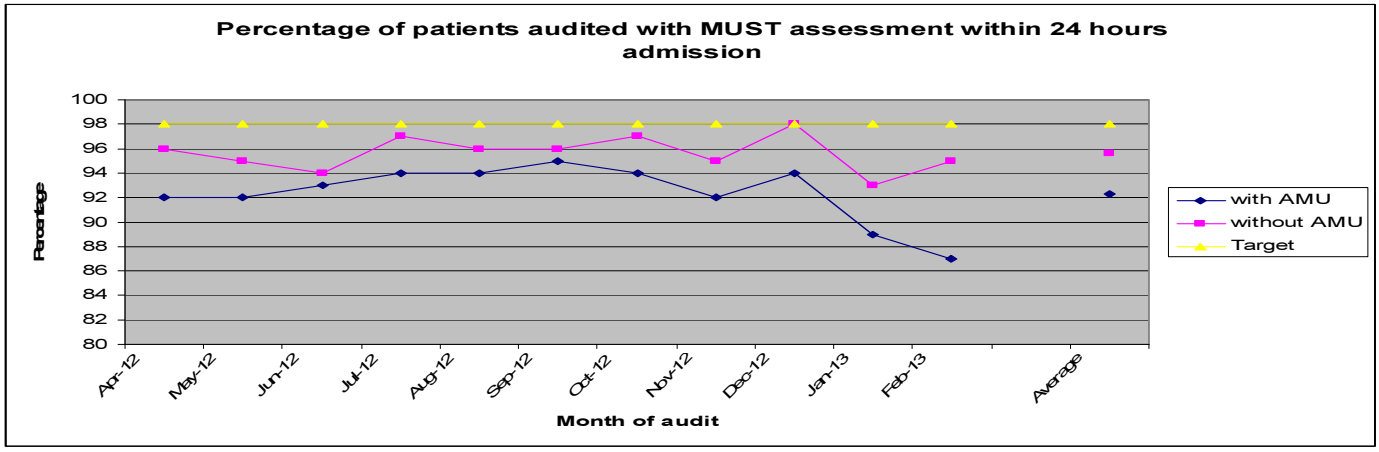
Our results for 2012 13 were:
Nearly 90% of wards now manage a protected mealtime for patients
Our MUST screening compliance is improved to 91.9%
86% of patients that need one, have a nutritional care plan

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

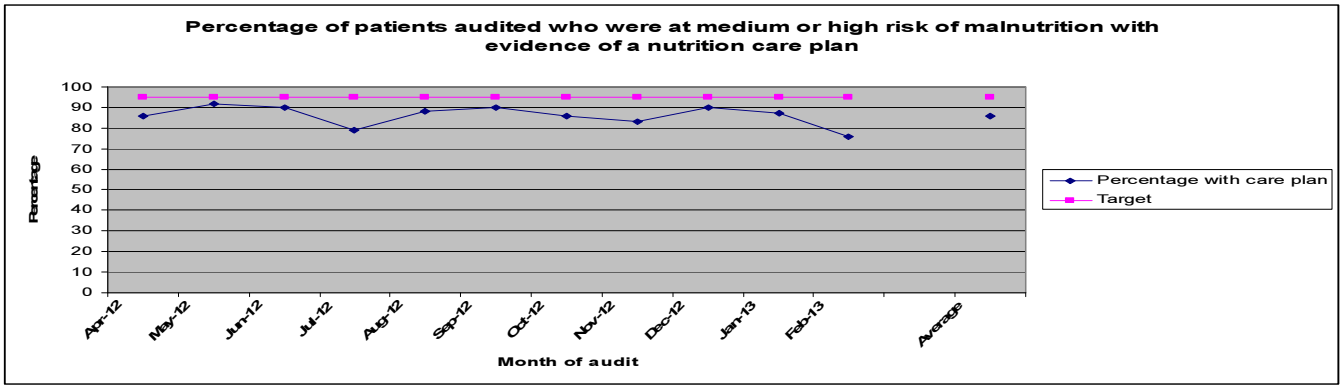
Protected mealtimes
We identified this as a priority issue for our patients through listening to patient feedback received in 2011 that only 60% of our wards were able to implement this.

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

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



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



Improve Patient Communication: discharge planning and patient information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What we did

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

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

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

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

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

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

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

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

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

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

Patient Outcomes priorities: Our 2012 13 progress

Reducing the Trust's Hospital Standardised Mortality Rate

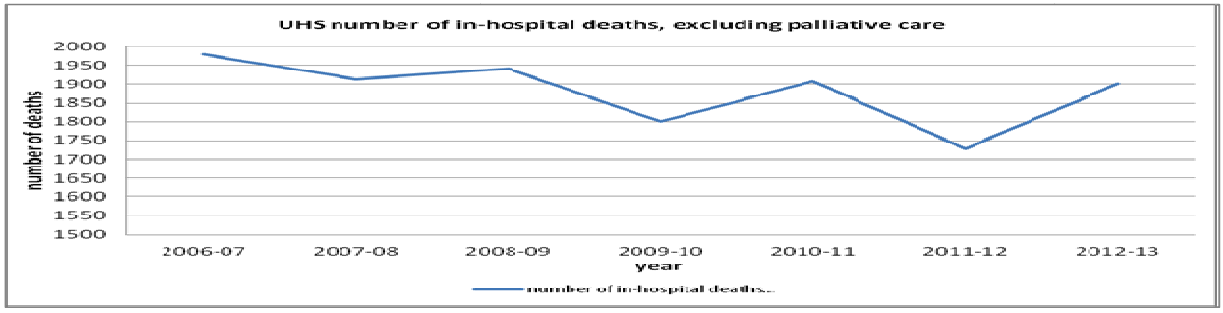
In 2012/13, our Aim was: To reduce the Trust's overall HSMR to 95 by the end of March 2013.

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

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

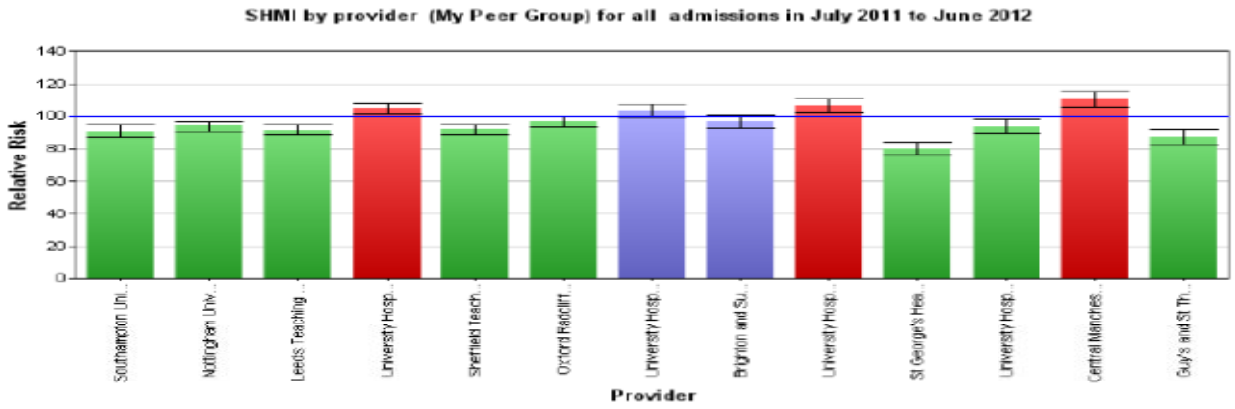
The number of patient deaths in the Trust has continued to fall gradually over the past 6 years. We track this as close to real-time as possible. Our areas of work to improve our mortality rates during last year focused on practical developments and on improving our communications and information systems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

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

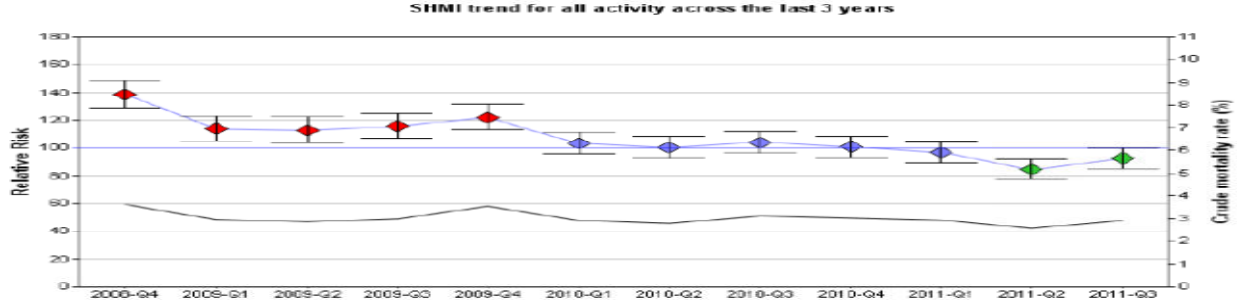


Our SHMI performance compared to other hospitals is demonstrated below (UHS on far left of graph).

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



SHMI trend for all activity across the last 3 years



What we did

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Education and training To include staff that only work nights

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

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

Improving Night Time Safety

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

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

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

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

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

Identifying deteriorating patients more quickly, to improve outcomes

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

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

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

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

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

Intensive Care outcomes for Children

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

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

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

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

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

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

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

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

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

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

Further Information about our Trust

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

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

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

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

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

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

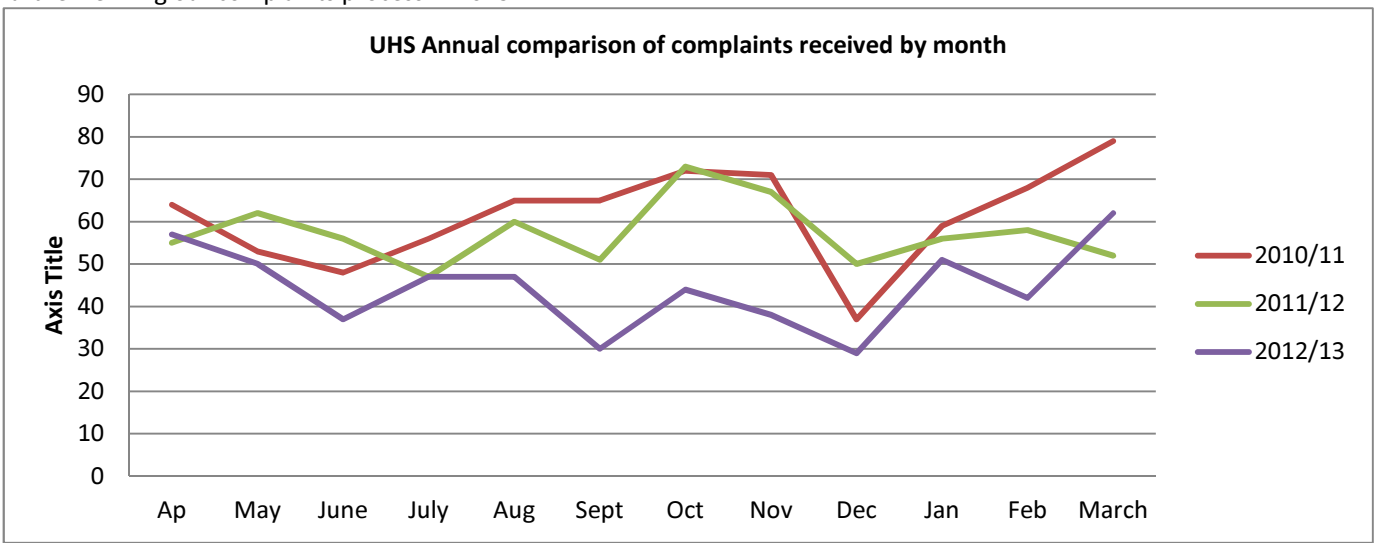
Patient feedback
Patients and visitors are able to give us feedback on the care we provide via our website, email, comment cards, enquiries through our patient support service/PALS and the NHS Choices website. We have used this feedback to help inform the priorities we have set for quality and to engage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

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

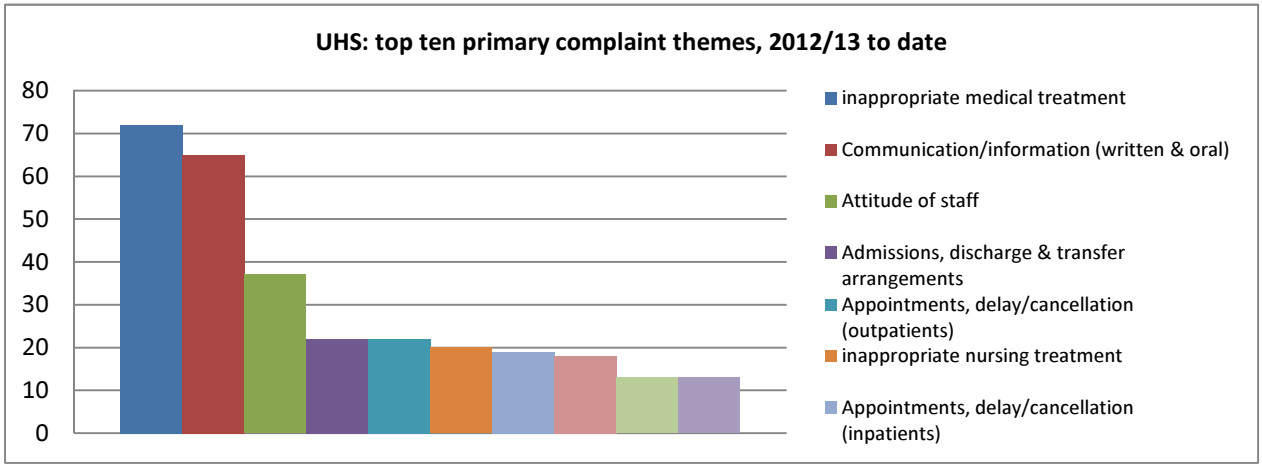
40% praise for services and/or staff
12% delays or waiting times
9% facilities
8% attitude of staff
7% food

Complaints

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



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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

Statement of Directors' responsibilities in respect of the quality report

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

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

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

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

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

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

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

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

Board minutes and papers for the period April 2012 to June 2013

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

Feedback from the commissioners dated XX/XX/20XX

Feedback from governors dated XX/XX/20XX

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

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

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

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

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

CQC quality and risk profiles dated 31/03/2013

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

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

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

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

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

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

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

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

NHS Commissioning Board Statement (1 page)

Southampton LINKs final support statement: (1 page)

UHS Members Council final statement (1 page)

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